

Calendar No. **175****AMENDMENT NO. 2786**

Purpose: In the nature of a substitute.

IN THE SENATE OF THE UNITED STATES—111th Cong., 1st Sess.**H. R. 3590**

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

November 19, 2009

Ordered to lie on the table and to be printed

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

Viz:

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

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL
AMERICANS

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

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

“PART A—INDIVIDUAL AND GROUP MARKET REFORMS

“SUBPART II—IMPROVING COVERAGE

“Sec. 2711. No lifetime or annual limits.

“Sec. 2712. Prohibition on rescissions.

“Sec. 2713. Coverage of preventive health services.

“Sec. 2714. Extension of dependent coverage.

“Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions.

“Sec. 2716. Prohibition of discrimination based on salary.

“Sec. 2717. Ensuring the quality of care.

“Sec. 2718. Bringing down the cost of health care coverage.

“Sec. 2719. Appeals process.

Sec. 1002. Health insurance consumer information.

Sec. 1003. Ensuring that consumers get value for their dollars.

Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1101. Immediate access to insurance for uninsured individuals with a pre-existing condition.

Sec. 1102. Reinsurance for early retirees.

Sec. 1103. Immediate information that allows consumers to identify affordable coverage options.

Sec. 1104. Administrative simplification.

Sec. 1105. Effective date.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

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

“SUBPART I—GENERAL REFORM

“Sec. 2701. Fair health insurance premiums.

“Sec. 2702. Guaranteed availability of coverage.

“Sec. 2703. Guaranteed renewability of coverage.

“Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status.

“Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status.

“Sec. 2706. Non-discrimination in health care.

“Sec. 2707. Comprehensive health insurance coverage.

“Sec. 2708. Prohibition on excessive waiting periods.

PART II—OTHER PROVISIONS

Sec. 1251. Preservation of right to maintain existing coverage.

Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.

Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

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

PART II—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH
HEALTH BENEFIT EXCHANGES

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

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

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

PART IV—STATE FLEXIBILITY TO ESTABLISH ALTERNATIVE PROGRAMS

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

PART V—REINSURANCE AND RISK ADJUSTMENT

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

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

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

SUBPART B—ELIGIBILITY DETERMINATIONS

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

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

PART II—SMALL BUSINESS TAX CREDIT

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

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

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

PART II—EMPLOYER RESPONSIBILITIES

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

Subtitle G—Miscellaneous Provisions

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

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

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

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

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

Subtitle C—Medicaid and CHIP Enrollment Simplification

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

Subtitle D—Improvements to Medicaid Services

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

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

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

Subtitle F—Medicaid Prescription Drug Coverage

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

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

- Sec. 2551. Disproportionate share hospital payments.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

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

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

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

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

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

Subtitle K—Protections for American Indians and Alaska Natives

Sec. 2901. Special rules relating to Indians.

Sec. 2902. Elimination of sunset for reimbursement for all medicare part B services furnished by certain indian hospitals and clinics.

Subtitle L—Maternal and Child Health Services

Sec. 2951. Maternal, infant, and early childhood home visiting programs.

Sec. 2952. Support, education, and research for postpartum depression.

Sec. 2953. Personal responsibility education.

Sec. 2954. Restoration of funding for abstinence education.

Sec. 2955. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

Sec. 3001. Hospital Value-Based purchasing program.

Sec. 3002. Improvements to the physician quality reporting system.

Sec. 3003. Improvements to the physician feedback program.

Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.

Sec. 3005. Quality reporting for PPS-exempt cancer hospitals.

Sec. 3006. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies.

Sec. 3007. Value-based payment modifier under the physician fee schedule.

Sec. 3008. Payment adjustment for conditions acquired in hospitals.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

Sec. 3011. National strategy.

Sec. 3012. Interagency Working Group on Health Care Quality.

Sec. 3013. Quality measure development.

Sec. 3014. Quality measurement.

Sec. 3015. Data collection; public reporting.

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.

Sec. 3022. Medicare shared savings program.

Sec. 3023. National pilot program on payment bundling.

Sec. 3024. Independence at home demonstration program.

Sec. 3025. Hospital readmissions reduction program.

Sec. 3026. Community-Based Care Transitions Program.

Sec. 3027. Extension of gainsharing demonstration.

Subtitle B—Improving Medicare for Patients and Providers

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

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

PART II—RURAL PROTECTIONS

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

PART III—IMPROVING PAYMENT ACCURACY

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

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

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

Subtitle E—Ensuring Medicare Sustainability

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

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

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- Sec. 3501. Health care delivery system research; Quality improvement technical assistance.
- Sec. 3502. Establishing community health teams to support the patient-centered medical home.
- Sec. 3503. Medication management services in treatment of chronic disease.
- Sec. 3504. Design and implementation of regionalized systems for emergency care.
- Sec. 3505. Trauma care centers and service availability.
- Sec. 3506. Program to facilitate shared decisionmaking.
- Sec. 3507. Presentation of prescription drug benefit and risk information.
- Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.
- Sec. 3509. Improving women's health.
- Sec. 3510. Patient navigator program.
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- Sec. 4001. National Prevention, Health Promotion and Public Health Council.
- Sec. 4002. Prevention and Public Health Fund.
- Sec. 4003. Clinical and community preventive services.
- Sec. 4004. Education and outreach campaign regarding preventive benefits.

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- Sec. 4101. School-based health centers.
- Sec. 4102. Oral healthcare prevention activities.
- Sec. 4103. Medicare coverage of annual wellness visit providing a personalized prevention plan.
- Sec. 4104. Removal of barriers to preventive services in Medicare.
- Sec. 4105. Evidence-based coverage of preventive services in Medicare.
- Sec. 4106. Improving access to preventive services for eligible adults in Medicaid.
- Sec. 4107. Coverage of comprehensive tobacco cessation services for pregnant women in Medicaid.
- Sec. 4108. Incentives for prevention of chronic diseases in Medicaid.

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- 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.

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- 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.
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- Sec. 4306. Funding for Childhood Obesity Demonstration Project.

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- Sec. 4401. Sense of the Senate concerning CBO scoring.
- Sec. 4402. Effectiveness of Federal health and wellness initiatives.

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- Sec. 5102. State health care workforce development grants.
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- 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.
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- 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.

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- Sec. 5302. Training opportunities for direct care workers.
- Sec. 5303. Training in general, pediatric, and public health dentistry.
- Sec. 5304. Alternative dental health care providers demonstration project.
- Sec. 5305. Geriatric education and training; career awards; comprehensive geriatric education.
- Sec. 5306. Mental and behavioral health education and training grants.
- Sec. 5307. Cultural competency, prevention, and public health and individuals with disabilities training.
- Sec. 5308. Advanced nursing education grants.
- Sec. 5309. Nurse education, practice, and retention grants.
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- Sec. 5404. Workforce diversity grants.
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- Sec. 5501. Expanding access to primary care services and general surgery services.
- Sec. 5502. Medicare Federally qualified health center improvements.
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- Sec. 5504. Counting resident time in outpatient settings and allowing flexibility for jointly operated residency training programs.
- Sec. 5505. Rules for counting resident time for didactic and scholarly activities and other activities.
- Sec. 5506. Preservation of resident cap positions from closed hospitals.
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- Sec. 5601. Spending for Federally Qualified Health Centers (FQHCs).
- Sec. 5602. Negotiated rulemaking 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.
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- Sec. 6003. Disclosure requirements for in-office ancillary services exception to the prohibition on physician self-referral for certain imaging services.
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- Sec. 6101. Required disclosure of ownership and additional disclosable parties information.
- 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.

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- 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.

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- Sec. 6121. Dementia and abuse prevention training.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

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

Subtitle D—Patient-Centered Outcomes Research

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

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

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

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

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- Sec. 6501. Termination of provider participation under Medicaid if terminated under Medicare or other State plan.
- Sec. 6502. Medicaid exclusion from participation relating to certain ownership, control, and management affiliations.
- Sec. 6503. Billing agents, clearinghouses, or other alternate payees required to register under Medicaid.
- Sec. 6504. Requirement to report expanded set of data elements under MMIS to detect fraud and abuse.
- Sec. 6505. Prohibition on payments to institutions or entities located outside of the United States.
- Sec. 6506. Overpayments.
- Sec. 6507. Mandatory State use of national correct coding initiative.
- Sec. 6508. General effective date.

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- 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 orders and summary seizures orders against plans that are in financially hazardous condition.
- Sec. 6607. Permitting evidentiary privilege and confidential communications.
- Sec. 6606. MEWA plan registration with Department of Labor.

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- Sec. 6701. Short title of subtitle.
- Sec. 6702. Definitions.
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- Sec. 6801. Sense of the Senate regarding medical malpractice.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

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- Sec. 7001. Short title.
- Sec. 7002. Approval pathway for biosimilar biological products.
- Sec. 7003. Savings.

Subtitle B—More Affordable Medicines for Children and Underserved Communities

- Sec. 7101. Expanded participation in 340B program.
- Sec. 7102. Improvements to 340B program integrity.
- Sec. 7103. GAO study to make recommendations on improving the 340B program.

TITLE VIII—CLASS ACT

- Sec. 8001. Short title of title.
- Sec. 8002. Establishment of national voluntary insurance program for purchasing community living assistance services and support.

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

Subtitle B—Other Provisions

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

1 **TITLE I—QUALITY, AFFORDABLE**
2 **HEALTH CARE FOR ALL**
3 **AMERICANS**

4 **Subtitle A—Immediate Improve-**
5 **ments in Health Care Coverage**
6 **for All Americans**

7 **SEC. 1001. AMENDMENTS TO THE PUBLIC HEALTH SERVICE**
8 **ACT.**

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

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

13 **“PART A—INDIVIDUAL AND GROUP MARKET**
14 **REFORMS”;**

15 (2) by redesignating sections 2704 through
16 2707 as sections 2725 through 2728, respectively;

17 (3) by redesignating sections 2711 through
18 2713 as sections 2731 through 2733, respectively;

19 (4) by redesignating sections 2721 through
20 2723 as sections 2735 through 2737, respectively;

21 and

22 (5) by inserting after section 2702, the fol-
23 lowing:

1 **“Subpart II—Improving Coverage**

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

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

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

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

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

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

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

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

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

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

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

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

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

25 “(b) INTERVAL.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish a minimum interval between the date on which
3 a recommendation described in subsection (a)(1) or
4 (a)(2) or a guideline under subsection (a)(3) is
5 issued and the plan year with respect to which the
6 requirement described in subsection (a) is effective
7 with respect to the service described in such rec-
8 ommendation or guideline.

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

11 “(c) VALUE-BASED INSURANCE DESIGN.—The Sec-
12 retary may develop guidelines to permit a group health
13 plan and a health insurance issuer offering group or indi-
14 vidual health insurance coverage to utilize value-based in-
15 surance designs.

16 **“SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.**

17 “(a) IN GENERAL.—A group health plan and a health
18 insurance issuer offering group or individual health insur-
19 ance coverage that provides dependent coverage of chil-
20 dren shall continue to make such coverage available for
21 an adult child (who is not married) until the child turns
22 26 years of age. Nothing in this section shall require a
23 health plan or a health insurance issuer described in the
24 preceding sentence to make coverage available for a child
25 of a child receiving dependent coverage.

1 “(b) REGULATIONS.—The Secretary shall promul-
2 gate regulations to define the dependents to which cov-
3 erage shall be made available under subsection (a).

4 “(c) RULE OF CONSTRUCTION.—Nothing in this sec-
5 tion shall be construed to modify the definition of ‘depend-
6 ent’ as used in the Internal Revenue Code of 1986 with
7 respect to the tax treatment of the cost of coverage.

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

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

1 cates including those representing individuals with limited
2 English proficiency, and other qualified individuals.

3 “(b) REQUIREMENTS.—The standards for the sum-
4 mary of benefits and coverage developed under subsection
5 (a) shall provide for the following:

6 “(1) APPEARANCE.—The standards shall en-
7 sure that the summary of benefits and coverage is
8 presented in a uniform format that does not exceed
9 4 pages in length and does not include print smaller
10 than 12-point font.

11 “(2) LANGUAGE.—The standards shall ensure
12 that the summary is presented in a culturally and
13 linguistically appropriate manner and utilizes termi-
14 nology understandable by the average plan enrollee.

15 “(3) CONTENTS.—The standards shall ensure
16 that the summary of benefits and coverage in-
17 cludes—

18 “(A) uniform definitions of standard insur-
19 ance terms and medical terms (consistent with
20 subsection (g)) so that consumers may compare
21 health insurance coverage and understand the
22 terms of coverage (or exception to such cov-
23 erage);

24 “(B) a description of the coverage, includ-
25 ing cost sharing for—

1 “(i) each of the categories of the es-
2 sential health benefits described in sub-
3 paragraphs (A) through (J) of section
4 1302(b)(1) of the Patient Protection and
5 Affordable Care Act; and

6 “(ii) other benefits, as identified by
7 the Secretary;

8 “(C) the exceptions, reductions, and limita-
9 tions on coverage;

10 “(D) the cost-sharing provisions, including
11 deductible, coinsurance, and co-payment obliga-
12 tions;

13 “(E) the renewability and continuation of
14 coverage provisions;

15 “(F) a coverage facts label that includes
16 examples to illustrate common benefits sce-
17 narios, including pregnancy and serious or
18 chronic medical conditions and related cost
19 sharing, such scenarios to be based on recog-
20 nized clinical practice guidelines;

21 “(G) a statement of whether the plan or
22 coverage—

23 “(i) provides minimum essential cov-
24 erage (as defined under section 5000A(f)
25 of the Internal Revenue Code 1986); and

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

5 “(H) a statement that the outline is a
6 summary of the policy or certificate and that
7 the coverage document itself should be con-
8 sulted to determine the governing contractual
9 provisions; and

10 “(I) a contact number for the consumer to
11 call with additional questions and an Internet
12 web address where a copy of the actual indi-
13 vidual coverage policy or group certificate of
14 coverage can be reviewed and obtained.

15 “(c) PERIODIC REVIEW AND UPDATING.—The Sec-
16 retary shall periodically review and update, as appropriate,
17 the standards developed under this section.

18 “(d) REQUIREMENT TO PROVIDE.—

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

1 “(A) an applicant at the time of applica-
2 tion;

3 “(B) an enrollee prior to the time of enroll-
4 ment or reenrollment, as applicable; and

5 “(C) a policyholder or certificate holder at
6 the time of issuance of the policy or delivery of
7 the certificate.

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

13 “(3) ENTITIES IN GENERAL.—An entity de-
14 scribed in this paragraph is—

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

19 “(B) in the case of a self-insured group
20 health plan, the plan sponsor or designated ad-
21 ministrator of the plan (as such terms are de-
22 fined in section 3(16) of the Employee Retirement
23 Income Security Act of 1974).

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

1 material modification in any of the terms of the plan
2 or coverage involved (as defined for purposes of sec-
3 tion 102 of the Employee Retirement Income Secu-
4 rity Act of 1974) that is not reflected in the most
5 recently provided summary of benefits and coverage,
6 the plan or issuer shall provide notice of such modi-
7 fication to enrollees not later than 60 days prior to
8 the date on which such modification will become ef-
9 fective.

10 “(e) PREEMPTION.—The standards developed under
11 subsection (a) shall preempt any related State standards
12 that require a summary of benefits and coverage that pro-
13 vides less information to consumers than that required to
14 be provided under this section, as determined by the Sec-
15 retary.

16 “(f) FAILURE TO PROVIDE.—An entity described in
17 subsection (d)(3) that willfully fails to provide the infor-
18 mation required under this section shall be subject to a
19 fine of not more than \$1,000 for each such failure. Such
20 failure with respect to each enrollee shall constitute a sep-
21 arate offense for purposes of this subsection.

22 “(g) DEVELOPMENT OF STANDARD DEFINITIONS.—
23 “(1) IN GENERAL.—The Secretary shall, by
24 regulation, provide for the development of standards
25 for the definitions of terms used in health insurance

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

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

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

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

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

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

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

20 “(a) QUALITY REPORTING.—

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

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

5 “(A) improve health outcomes through the
6 implementation of activities such as quality re-
7 porting, effective case management, care coordi-
8 nation, chronic disease management, and medi-
9 cation and care compliance initiatives, including
10 through the use of the medical homes model as
11 defined for purposes of section 3602 of the Pa-
12 tient Protection and Affordable Care Act, for
13 treatment or services under the plan or cov-
14 erage;

15 “(B) implement activities to prevent hos-
16 pital readmissions through a comprehensive
17 program for hospital discharge that includes pa-
18 tient-centered education and counseling, com-
19 prehensive discharge planning, and post dis-
20 charge reinforcement by an appropriate health
21 care professional;

22 “(C) implement activities to improve pa-
23 tient safety and reduce medical errors through
24 the appropriate use of best clinical practices,

1 evidence based medicine, and health informa-
2 tion technology under the plan or coverage; and

3 “(D) implement wellness and health pro-
4 motion activities.

5 “(2) REPORTING REQUIREMENTS.—

6 “(A) IN GENERAL.—A group health plan
7 and a health insurance issuer offering group or
8 individual health insurance coverage shall annu-
9 ally submit to the Secretary, and to enrollees
10 under the plan or coverage, a report on whether
11 the benefits under the plan or coverage satisfy
12 the elements described in subparagraphs (A)
13 through (D) of paragraph (1).

14 “(B) TIMING OF REPORTS.—A report
15 under subparagraph (A) shall be made available
16 to an enrollee under the plan or coverage dur-
17 ing each open enrollment period.

18 “(C) AVAILABILITY OF REPORTS.—The
19 Secretary shall make reports submitted under
20 subparagraph (A) available to the public
21 through an Internet website

22 “(D) PENALTIES.—In developing the re-
23 porting requirements under paragraph (1), the
24 Secretary may develop and impose appropriate

1 penalties for non-compliance with such require-
2 ments.

3 “(E) EXCEPTIONS.—In developing the re-
4 porting requirements under paragraph (1), the
5 Secretary may provide for exceptions to such
6 requirements for group health plans and health
7 insurance issuers that substantially meet the
8 goals of this section.

9 “(b) WELLNESS AND PREVENTION PROGRAMS.—For
10 purposes of subsection (a)(1)(D), wellness and health pro-
11 motion activities may include personalized wellness and
12 prevention services, which are coordinated, maintained or
13 delivered by a health care provider, a wellness and preven-
14 tion plan manager, or a health, wellness or prevention
15 services organization that conducts health risk assess-
16 ments or offers ongoing face-to-face, telephonic or web-
17 based intervention efforts for each of the program’s par-
18 ticipants, and which may include the following wellness
19 and prevention efforts:

20 “(1) Smoking cessation.

21 “(2) Weight management.

22 “(3) Stress management.

23 “(4) Physical fitness.

24 “(5) Nutrition.

25 “(6) Heart disease prevention.

1 “(7) Healthy lifestyle support.

2 “(8) Diabetes prevention.

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

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

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

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

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

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

3 “(3) on all other non-claims costs, including an
4 explanation of the nature of such costs, and exclud-
5 ing State taxes and licensing or regulatory fees.

6 The Secretary shall make reports received under this sec-
7 tion available to the public on the Internet website of the
8 Department of Health and Human Services.

9 “(b) ENSURING THAT CONSUMERS RECEIVE VALUE
10 FOR THEIR PREMIUM PAYMENTS.—

11 “(1) REQUIREMENT TO PROVIDE VALUE FOR
12 PREMIUM PAYMENTS.—A health insurance issuer of-
13 fering group or individual health insurance coverage
14 shall, with respect to each plan year, provide an an-
15 nual rebate to each enrollee under such coverage, on
16 a pro rata basis, in an amount that is equal to the
17 amount by which premium revenue expended by the
18 issuer on activities described in subsection (a)(3) ex-
19 ceeds—

20 “(A) with respect to a health insurance
21 issuer offering coverage in the group market,
22 20 percent, or such lower percentage as a State
23 may by regulation determine; or

24 “(B) with respect to a health insurance
25 issuer offering coverage in the individual mar-

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

7 “(2) CONSIDERATION IN SETTING PERCENT-
8 AGES.—In determining the percentages under para-
9 graph (1), a State shall seek to ensure adequate par-
10 ticipation by health insurance issuers, competition in
11 the health insurance market in the State, and value
12 for consumers so that premiums are used for clinical
13 services and quality improvements.

14 “(3) TERMINATION.—The provisions of this
15 subsection shall have no force or effect after Decem-
16 ber 31, 2013.

17 “(c) STANDARD HOSPITAL CHARGES.—Each hospital
18 operating within the United States shall for each year es-
19 tablish (and update) and make public (in accordance with
20 guidelines developed by the Secretary) a list of the hos-
21 pital’s standard charges for items and services provided
22 by the hospital, including for diagnosis-related groups es-
23 tablished under section 1886(d)(4) of the Social Security
24 Act.

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

5 **“SEC. 2719. APPEALS PROCESS.**

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

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

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

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

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

1 consumer protections set forth in the Uniform Ex-
 2 ternal Review Model Act promulgated by the Na-
 3 tional Association of Insurance Commissioners and
 4 is binding on such plans.”.

5 **SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.**

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

9 **“SEC. 2793. HEALTH INSURANCE CONSUMER INFORMA-**
 10 **TION.**

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

15 “(1) offices of health insurance consumer as-
 16 sistance; or

17 “(2) health insurance ombudsman programs.

18 “(b) ELIGIBILITY.—

19 “(1) IN GENERAL.—To be eligible to receive a
 20 grant, a State shall designate an independent office
 21 of health insurance consumer assistance, or an om-
 22 budsman, that, directly or in coordination with State
 23 health insurance regulators and consumer assistance
 24 organizations, receives and responds to inquiries and
 25 complaints concerning health insurance coverage

1 with respect to Federal health insurance require-
2 ments and under State law.

3 “(2) CRITERIA.—A State that receives a grant
4 under this section shall comply with criteria estab-
5 lished by the Secretary for carrying out activities
6 under such grant.

7 “(c) DUTIES.—The office of health insurance con-
8 sumer assistance or health insurance ombudsman shall—

9 “(1) assist with the filing of complaints and ap-
10 peals, including filing appeals with the internal ap-
11 peal or grievance process of the group health plan or
12 health insurance issuer involved and providing infor-
13 mation about the external appeal process;

14 “(2) collect, track, and quantify problems and
15 inquiries encountered by consumers;

16 “(3) educate consumers on their rights and re-
17 sponsibilities with respect to group health plans and
18 health insurance coverage;

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

22 “(5) resolve problems with obtaining premium
23 tax credits under section 36B of the Internal Rev-
24 enue Code of 1986.

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

12 “(e) FUNDING.—

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

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

1 **SEC. 1003. ENSURING THAT CONSUMERS GET VALUE FOR**
2 **THEIR DOLLARS.**

3 Part C of title XXVII of the Public Health Service
4 Act (42 U.S.C. 300gg-91 et seq.), as amended by section
5 1002, is further amended by adding at the end the fol-
6 lowing:

7 **“SEC. 2794. ENSURING THAT CONSUMERS GET VALUE FOR**
8 **THEIR DOLLARS.**

9 “(a) INITIAL PREMIUM REVIEW PROCESS.—

10 “(1) IN GENERAL.—The Secretary, in conjunc-
11 tion with States, shall establish a process for the an-
12 nual review, beginning with the 2010 plan year and
13 subject to subsection (b)(2)(A), of unreasonable in-
14 creases in premiums for health insurance coverage.

15 “(2) JUSTIFICATION AND DISCLOSURE.—The
16 process established under paragraph (1) shall re-
17 quire health insurance issuers to submit to the Sec-
18 retary and the relevant State a justification for an
19 unreasonable premium increase prior to the imple-
20 mentation of the increase. Such issuers shall promi-
21 nently post such information on their Internet
22 websites. The Secretary shall ensure the public dis-
23 closure of information on such increases and jus-
24 tifications for all health insurance issuers.

25 “(b) CONTINUING PREMIUM REVIEW PROCESS.—

1 “(1) INFORMING SECRETARY OF PREMIUM IN-
2 CREASE PATTERNS.—As a condition of receiving a
3 grant under subsection (c)(1), a State, through its
4 Commissioner of Insurance, shall—

5 “(A) provide the Secretary with informa-
6 tion about trends in premium increases in
7 health insurance coverage in premium rating
8 areas in the State; and

9 “(B) make recommendations, as appro-
10 priate, to the State Exchange about whether
11 particular health insurance issuers should be
12 excluded from participation in the Exchange
13 based on a pattern or practice of excessive or
14 unjustified premium increases.

15 “(2) MONITORING BY SECRETARY OF PREMIUM
16 INCREASES.—

17 “(A) IN GENERAL.—Beginning with plan
18 years beginning in 2014, the Secretary, in con-
19 junction with the States and consistent with the
20 provisions of subsection (a)(2), shall monitor
21 premium increases of health insurance coverage
22 offered through an Exchange and outside of an
23 Exchange.

24 “(B) CONSIDERATION IN OPENING EX-
25 CHANGE.—In determining under section

1 1312(f)(2)(B) of the Patient Protection and Af-
2 fordable Care Act whether to offer qualified
3 health plans in the large group market through
4 an Exchange, the State shall take into account
5 any excess of premium growth outside of the
6 Exchange as compared to the rate of such
7 growth inside the Exchange.

8 “(c) GRANTS IN SUPPORT OF PROCESS.—

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

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

17 “(B) in providing information and rec-
18 ommendations to the Secretary under sub-
19 section (b)(1).

20 “(2) FUNDING.—

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

1 “(B) FURTHER AVAILABILITY FOR INSUR-
2 ANCE REFORM AND CONSUMER PROTECTION.—
3 If the amounts appropriated under subpara-
4 graph (A) are not fully obligated under grants
5 under paragraph (1) by the end of fiscal year
6 2014, any remaining funds shall remain avail-
7 able to the Secretary for grants to States for
8 planning and implementing the insurance re-
9 forms and consumer protections under part A.

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

14 “(i) the Secretary shall consider the
15 number of plans of health insurance cov-
16 erage offered in each State and the popu-
17 lation of the State; and

18 “(ii) no State qualifying for a grant
19 under paragraph (1) shall receive less than
20 \$1,000,000, or more than \$5,000,000 for a
21 grant year.”.

22 **SEC. 1004. EFFECTIVE DATES.**

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

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

5 (b) SPECIAL RULE.—The amendments made by sec-
 6 tions 1002 and 1003 shall take effect on the date of enact-
 7 ment of this Act.

8 **Subtitle B—Immediate Actions to**
 9 **Preserve and Expand Coverage**

10 **SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNIN-**
 11 **SURED INDIVIDUALS WITH A PREEXISTING**
 12 **CONDITION.**

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

19 (b) ADMINISTRATION.—

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

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

25 (A) be a State or nonprofit private entity;

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

5 (C) agree to utilize contract funding to es-
6 tablish and administer a qualified high risk pool
7 for eligible individuals.

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

15 (c) QUALIFIED HIGH RISK POOL.—

16 (1) IN GENERAL.—Amounts made available
17 under this section shall be used to establish a quali-
18 fied high risk pool that meets the requirements of
19 paragraph (2).

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

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

1 any preexisting condition exclusion with respect
2 to such coverage;

3 (B) provides health insurance coverage—

4 (i) in which the issuer's share of the
5 total allowed costs of benefits provided
6 under such coverage is not less than 65
7 percent of such costs; and

8 (ii) that has an out of pocket limit not
9 greater than the applicable amount de-
10 scribed in section 223(c)(2) of the Internal
11 Revenue Code of 1986 for the year in-
12 volved, except that the Secretary may mod-
13 ify such limit if necessary to ensure the
14 pool meets the actuarial value limit under
15 clause (i);

16 (C) ensures that with respect to the pre-
17 mium rate charged for health insurance cov-
18 erage offered to eligible individuals through the
19 high risk pool, such rate shall—

20 (i) except as provided in clause (ii),
21 vary only as provided for under section
22 2701 of the Public Health Service Act (as
23 amended by this Act and notwithstanding
24 the date on which such amendments take
25 effect);

1 (ii) vary on the basis of age by a fac-
2 tor of not greater than 4 to 1; and

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

5 (D) meets any other requirements deter-
6 mined appropriate by the Secretary.

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

10 (1) is a citizen or national of the United States
11 or is lawfully present in the United States (as deter-
12 mined in accordance with section 1411);

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

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

22 (e) PROTECTION AGAINST DUMPING RISK BY INSUR-
23 ERS.—

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

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

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

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

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

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

1 (ii) in the case of an individual whose
2 premium for the prior coverage exceeded
3 the premium required by the program (ad-
4 justed based on the age factors applied to
5 the prior coverage)—

6 (I) the prior coverage is a policy
7 that is no longer being actively mar-
8 keted (as defined by the Secretary) by
9 the issuer; or

10 (II) the prior coverage is a policy
11 for which duration of coverage form
12 issue or health status are factors that
13 can be considered in determining pre-
14 miums at renewal.

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

21 (f) OVERSIGHT.—The Secretary shall establish—

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

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

1 (g) FUNDING; TERMINATION OF AUTHORITY.—

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

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

17 (3) TERMINATION OF AUTHORITY.—

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

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

1 high risk pool established under this section
2 into qualified health plans offered through an
3 Exchange. Such procedures shall ensure that
4 there is no lapse in coverage with respect to the
5 individual and may extend coverage after the
6 termination of the risk pool involved, if the Sec-
7 retary determines necessary to avoid such a
8 lapse.

9 (4) LIMITATIONS.—The Secretary has the au-
10 thority to stop taking applications for participation
11 in the program under this section to comply with the
12 funding limitation provided for in paragraph (1).

13 (5) RELATION TO STATE LAWS.—The standards
14 established under this section shall supersede any
15 State law or regulation (other than State licensing
16 laws or State laws relating to plan solvency) with re-
17 spect to qualified high risk pools which are estab-
18 lished in accordance with this section.

19 **SEC. 1102. REINSURANCE FOR EARLY RETIREES.**

20 (a) ADMINISTRATION.—

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

1 health insurance coverage to early retirees (and to
2 the eligible spouses, surviving spouses, and depend-
3 ents of such retirees) during the period beginning on
4 the date on which such program is established and
5 ending on January 1, 2014.

6 (2) REFERENCE.—In this section:

7 (A) HEALTH BENEFITS.—The term
8 “health benefits” means medical, surgical, hos-
9 pital, prescription drug, and such other benefits
10 as shall be determined by the Secretary, wheth-
11 er self-funded, or delivered through the pur-
12 chase of insurance or otherwise.

13 (B) EMPLOYMENT-BASED PLAN.—The
14 term “employment-based plan” means a group
15 health benefits plan that—

16 (i) is—

17 (I) maintained by one or more
18 current or former employers (includ-
19 ing without limitation any State or
20 local government or political subdivi-
21 sion thereof), employee organization, a
22 voluntary employees’ beneficiary asso-
23 ciation, or a committee or board of in-
24 dividuals appointed to administer such
25 plan; or

1 (II) a multiemployer plan (as de-
2 fined in section 3(37) of the Employee
3 Retirement Income Security Act of
4 1974); and

5 (ii) provides health benefits to early
6 retirees.

7 (C) EARLY RETIREES.—The term “early
8 retirees” means individuals who are age 55 and
9 older but are not eligible for coverage under
10 title XVIII of the Social Security Act, and who
11 are not active employees of an employer main-
12 taining, or currently contributing to, the em-
13 ployment-based plan or of any employer that
14 has made substantial contributions to fund such
15 plan.

16 (b) PARTICIPATION.—

17 (1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—

18 A participating employment-based plan is an em-
19 ployment-based plan that—

20 (A) meets the requirements of paragraph

21 (2) with respect to health benefits provided
22 under the plan; and

23 (B) submits to the Secretary an applica-
24 tion for participation in the program, at such

1 time, in such manner, and containing such in-
2 formation as the Secretary shall require.

3 (2) EMPLOYMENT-BASED HEALTH BENEFITS.—

4 An employment-based plan meets the requirements
5 of this paragraph if the plan—

6 (A) implements programs and procedures
7 to generate cost-savings with respect to partici-
8 pants with chronic and high-cost conditions;

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

11 (C) is certified by the Secretary.

12 (c) PAYMENTS.—

13 (1) SUBMISSION OF CLAIMS.—

14 (A) IN GENERAL.—A participating employ-
15 ment-based plan shall submit claims for reim-
16 bursement to the Secretary which shall contain
17 documentation of the actual costs of the items
18 and services for which each claim is being sub-
19 mitted.

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

1 pendent of such retiree. In determining the
2 amount of a claim for purposes of this sub-
3 section, the participating employment-based
4 plan shall take into account any negotiated
5 price concessions (such as discounts, direct or
6 indirect subsidies, rebates, and direct or indi-
7 rect remunerations) obtained by such plan with
8 respect to such health benefit. For purposes of
9 determining the amount of any such claim, the
10 costs paid by the early retiree or the retiree's
11 spouse, surviving spouse, or dependent in the
12 form of deductibles, co-payments, or co-insur-
13 ance shall be included in the amounts paid by
14 the participating employment-based plan.

15 (2) PROGRAM PAYMENTS.—If the Secretary de-
16 termines that a participating employment-based plan
17 has submitted a valid claim under paragraph (1),
18 the Secretary shall reimburse such plan for 80 per-
19 cent of that portion of the costs attributable to such
20 claim that exceed \$15,000, subject to the limits con-
21 tained in paragraph (3).

22 (3) LIMIT.—To be eligible for reimbursement
23 under the program, a claim submitted by a partici-
24 pating employment-based plan shall not be less than
25 \$15,000 nor greater than \$90,000. Such amounts

1 shall be adjusted each fiscal year based on the per-
2 centage increase in the Medical Care Component of
3 the Consumer Price Index for all urban consumers
4 (rounded to the nearest multiple of \$1,000) for the
5 year involved.

6 (4) USE OF PAYMENTS.—Amounts paid to a
7 participating employment-based plan under this sub-
8 section shall be used to lower costs for the plan.
9 Such payments may be used to reduce premium
10 costs for an entity described in subsection
11 (a)(2)(B)(i) or to reduce premium contributions, co-
12 payments, deductibles, co-insurance, or other out-of-
13 pocket costs for plan participants. Such payments
14 shall not be used as general revenues for an entity
15 described in subsection (a)(2)(B)(i). The Secretary
16 shall develop a mechanism to monitor the appro-
17 priate use of such payments by such entities.

18 (5) PAYMENTS NOT TREATED AS INCOME.—
19 Payments received under this subsection shall not be
20 included in determining the gross income of an enti-
21 ty described in subsection (a)(2)(B)(i) that is main-
22 taining or currently contributing to a participating
23 employment-based plan.

24 (6) APPEALS.—The Secretary shall establish—

1 (A) an appeals process to permit partici-
2 pating employment-based plans to appeal a de-
3 termination of the Secretary with respect to
4 claims submitted under this section; and

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

7 (d) AUDITS.—The Secretary shall conduct annual au-
8 dits of claims data submitted by participating employ-
9 ment-based plans under this section to ensure that such
10 plans are in compliance with the requirements of this sec-
11 tion.

12 (e) FUNDING.—There is appropriated to the Sec-
13 retary, out of any moneys in the Treasury not otherwise
14 appropriated, \$5,000,000,000 to carry out the program
15 under this section. Such funds shall be available without
16 fiscal year limitation.

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

20 **SEC. 1103. IMMEDIATE INFORMATION THAT ALLOWS CON-**
21 **SUMERS TO IDENTIFY AFFORDABLE COV-**
22 **ERAGE OPTIONS.**

23 (a) INTERNET PORTAL TO AFFORDABLE COVERAGE
24 OPTIONS.—

1 (1) IMMEDIATE ESTABLISHMENT.—Not later
2 than July 1, 2010, the Secretary, in consultation
3 with the States, shall establish a mechanism, includ-
4 ing an Internet website, through which a resident of
5 any State may identify affordable health insurance
6 coverage options in that State.

7 (2) CONNECTING TO AFFORDABLE COV-
8 ERAGE.—An Internet website established under
9 paragraph (1) shall, to the extent practicable, pro-
10 vide ways for residents of any State to receive infor-
11 mation on at least the following coverage options:

12 (A) Health insurance coverage offered by
13 health insurance issuers, other than coverage
14 that provides reimbursement only for the treat-
15 ment or mitigation of—

16 (i) a single disease or condition; or
17 (ii) an unreasonably limited set of dis-
18 eases or conditions (as determined by the
19 Secretary);

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

22 (C) Coverage under title XXI of the Social
23 Security Act.

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

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

6 (b) ENHANCING COMPARATIVE PURCHASING OP-
7 TIONS.—

8 (1) IN GENERAL.—Not later than 60 days after
9 the date of enactment of this Act, the Secretary
10 shall develop a standardized format to be used for
11 the presentation of information relating to the cov-
12 erage options described in subsection (a)(2). Such
13 format shall, at a minimum, require the inclusion of
14 information on the percentage of total premium rev-
15 enue expended on nonclinical costs (as reported
16 under section 2718(a) of the Public Health Service
17 Act), eligibility, availability, premium rates, and cost
18 sharing with respect to such coverage options and be
19 consistent with the standards adopted for the uni-
20 form explanation of coverage as provided for in sec-
21 tion 2715 of the Public Health Service Act.

22 (2) USE OF FORMAT.—The Secretary shall uti-
23 lize the format developed under paragraph (1) in
24 compiling information concerning coverage options

1 on the Internet website established under subsection
2 (a).

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

6 **SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.**

7 (a) **PURPOSE OF ADMINISTRATIVE SIMPLIFICA-**
8 **TION.**—Section 261 of the Health Insurance Portability
9 and Accountability Act of 1996 (42 U.S.C. 1320d note)
10 is amended—

11 (1) by inserting “uniform” before “standards”;
12 and

13 (2) by inserting “and to reduce the clerical bur-

14 den on patients, health care providers, and health
15 plans” before the period at the end.

16 (b) **OPERATING RULES FOR HEALTH INFORMATION**
17 **TRANSACTIONS.**—

18 (1) **DEFINITION OF OPERATING RULES.**—Sec-
19 tion 1171 of the Social Security Act (42 U.S.C.
20 1320d) is amended by adding at the end the fol-
21 lowing:

22 “(9) **OPERATING RULES.**—The term ‘operating
23 rules’ means the necessary business rules and guide-
24 lines for the electronic exchange of information that

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

3 (2) TRANSACTION STANDARDS; OPERATING
4 RULES AND COMPLIANCE.—Section 1173 of the So-
5 cial Security Act (42 U.S.C. 1320d–2) is amended—

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

8 “(J) Electronic funds transfers.”;

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

11 “(4) REQUIREMENTS FOR FINANCIAL AND AD-
12 MINISTRATIVE TRANSACTIONS.—

13 “(A) IN GENERAL.—The standards and as-
14 sociated operating rules adopted by the Sec-
15 retary shall—

16 “(i) to the extent feasible and appro-
17 priate, enable determination of an individ-
18 ual’s eligibility and financial responsibility
19 for specific services prior to or at the point
20 of care;

21 “(ii) be comprehensive, requiring
22 minimal augmentation by paper or other
23 communications;

24 “(iii) provide for timely acknowledg-
25 ment, response, and status reporting that

1 supports a transparent claims and denial
2 management process (including adjudica-
3 tion and appeals); and

4 “(iv) describe all data elements (in-
5 cluding reason and remark codes) in un-
6 ambiguous terms, require that such data
7 elements be required or conditioned upon
8 set values in other fields, and prohibit ad-
9 ditional conditions (except where necessary
10 to implement State or Federal law, or to
11 protect against fraud and abuse).

12 “(B) REDUCTION OF CLERICAL BUR-
13 DEN.—In adopting standards and operating
14 rules for the transactions referred to under
15 paragraph (1), the Secretary shall seek to re-
16 duce the number and complexity of forms (in-
17 cluding paper and electronic forms) and data
18 entry required by patients and providers.”; and

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

21 “(g) OPERATING RULES.—

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

1 of the electronic standards as possible. Such oper-
2 ating rules shall be consensus-based and reflect the
3 necessary business rules affecting health plans and
4 health care providers and the manner in which they
5 operate pursuant to standards issued under Health
6 Insurance Portability and Accountability Act of
7 1996.

8 “(2) OPERATING RULES DEVELOPMENT.—In
9 adopting operating rules under this subsection, the
10 Secretary shall consider recommendations for oper-
11 ating rules developed by a qualified nonprofit entity
12 that meets the following requirements:

13 “(A) The entity focuses its mission on ad-
14 ministrative simplification.

15 “(B) The entity demonstrates a multi-
16 stakeholder and consensus-based process for de-
17 velopment of operating rules, including rep-
18 resentation by or participation from health
19 plans, health care providers, vendors, relevant
20 Federal agencies, and other standard develop-
21 ment organizations.

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

1 cies that demonstrate a commitment to open,
2 fair, and nondiscriminatory practices.

3 “(D) The entity builds on the transaction
4 standards issued under Health Insurance Port-
5 ability and Accountability Act of 1996.

6 “(E) The entity allows for public review
7 and updates of the operating rules.

8 “(3) REVIEW AND RECOMMENDATIONS.—The
9 National Committee on Vital and Health Statistics
10 shall—

11 “(A) advise the Secretary as to whether a
12 nonprofit entity meets the requirements under
13 paragraph (2);

14 “(B) review the operating rules developed
15 and recommended by such nonprofit entity;

16 “(C) determine whether such operating
17 rules represent a consensus view of the health
18 care stakeholders and are consistent with and
19 do not conflict with other existing standards;

20 “(D) evaluate whether such operating rules
21 are consistent with electronic standards adopted
22 for health information technology; and

23 “(E) submit to the Secretary a rec-
24 ommendation as to whether the Secretary
25 should adopt such operating rules.

1 “(4) IMPLEMENTATION.—

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

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

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

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

1 TANCE ADVICE.—The set of operating
2 rules for electronic funds transfers and
3 health care payment and remittance advice
4 transactions shall—

5 “(I) allow for automated rec-
6 onciliation of the electronic payment
7 with the remittance advice; and

8 “(II) be adopted not later than
9 July 1, 2012, in a manner ensuring
10 that such operating rules are effective
11 not later than January 1, 2014.

12 “(iii) HEALTH CLAIMS OR EQUIVA-
13 LENT ENCOUNTER INFORMATION, ENROLL-
14 MENT AND DISENROLLMENT IN A HEALTH
15 PLAN, HEALTH PLAN PREMIUM PAYMENTS,
16 REFERRAL CERTIFICATION AND AUTHOR-
17 IZATION.—The set of operating rules for
18 health claims or equivalent encounter in-
19 formation, enrollment and disenrollment in
20 a health plan, health plan premium pay-
21 ments, and referral certification and au-
22 thorization transactions shall be adopted
23 not later than July 1, 2014, in a manner
24 ensuring that such operating rules are ef-
25 fective not later than January 1, 2016.

1 “(C) EXPEDITED RULEMAKING.—The Sec-
2 retary shall promulgate an interim final rule
3 applying any standard or operating rule rec-
4 ommended by the National Committee on Vital
5 and Health Statistics pursuant to paragraph
6 (3). The Secretary shall accept and consider
7 public comments on any interim final rule pub-
8 lished under this subparagraph for 60 days
9 after the date of such publication.

10 “(h) COMPLIANCE.—

11 “(1) HEALTH PLAN CERTIFICATION.—

12 “(A) ELIGIBILITY FOR A HEALTH PLAN,
13 HEALTH CLAIM STATUS, ELECTRONIC FUNDS
14 TRANSFERS, HEALTH CARE PAYMENT AND RE-
15 MITTANCE ADVICE.—Not later than December
16 31, 2013, a health plan shall file a statement
17 with the Secretary, in such form as the Sec-
18 retary may require, certifying that the data and
19 information systems for such plan are in com-
20 pliance with any applicable standards (as de-
21 scribed under paragraph (7) of section 1171)
22 and associated operating rules (as described
23 under paragraph (9) of such section) for elec-
24 tronic funds transfers, eligibility for a health

1 plan, health claim status, and health care pay-
2 ment and remittance advice, respectively.

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

24 “(2) DOCUMENTATION OF COMPLIANCE.—A
25 health plan shall provide the Secretary, in such form

1 as the Secretary may require, with adequate docu-
2 mentation of compliance with the standards and op-
3 erating rules described under paragraph (1). A
4 health plan shall not be considered to have provided
5 adequate documentation and shall not be certified as
6 being in compliance with such standards, unless the
7 health plan—

8 “(A) demonstrates to the Secretary that
9 the plan conducts the electronic transactions
10 specified in paragraph (1) in a manner that
11 fully complies with the regulations of the Sec-
12 retary; and

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

17 “(3) SERVICE CONTRACTS.—A health plan shall
18 be required to ensure that any entities that provide
19 services pursuant to a contract with such health
20 plan shall comply with any applicable certification
21 and compliance requirements (and provide the Sec-
22 retary with adequate documentation of such compli-
23 ance) under this subsection.

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

1 entities to certify that a health plan has complied
2 with the requirements under this subsection, pro-
3 vided that the certification standards employed by
4 such entities are in accordance with any standards
5 or operating rules issued by the Secretary.

6 “(5) COMPLIANCE WITH REVISED STANDARDS
7 AND OPERATING RULES.—

8 “(A) IN GENERAL.—A health plan (includ-
9 ing entities described under paragraph (3))
10 shall file a statement with the Secretary, in
11 such form as the Secretary may require, certi-
12 fying that the data and information systems for
13 such plan are in compliance with any applicable
14 revised standards and associated operating
15 rules under this subsection for any interim final
16 rule promulgated by the Secretary under sub-
17 section (i) that—

18 “(i) amends any standard or oper-
19 ating rule described under paragraph (1)
20 of this subsection; or

21 “(ii) establishes a standard (as de-
22 scribed under subsection (a)(1)(B)) or as-
23 sociated operating rules (as described
24 under subsection (i)(5)) for any other fi-
25 nancial and administrative transactions.

1 “(B) DATE OF COMPLIANCE.—A health
2 plan shall comply with such requirements not
3 later than the effective date of the applicable
4 standard or operating rule.

5 “(6) AUDITS OF HEALTH PLANS.—The Sec-
6 retary shall conduct periodic audits to ensure that
7 health plans (including entities described under
8 paragraph (3)) are in compliance with any standards
9 and operating rules that are described under para-
10 graph (1) or subsection (i)(5).

11 “(i) REVIEW AND AMENDMENT OF STANDARDS AND
12 OPERATING RULES.—

13 “(1) ESTABLISHMENT.—Not later than Janu-
14 ary 1, 2014, the Secretary shall establish a review
15 committee (as described under paragraph (4)).

16 “(2) EVALUATIONS AND REPORTS.—

17 “(A) HEARINGS.—Not later than April 1,
18 2014, and not less than biennially thereafter,
19 the Secretary, acting through the review com-
20 mittee, shall conduct hearings to evaluate and
21 review the adopted standards and operating
22 rules established under this section.

23 “(B) REPORT.—Not later than July 1,
24 2014, and not less than biennially thereafter,
25 the review committee shall provide rec-

1 ommendations for updating and improving such
2 standards and operating rules. The review com-
3 mittee shall recommend a single set of oper-
4 ating rules per transaction standard and main-
5 tain the goal of creating as much uniformity as
6 possible in the implementation of the electronic
7 standards.

8 “(3) INTERIM FINAL RULEMAKING.—

9 “(A) IN GENERAL.—Any recommendations
10 to amend adopted standards and operating
11 rules that have been approved by the review
12 committee and reported to the Secretary under
13 paragraph (2)(B) shall be adopted by the Sec-
14 retary through promulgation of an interim final
15 rule not later than 90 days after receipt of the
16 committee’s report.

17 “(B) PUBLIC COMMENT.—

18 “(i) PUBLIC COMMENT PERIOD.—The
19 Secretary shall accept and consider public
20 comments on any interim final rule pub-
21 lished under this paragraph for 60 days
22 after the date of such publication.

23 “(ii) EFFECTIVE DATE.—The effective
24 date of any amendment to existing stand-
25 ards or operating rules that is adopted

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

5 “(4) REVIEW COMMITTEE.—

6 “(A) DEFINITION.—For the purposes of
7 this subsection, the term ‘review committee’
8 means a committee chartered by or within the
9 Department of Health and Human services that
10 has been designated by the Secretary to carry
11 out this subsection, including—

12 “(i) the National Committee on Vital
13 and Health Statistics; or

14 “(ii) any appropriate committee as de-
15 termined by the Secretary.

16 “(B) COORDINATION OF HIT STAND-
17 ARDS.—In developing recommendations under
18 this subsection, the review committee shall en-
19 sure coordination, as appropriate, with the
20 standards that support the certified electronic
21 health record technology approved by the Office
22 of the National Coordinator for Health Infor-
23 mation Technology.

24 “(5) OPERATING RULES FOR OTHER STAND-
25 ARDS ADOPTED BY THE SECRETARY.—The Secretary

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

5 “(j) PENALTIES.—

6 “(1) PENALTY FEE.—

7 “(A) IN GENERAL.—Not later than April
8 1, 2014, and annually thereafter, the Secretary
9 shall assess a penalty fee (as determined under
10 subparagraph (B)) against a health plan that
11 has failed to meet the requirements under sub-
12 section (h) with respect to certification and doc-
13 umentation of compliance with—

14 “(i) the standards and associated op-
15 erating rules described under paragraph
16 (1) of such subsection; and

17 “(ii) a standard (as described under
18 subsection (a)(1)(B)) and associated oper-
19 ating rules (as described under subsection
20 (i)(5)) for any other financial and adminis-
21 trative transactions.

22 “(B) FEE AMOUNT.—Subject to subpara-
23 graphs (C), (D), and (E), the Secretary shall
24 assess a penalty fee against a health plan in the
25 amount of \$1 per covered life until certification

1 is complete. The penalty shall be assessed per
2 person covered by the plan for which its data
3 systems for major medical policies are not in
4 compliance and shall be imposed against the
5 health plan for each day that the plan is not in
6 compliance with the requirements under sub-
7 section (h).

8 “(C) ADDITIONAL PENALTY FOR MIS-
9 REPRESENTATION.—A health plan that know-
10 ingly provides inaccurate or incomplete informa-
11 tion in a statement of certification or docu-
12 mentation of compliance under subsection (h)
13 shall be subject to a penalty fee that is double
14 the amount that would otherwise be imposed
15 under this subsection.

16 “(D) ANNUAL FEE INCREASE.—The
17 amount of the penalty fee imposed under this
18 subsection shall be increased on an annual basis
19 by the annual percentage increase in total na-
20 tional health care expenditures, as determined
21 by the Secretary.

22 “(E) PENALTY LIMIT.—A penalty fee as-
23 sessed against a health plan under this sub-
24 section shall not exceed, on an annual basis—

1 “(i) an amount equal to \$20 per cov-
2 ered life under such plan; or

3 “(ii) an amount equal to \$40 per cov-
4 ered life under the plan if such plan has
5 knowingly provided inaccurate or incom-
6 plete information (as described under sub-
7 paragraph (C)).

8 “(F) DETERMINATION OF COVERED INDI-
9 VIDUALS.—The Secretary shall determine the
10 number of covered lives under a health plan
11 based upon the most recent statements and fil-
12 ings that have been submitted by such plan to
13 the Securities and Exchange Commission.

14 “(2) NOTICE AND DISPUTE PROCEDURE.—The
15 Secretary shall establish a procedure for assessment
16 of penalty fees under this subsection that provides a
17 health plan with reasonable notice and a dispute res-
18 olution procedure prior to provision of a notice of as-
19 sessment by the Secretary of the Treasury (as de-
20 scribed under paragraph (4)(B)).

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

1 “(4) COLLECTION OF PENALTY FEE.—

2 “(A) IN GENERAL.—The Secretary of the
3 Treasury, acting through the Financial Man-
4 agement Service, shall administer the collection
5 of penalty fees from health plans that have been
6 identified by the Secretary in the penalty fee re-
7 port provided under paragraph (3).

8 “(B) NOTICE.—Not later than August 1,
9 2014, and annually thereafter, the Secretary of
10 the Treasury shall provide notice to each health
11 plan that has been assessed a penalty fee by the
12 Secretary under this subsection. Such notice
13 shall include the amount of the penalty fee as-
14 sessed by the Secretary and the due date for
15 payment of such fee to the Secretary of the
16 Treasury (as described in subparagraph (C)).

17 “(C) PAYMENT DUE DATE.—Payment by a
18 health plan for a penalty fee assessed under
19 this subsection shall be made to the Secretary
20 of the Treasury not later than November 1,
21 2014, and annually thereafter.

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

1 ment has not been made by the due date pro-
2 vided under subparagraph (C) shall be—

3 “(i) increased by the interest accrued
4 on such amount, as determined pursuant
5 to the underpayment rate established
6 under section 6621 of the Internal Rev-
7 enue Code of 1986; and

8 “(ii) treated as a past-due, legally en-
9 forceable debt owed to a Federal agency
10 for purposes of section 6402(d) of the In-
11 ternal Revenue Code of 1986.

12 “(E) ADMINISTRATIVE FEES.—Any fee
13 charged or allocated for collection activities con-
14 ducted by the Financial Management Service
15 will be passed on to a health plan on a pro-rata
16 basis and added to any penalty fee collected
17 from the plan.”.

18 (c) PROMULGATION OF RULES.—

19 (1) UNIQUE HEALTH PLAN IDENTIFIER.—The
20 Secretary shall promulgate a final rule to establish
21 a unique health plan identifier (as described in sec-
22 tion 1173(b) of the Social Security Act (42 U.S.C.
23 1320d-2(b))) based on the input of the National
24 Committee on Vital and Health Statistics. The Sec-
25 retary may do so on an interim final basis and such

1 rule shall be effective not later than October 1,
2 2012.

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

12 (3) HEALTH CLAIMS ATTACHMENTS.—The Sec-
13 retary shall promulgate a final rule to establish a
14 transaction standard and a single set of associated
15 operating rules for health claims attachments (as de-
16 scribed in section 1173(a)(2)(B) of the Social Secu-
17 rity Act (42 U.S.C. 1320d-2(a)(2)(B))) that is con-
18 sistent with the X12 Version 5010 transaction
19 standards. The Secretary may do so on an interim
20 final basis and shall adopt a transaction standard
21 and a single set of associated operating rules not
22 later than January 1, 2014, in a manner ensuring
23 that such standard is effective not later than Janu-
24 ary 1, 2016.

1 (d) EXPANSION OF ELECTRONIC TRANSACTIONS IN
2 MEDICARE.—Section 1862(a) of the Social Security Act
3 (42 U.S.C. 1395y(a)) is amended—

4 (1) in paragraph (23), by striking the “or” at
5 the end;

6 (2) in paragraph (24), by striking the period
7 and inserting “; or”; and

8 (3) by inserting after paragraph (24) the fol-
9 lowing new paragraph:

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

15 **SEC. 1105. EFFECTIVE DATE.**

16 This subtitle shall take effect on the date of enact-
17 ment of this Act.

1 **Subtitle C—Quality Health Insur-**
 2 **ance Coverage for All Ameri-**
 3 **cans**

4 **PART I—HEALTH INSURANCE MARKET REFORMS**

5 **SEC. 1201. AMENDMENT TO THE PUBLIC HEALTH SERVICE**

6 **ACT.**

7 Part A of title XXVII of the Public Health Service
 8 Act (42 U.S.C. 300gg et seq.), as amended by section
 9 1001, is further amended—

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

12 **“Subpart I—General Reform”;**

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

16 **“SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EX-**
 17 **CLUSIONS OR OTHER DISCRIMINATION**
 18 **BASED ON HEALTH STATUS.**

19 “(a) IN GENERAL.—A group health plan and a health
 20 insurance issuer offering group or individual health insur-
 21 ance coverage may not impose any preexisting condition
 22 exclusion with respect to such plan or coverage.”; and

23 (B) by transferring such section (as amended
 24 by subparagraph (A)) so as to appear after the sec-
 25 tion 2703 added by paragraph (4);

- 1 (3)(A) in section 2702 (42 U.S.C. 300gg-1)—
- 2 (i) by striking the section heading and all
- 3 that follows through subsection (a);
- 4 (ii) in subsection (b)—
- 5 (I) by striking “health insurance
- 6 issuer offering health insurance coverage in
- 7 connection with a group health plan” each
- 8 place that such appears and inserting
- 9 “health insurance issuer offering group or
- 10 individual health insurance coverage”; and
- 11 (II) in paragraph (2)(A)—
- 12 (aa) by inserting “or individual”
- 13 after “employer”; and
- 14 (bb) by inserting “or individual
- 15 health coverage, as the case may be”
- 16 before the semicolon; and
- 17 (iii) in subsection (e)—
- 18 (I) by striking “(a)(1)(F)” and insert-
- 19 ing “(a)(6)”;
- 20 (II) by striking “2701” and inserting
- 21 “2704”; and
- 22 (III) by striking “2721(a)” and in-
- 23 serting “2735(a)”;

1 (B) by transferring such section (as
2 amended by subparagraph (A)) to appear after
3 section 2705(a) as added by paragraph (4); and
4 (4) by inserting after the subpart heading (as
5 added by paragraph (1)) the following:

6 **“SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.**

7 “(a) PROHIBITING DISCRIMINATORY PREMIUM
8 RATES.—

9 “(1) IN GENERAL.—With respect to the pre-
10 mium rate charged by a health insurance issuer for
11 health insurance coverage offered in the individual
12 or small group market—

13 “(A) such rate shall vary with respect to
14 the particular plan or coverage involved only
15 by—

16 “(i) whether such plan or coverage
17 covers an individual or family;

18 “(ii) rating area, as established in ac-
19 cordance with paragraph (2);

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

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

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

5 “(2) RATING AREA.—

6 “(A) IN GENERAL.—Each State shall es-
7 tablish 1 or more rating areas within that State
8 for purposes of applying the requirements of
9 this title.

10 “(B) SECRETARIAL REVIEW.—The Sec-
11 retary shall review the rating areas established
12 by each State under subparagraph (A) to en-
13 sure the adequacy of such areas for purposes of
14 carrying out the requirements of this title. If
15 the Secretary determines a State’s rating areas
16 are not adequate, or that a State does not es-
17 tablish such areas, the Secretary may establish
18 rating areas for that State.

19 “(3) PERMISSIBLE AGE BANDS.—The Sec-
20 retary, in consultation with the National Association
21 of Insurance Commissioners, shall define the permis-
22 sible age bands for rating purposes under paragraph
23 (1)(A)(iii).

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

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

7 “(5) SPECIAL RULE FOR LARGE GROUP MAR-
8 KET.—If a State permits health insurance issuers
9 that offer coverage in the large group market in the
10 State to offer such coverage through the State Ex-
11 change (as provided for under section 1312(f)(2)(B)
12 of the Patient Protection and Affordable Care Act),
13 the provisions of this subsection shall apply to all
14 coverage offered in such market in the State.

15 **“SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.**

16 “(a) GUARANTEED ISSUANCE OF COVERAGE IN THE
17 INDIVIDUAL AND GROUP MARKET.—Subject to sub-
18 sections (b) through (e), each health insurance issuer that
19 offers health insurance coverage in the individual or group
20 market in a State must accept every employer and indi-
21 vidual in the State that applies for such coverage.

22 “(b) ENROLLMENT.—

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

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

3 “(2) ESTABLISHMENT.—A health insurance
4 issuer described in subsection (a) shall, in accord-
5 ance with the regulations promulgated under para-
6 graph (3), establish special enrollment periods for
7 qualifying events (under section 603 of the Em-
8 ployee Retirement Income Security Act of 1974).

9 “(3) REGULATIONS.—The Secretary shall pro-
10 mulgate regulations with respect to enrollment peri-
11 ods under paragraphs (1) and (2).

12 **“SEC. 2703. GUARANTEED RENEWABILITY OF COVERAGE.**

13 “(a) IN GENERAL.—Except as provided in this sec-
14 tion, if a health insurance issuer offers health insurance
15 coverage in the individual or group market, the issuer
16 must renew or continue in force such coverage at the op-
17 tion of the plan sponsor or the individual, as applicable.

18 **“SEC. 2705. PROHIBITING DISCRIMINATION AGAINST INDI-
19 VIDUAL PARTICIPANTS AND BENEFICIARIES
20 BASED ON HEALTH STATUS.**

21 “(a) IN GENERAL.—A group health plan and a health
22 insurance issuer offering group or individual health insur-
23 ance coverage may not establish rules for eligibility (in-
24 cluding continued eligibility) of any individual to enroll
25 under the terms of the plan or coverage based on any of

1 the following health status-related factors in relation to
2 the individual or a dependent of the individual:

3 “(1) Health status.

4 “(2) Medical condition (including both physical
5 and mental illnesses).

6 “(3) Claims experience.

7 “(4) Receipt of health care.

8 “(5) Medical history.

9 “(6) Genetic information.

10 “(7) Evidence of insurability (including condi-
11 tions arising out of acts of domestic violence).

12 “(8) Disability.

13 “(9) Any other health status-related factor de-
14 termined appropriate by the Secretary.

15 “(j) PROGRAMS OF HEALTH PROMOTION OR DIS-
16 EASE PREVENTION.—

17 “(1) GENERAL PROVISIONS.—

18 “(A) GENERAL RULE.—For purposes of
19 subsection (b)(2)(B), a program of health pro-
20 motion or disease prevention (referred to in this
21 subsection as a ‘wellness program’) shall be a
22 program offered by an employer that is de-
23 signed to promote health or prevent disease
24 that meets the applicable requirements of this
25 subsection.

1 “(B) NO CONDITIONS BASED ON HEALTH
2 STATUS FACTOR.—If none of the conditions for
3 obtaining a premium discount or rebate or
4 other reward for participation in a wellness pro-
5 gram is based on an individual satisfying a
6 standard that is related to a health status fac-
7 tor, such wellness program shall not violate this
8 section if participation in the program is made
9 available to all similarly situated individuals
10 and the requirements of paragraph (2) are com-
11 plied with.

12 “(C) CONDITIONS BASED ON HEALTH STA-
13 TUS FACTOR.—If any of the conditions for ob-
14 taining a premium discount or rebate or other
15 reward for participation in a wellness program
16 is based on an individual satisfying a standard
17 that is related to a health status factor, such
18 wellness program shall not violate this section if
19 the requirements of paragraph (3) are complied
20 with.

21 “(2) WELLNESS PROGRAMS NOT SUBJECT TO
22 REQUIREMENTS.—If none of the conditions for ob-
23 taining a premium discount or rebate or other re-
24 ward under a wellness program as described in para-
25 graph (1)(B) are based on an individual satisfying

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

10 “(A) A program that reimburses all or
11 part of the cost for memberships in a fitness
12 center.

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

16 “(C) A program that encourages preven-
17 tive care related to a health condition through
18 the waiver of the copayment or deductible re-
19 quirement under group health plan for the costs
20 of certain items or services related to a health
21 condition (such as prenatal care or well-baby
22 visits).

23 “(D) A program that reimburses individ-
24 uals for the costs of smoking cessation pro-

1 grams without regard to whether the individual
2 quits smoking.

3 “(E) A program that provides a reward to
4 individuals for attending a periodic health edu-
5 cation seminar.

6 “(3) WELLNESS PROGRAMS SUBJECT TO RE-
7 QUIREMENTS.—If any of the conditions for obtaining
8 a premium discount, rebate, or reward under a
9 wellness program as described in paragraph (1)(C)
10 is based on an individual satisfying a standard that
11 is related to a health status factor, the wellness pro-
12 gram shall not violate this section if the following re-
13 quirements are complied with:

14 “(A) The reward for the wellness program,
15 together with the reward for other wellness pro-
16 grams with respect to the plan that requires
17 satisfaction of a standard related to a health
18 status factor, shall not exceed 30 percent of the
19 cost of employee-only coverage under the plan.
20 If, in addition to employees or individuals, any
21 class of dependents (such as spouses or spouses
22 and dependent children) may participate fully
23 in the wellness program, such reward shall not
24 exceed 30 percent of the cost of the coverage in
25 which an employee or individual and any de-

1 dependents are enrolled. For purposes of this
2 paragraph, the cost of coverage shall be deter-
3 mined based on the total amount of employer
4 and employee contributions for the benefit
5 package under which the employee is (or the
6 employee and any dependents are) receiving
7 coverage. A reward may be in the form of a dis-
8 count or rebate of a premium or contribution,
9 a waiver of all or part of a cost-sharing mecha-
10 nism (such as deductibles, copayments, or coin-
11 surance), the absence of a surcharge, or the
12 value of a benefit that would otherwise not be
13 provided under the plan. The Secretaries of
14 Labor, Health and Human Services, and the
15 Treasury may increase the reward available
16 under this subparagraph to up to 50 percent of
17 the cost of coverage if the Secretaries determine
18 that such an increase is appropriate.

19 “(B) The wellness program shall be rea-
20 sonably designed to promote health or prevent
21 disease. A program complies with the preceding
22 sentence if the program has a reasonable
23 chance of improving the health of, or preventing
24 disease in, participating individuals and it is
25 not overly burdensome, is not a subterfuge for

1 discriminating based on a health status factor,
2 and is not highly suspect in the method chosen
3 to promote health or prevent disease.

4 “(C) The plan shall give individuals eligible
5 for the program the opportunity to qualify for
6 the reward under the program at least once
7 each year.

8 “(D) The full reward under the wellness
9 program shall be made available to all similarly
10 situated individuals. For such purpose, among
11 other things:

12 “(i) The reward is not available to all
13 similarly situated individuals for a period
14 unless the wellness program allows—

15 “(I) for a reasonable alternative
16 standard (or waiver of the otherwise
17 applicable standard) for obtaining the
18 reward for any individual for whom,
19 for that period, it is unreasonably dif-
20 ficult due to a medical condition to
21 satisfy the otherwise applicable stand-
22 ard; and

23 “(II) for a reasonable alternative
24 standard (or waiver of the otherwise
25 applicable standard) for obtaining the

1 reward for any individual for whom,
2 for that period, it is medically inadvis-
3 able to attempt to satisfy the other-
4 wise applicable standard.

5 “(ii) If reasonable under the cir-
6 cumstances, the plan or issuer may seek
7 verification, such as a statement from an
8 individual’s physician, that a health status
9 factor makes it unreasonably difficult or
10 medically inadvisable for the individual to
11 satisfy or attempt to satisfy the otherwise
12 applicable standard.

13 “(E) The plan or issuer involved shall dis-
14 close in all plan materials describing the terms
15 of the wellness program the availability of a
16 reasonable alternative standard (or the possi-
17 bility of waiver of the otherwise applicable
18 standard) required under subparagraph (D). If
19 plan materials disclose that such a program is
20 available, without describing its terms, the dis-
21 closure under this subparagraph shall not be re-
22 quired.

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

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

5 “(1) WELLNESS PROGRAM DEMONSTRATION
6 PROJECT.—

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

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

24 “(3) REQUIREMENTS.—

1 “(A) MAINTENANCE OF COVERAGE.—The
2 Secretary, in consultation with the Secretary of
3 the Treasury and the Secretary of Labor, shall
4 not approve the participation of a State in the
5 demonstration project under this section unless
6 the Secretaries determine that the State’s
7 project is designed in a manner that—

8 “(i) will not result in any decrease in
9 coverage; and

10 “(ii) will not increase the cost to the
11 Federal Government in providing credits
12 under section 36B of the Internal Revenue
13 Code of 1986 or cost-sharing assistance
14 under section 1402 of the Patient Protec-
15 tion and Affordable Care Act.

16 “(B) OTHER REQUIREMENTS.—States that
17 participate in the demonstration project under
18 this subsection—

19 “(i) may permit premium discounts or
20 rebates or the modification of otherwise
21 applicable copayments or deductibles for
22 adherence to, or participation in, a reason-
23 ably designed program of health promotion
24 and disease prevention;

1 “(ii) shall ensure that requirements of
2 consumer protection are met in programs
3 of health promotion in the individual mar-
4 ket;

5 “(iii) shall require verification from
6 health insurance issuers that offer health
7 insurance coverage in the individual mar-
8 ket of such State that premium dis-
9 counts—

10 “(I) do not create undue burdens
11 for individuals insured in the indi-
12 vidual market;

13 “(II) do not lead to cost shifting;
14 and

15 “(III) are not a subterfuge for
16 discrimination;

17 “(iv) shall ensure that consumer data
18 is protected in accordance with the require-
19 ments of section 264(c) of the Health In-
20 surance Portability and Accountability Act
21 of 1996 (42 U.S.C. 1320d-2 note); and

22 “(v) shall ensure and demonstrate to
23 the satisfaction of the Secretary that the
24 discounts or other rewards provided under
25 the project reflect the expected level of par-

1 ticipation in the wellness program involved
2 and the anticipated effect the program will
3 have on utilization or medical claim costs.

4 “(m) REPORT.—

5 “(1) IN GENERAL.—Not later than 3 years
6 after the date of enactment of the Patient Protection
7 and Affordable Care Act, the Secretary, in consulta-
8 tion with the Secretary of the Treasury and the Sec-
9 retary of Labor, shall submit a report to the appro-
10 prium committees of Congress concerning—

11 “(A) the effectiveness of wellness programs
12 (as defined in subsection (j)) in promoting
13 health and preventing disease;

14 “(B) the impact of such wellness programs
15 on the access to care and affordability of cov-
16 erage for participants and non-participants of
17 such programs;

18 “(C) the impact of premium-based and
19 cost-sharing incentives on participant behavior
20 and the role of such programs in changing be-
21 havior; and

22 “(D) the effectiveness of different types of
23 rewards.

24 “(2) DATA COLLECTION.—In preparing the re-
25 port described in paragraph (1), the Secretaries

1 shall gather relevant information from employers
2 who provide employees with access to wellness pro-
3 grams, including State and Federal agencies.

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

8 **“SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.**

9 “(a) PROVIDERS.—A group health plan and a health
10 insurance issuer offering group or individual health insur-
11 ance coverage shall not discriminate with respect to par-
12 ticipation under the plan or coverage against any health
13 care provider who is acting within the scope of that pro-
14 vider’s license or certification under applicable State law.
15 This section shall not require that a group health plan
16 or health insurance issuer contract with any health care
17 provider willing to abide by the terms and conditions for
18 participation established by the plan or issuer. Nothing
19 in this section shall be construed as preventing a group
20 health plan, a health insurance issuer, or the Secretary
21 from establishing varying reimbursement rates based on
22 quality or performance measures.

23 “(b) INDIVIDUALS.—The provisions of section 1558
24 of the Patient Protection and Affordable Care Act (relat-
25 ing to non-discrimination) shall apply with respect to a

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

3 **“SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COV-**
4 **ERAGE.**

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

11 “(b) **COST-SHARING UNDER GROUP HEALTH**
12 **PLANS.**—A group health plan shall ensure that any an-
13 nual cost-sharing imposed under the plan does not exceed
14 the limitations provided for under paragraphs (1) and (2)
15 of section 1302(c).

16 “(c) **CHILD-ONLY PLANS.**—If a health insurance
17 issuer offers health insurance coverage in any level of cov-
18 erage specified under section 1302(d) of the Patient Pro-
19 tection and Affordable Care Act, the issuer shall also offer
20 such coverage in that level as a plan in which the only
21 enrollees are individuals who, as of the beginning of a plan
22 year, have not attained the age of 21.

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

1 **“SEC. 2708. PROHIBITION ON EXCESSIVE WAITING PERI-**
 2 **ODS.**

3 “A group health plan and a health insurance issuer
 4 offering group or individual health insurance coverage
 5 shall not apply any waiting period (as defined in section
 6 2704(b)(4)) that exceeds 90 days.”.

7 **PART II—OTHER PROVISIONS**

8 **SEC. 1251. PRESERVATION OF RIGHT TO MAINTAIN EXIST-**
 9 **ING COVERAGE.**

10 (a) NO CHANGES TO EXISTING COVERAGE.—

11 (1) IN GENERAL.—Nothing in this Act (or an
 12 amendment made by this Act) shall be construed to
 13 require that an individual terminate coverage under
 14 a group health plan or health insurance coverage in
 15 which such individual was enrolled on the date of en-
 16 actment of this Act.

17 (2) CONTINUATION OF COVERAGE.—With re-
 18 spect to a group health plan or health insurance cov-
 19 erage in which an individual was enrolled on the
 20 date of enactment of this Act, this subtitle and sub-
 21 title A (and the amendments made by such subtitles)
 22 shall not apply to such plan or coverage, regardless
 23 of whether the individual renews such coverage after
 24 such date of enactment.

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

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

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

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

1 which amends the coverage solely to conform to any re-
2 quirement added by this subtitle or subtitle A (or amend-
3 ments) shall not be treated as a termination of such collec-
4 tive bargaining agreement.

5 (e) DEFINITION.—In this title, the term “grand-
6 fathered health plan” means any group health plan or
7 health insurance coverage to which this section applies.

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

11 Any standard or requirement adopted by a State pur-
12 suant to this title, or any amendment made by this title,
13 shall be applied uniformly to all health plans in each insur-
14 ance market to which the standard and requirements
15 apply. The preceding sentence shall also apply to a State
16 standard or requirement relating to the standard or re-
17 quirement required by this title (or any such amendment)
18 that is not the same as the standard or requirement but
19 that is not preempted under section 1321(d).

20 **SEC. 1253. EFFECTIVE DATES.**

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

1 **Subtitle D—Available Coverage**
2 **Choices for All Americans**

3 **PART I—ESTABLISHMENT OF QUALIFIED**
4 **HEALTH PLANS**

5 **SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.**

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

7 (1) **IN GENERAL.**—The term “qualified health
8 plan” means a health plan that—

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

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

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

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

23 (ii) agrees to offer at least one quali-
24 fied health plan in the silver level and at

1 least one plan in the gold level in each
2 such Exchange;

3 (iii) agrees to charge the same pre-
4 mium rate for each qualified health plan of
5 the issuer without regard to whether the
6 plan is offered through an Exchange or
7 whether the plan is offered directly from
8 the issuer or through an agent; and

9 (iv) complies with the regulations de-
10 veloped by the Secretary under section
11 1311(d) and such other requirements as
12 an applicable Exchange may establish.

13 (2) INCLUSION OF CO-OP PLANS AND COMMU-
14 NITY HEALTH INSURANCE OPTION.—Any reference
15 in this title to a qualified health plan shall be
16 deemed to include a qualified health plan offered
17 through the CO-OP program under section 1322 or
18 a community health insurance option under section
19 1323, unless specifically provided for otherwise.

20 (b) TERMS RELATING TO HEALTH PLANS.—In this
21 title:

22 (1) HEALTH PLAN.—

23 (A) IN GENERAL.—The term “health plan”
24 means health insurance coverage and a group
25 health plan.

1 (B) EXCEPTION FOR SELF-INSURED PLANS
2 AND MEWAS.—Except to the extent specifically
3 provided by this title, the term “health plan”
4 shall not include a group health plan or mul-
5 tiple employer welfare arrangement to the ex-
6 tent the plan or arrangement is not subject to
7 State insurance regulation under section 514 of
8 the Employee Retirement Income Security Act
9 of 1974.

10 (2) HEALTH INSURANCE COVERAGE AND
11 ISSUER.—The terms “health insurance coverage”
12 and “health insurance issuer” have the meanings
13 given such terms by section 2791(b) of the Public
14 Health Service Act.

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

18 **SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.**

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

22 (1) provides for the essential health benefits de-
23 fined by the Secretary under subsection (b);

24 (2) limits cost-sharing for such coverage in ac-
25 cordance with subsection (c); and

1 (3) subject to subsection (e), provides either the
2 bronze, silver, gold, or platinum level of coverage de-
3 scribed in subsection (d).

4 (b) ESSENTIAL HEALTH BENEFITS.—

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

10 (A) Ambulatory patient services.

11 (B) Emergency services.

12 (C) Hospitalization.

13 (D) Maternity and newborn care.

14 (E) Mental health and substance use dis-
15 order services, including behavioral health treat-
16 ment.

17 (F) Prescription drugs.

18 (G) Rehabilitative and habilitative services
19 and devices.

20 (H) Laboratory services.

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

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

25 (2) LIMITATION.—

1 (A) IN GENERAL.—The Secretary shall en-
2 sure that the scope of the essential health bene-
3 fits under paragraph (1) is equal to the scope
4 of benefits provided under a typical employer
5 plan, as determined by the Secretary. To in-
6 form this determination, the Secretary of Labor
7 shall conduct a survey of employer-sponsored
8 coverage to determine the benefits typically cov-
9 ered by employers, including multiemployer
10 plans, and provide a report on such survey to
11 the Secretary.

12 (B) CERTIFICATION.—In defining the es-
13 sential health benefits described in paragraph
14 (1), and in revising the benefits under para-
15 graph (4)(H), the Secretary shall submit a re-
16 port to the appropriate committees of Congress
17 containing a certification from the Chief Actua-
18 ry of the Centers for Medicare & Medicaid
19 Services that such essential health benefits meet
20 the limitation described in paragraph (2).

21 (3) NOTICE AND HEARING.—In defining the es-
22 sential health benefits described in paragraph (1),
23 and in revising the benefits under paragraph (4)(H),
24 the Secretary shall provide notice and an oppor-
25 tunity for public comment.

1 (4) REQUIRED ELEMENTS FOR CONSIDER-
2 ATION.—In defining the essential health benefits
3 under paragraph (1), the Secretary shall—

4 (A) ensure that such essential health bene-
5 fits reflect an appropriate balance among the
6 categories described in such subsection, so that
7 benefits are not unduly weighted toward any
8 category;

9 (B) not make coverage decisions, deter-
10 mine reimbursement rates, establish incentive
11 programs, or design benefits in ways that dis-
12 criminate against individuals because of their
13 age, disability, or expected length of life;

14 (C) take into account the health care needs
15 of diverse segments of the population, including
16 women, children, persons with disabilities, and
17 other groups;

18 (D) ensure that health benefits established
19 as essential not be subject to denial to individ-
20 uals against their wishes on the basis of the in-
21 dividuals' age or expected length of life or of
22 the individuals' present or predicted disability,
23 degree of medical dependency, or quality of life;

24 (E) provide that a qualified health plan
25 shall not be treated as providing coverage for

1 the essential health benefits described in para-
2 graph (1) unless the plan provides that—

3 (i) coverage for emergency department
4 services will be provided without imposing
5 any requirement under the plan for prior
6 authorization of services or any limitation
7 on coverage where the provider of services
8 does not have a contractual relationship
9 with the plan for the providing of services
10 that is more restrictive than the require-
11 ments or limitations that apply to emer-
12 gency department services received from
13 providers who do have such a contractual
14 relationship with the plan; and

15 (ii) if such services are provided out-
16 of-network, the cost-sharing requirement
17 (expressed as a copayment amount or coin-
18 surance rate) is the same requirement that
19 would apply if such services were provided
20 in-network;

21 (F) provide that if a plan described in sec-
22 tion 1311(b)(2)(B)(ii) (relating to stand-alone
23 dental benefits plans) is offered through an Ex-
24 change, another health plan offered through
25 such Exchange shall not fail to be treated as a

1 qualified health plan solely because the plan
2 does not offer coverage of benefits offered
3 through the stand-alone plan that are otherwise
4 required under paragraph (1)(J); and

5 (G) periodically review the essential health
6 benefits under paragraph (1), and provide a re-
7 port to Congress and the public that contains—

8 (i) an assessment of whether enrollees
9 are facing any difficulty accessing needed
10 services for reasons of coverage or cost;

11 (ii) an assessment of whether the es-
12 sential health benefits needs to be modified
13 or updated to account for changes in med-
14 ical evidence or scientific advancement;

15 (iii) information on how the essential
16 health benefits will be modified to address
17 any such gaps in access or changes in the
18 evidence base;

19 (iv) an assessment of the potential of
20 additional or expanded benefits to increase
21 costs and the interactions between the ad-
22 dition or expansion of benefits and reduc-
23 tions in existing benefits to meet actuarial
24 limitations described in paragraph (2); and

1 (H) periodically update the essential health
2 benefits under paragraph (1) to address any
3 gaps in access to coverage or changes in the
4 evidence base the Secretary identifies in the re-
5 view conducted under subparagraph (G).

6 (5) RULE OF CONSTRUCTION.—Nothing in this
7 title shall be construed to prohibit a health plan
8 from providing benefits in excess of the essential
9 health benefits described in this subsection.

10 (c) REQUIREMENTS RELATING TO COST-SHARING.—

11 (1) ANNUAL LIMITATION ON COST-SHARING.—

12 (A) 2014.—The cost-sharing incurred
13 under a health plan with respect to self-only
14 coverage or coverage other than self-only cov-
15 erage for a plan year beginning in 2014 shall
16 not exceed the dollar amounts in effect under
17 section 223(c)(2)(A)(ii) of the Internal Revenue
18 Code of 1986 for self-only and family coverage,
19 respectively, for taxable years beginning in
20 2014.

21 (B) 2015 AND LATER.—In the case of any
22 plan year beginning in a calendar year after
23 2014, the limitation under this paragraph
24 shall—

1 (i) in the case of self-only coverage, be
2 equal to the dollar amount under subpara-
3 graph (A) for self-only coverage for plan
4 years beginning in 2014, increased by an
5 amount equal to the product of that
6 amount and the premium adjustment per-
7 centage under paragraph (4) for the cal-
8 endar year; and

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

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

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

16 (A) IN GENERAL.—In the case of a health
17 plan offered in the small group market, the de-
18 ductible under the plan shall not exceed—

19 (i) \$2,000 in the case of a plan cov-
20 ering a single individual; and

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

23 The amounts under clauses (i) and (ii) may be
24 increased by the maximum amount of reim-
25 bursement which is reasonably available to a

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

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

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

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

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

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

1 manner so as to not affect the actuarial value
2 of any health plan, including a plan in the
3 bronze level.

4 (D) COORDINATION WITH PREVENTIVE
5 LIMITS.—Nothing in this paragraph shall be
6 construed to allow a plan to have a deductible
7 under the plan apply to benefits described in
8 section 2713 of the Public Health Service Act.

9 (3) COST-SHARING.—In this title—

10 (A) IN GENERAL.—The term “cost-shar-
11 ing” includes—

12 (i) deductibles, coinsurance, copay-
13 ments, or similar charges; and

14 (ii) any other expenditure required of
15 an insured individual which is a qualified
16 medical expense (within the meaning of
17 section 223(d)(2) of the Internal Revenue
18 Code of 1986) with respect to essential
19 health benefits covered under the plan.

20 (B) EXCEPTIONS.—Such term does not in-
21 clude premiums, balance billing amounts for
22 non-network providers, or spending for non-cov-
23 ered services.

24 (4) PREMIUM ADJUSTMENT PERCENTAGE.—For
25 purposes of paragraphs (1)(B)(i) and (2)(B)(i), the

1 premium adjustment percentage for any calendar
2 year is the percentage (if any) by which the average
3 per capita premium for health insurance coverage in
4 the United States for the preceding calendar year
5 (as estimated by the Secretary no later than October
6 1 of such preceding calendar year) exceeds such av-
7 erage per capita premium for 2013 (as determined
8 by the Secretary).

9 (d) LEVELS OF COVERAGE.—

10 (1) LEVELS OF COVERAGE DEFINED.—The lev-
11 els of coverage described in this subsection are as
12 follows:

13 (A) BRONZE LEVEL.—A plan in the bronze
14 level shall provide a level of coverage that is de-
15 signed to provide benefits that are actuarially
16 equivalent to 60 percent of the full actuarial
17 value of the benefits provided under the plan.

18 (B) SILVER LEVEL.—A plan in the silver
19 level shall provide a level of coverage that is de-
20 signed to provide benefits that are actuarially
21 equivalent to 70 percent of the full actuarial
22 value of the benefits provided under the plan.

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

1 lent to 80 percent of the full actuarial value of
2 the benefits provided under the plan.

3 (D) PLATINUM LEVEL.—A plan in the
4 platinum level shall provide a level of coverage
5 that is designed to provide benefits that are ac-
6 tuarially equivalent to 90 percent of the full ac-
7 tuarial value of the benefits provided under the
8 plan.

9 (2) ACTUARIAL VALUE.—

10 (A) IN GENERAL.—Under regulations
11 issued by the Secretary, the level of coverage of
12 a plan shall be determined on the basis that the
13 essential health benefits described in subsection
14 (b) shall be provided to a standard population
15 (and without regard to the population the plan
16 may actually provide benefits to).

17 (B) EMPLOYER CONTRIBUTIONS.—The
18 Secretary may issue regulations under which
19 employer contributions to a health savings ac-
20 count (within the meaning of section 223 of the
21 Internal Revenue Code of 1986) may be taken
22 into account in determining the level of cov-
23 erage for a plan of the employer.

24 (C) APPLICATION.—In determining under
25 this title, the Public Health Service Act, or the

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

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

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

17 (e) CATASTROPHIC PLAN.—

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

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

25 (B) the plan provides—

1 (i) except as provided in clause (ii),
2 the essential health benefits determined
3 under subsection (b), except that the plan
4 provides no benefits for any plan year until
5 the individual has incurred cost-sharing ex-
6 penses in an amount equal to the annual
7 limitation in effect under subsection (e)(1)
8 for the plan year (except as provided for in
9 section 2713); and

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

12 (2) INDIVIDUALS ELIGIBLE FOR ENROLL-
13 MENT.—An individual is described in this paragraph
14 for any plan year if the individual—

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

17 (B) has a certification in effect for any
18 plan year under this title that the individual is
19 exempt from the requirement under section
20 5000A of the Internal Revenue Code of 1986
21 by reason of—

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

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

3 (3) RESTRICTION TO INDIVIDUAL MARKET.—If
4 a health insurance issuer offers a health plan de-
5 scribed in this subsection, the issuer may only offer
6 the plan in the individual market.

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

14 **SEC. 1303. SPECIAL RULES.**

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

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

19 (A) IN GENERAL.—Notwithstanding any
20 other provision of this title (or any amendment
21 made by this title), and subject to subpara-
22 graphs (C) and (D)—

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

1 to provide coverage of services described in
2 subparagraph (B)(i) or (B)(ii) as part of
3 its essential health benefits for any plan
4 year; and

5 (ii) the issuer of a qualified health
6 plan shall determine whether or not the
7 plan provides coverage of services described
8 in subparagraph (B)(i) or (B)(ii) as part
9 of such benefits for the plan year.

10 (B) ABORTION SERVICES.—

11 (i) ABORTIONS FOR WHICH PUBLIC
12 FUNDING IS PROHIBITED.—The services
13 described in this clause are abortions for
14 which the expenditure of Federal funds ap-
15 propriated for the Department of Health
16 and Human Services is not permitted,
17 based on the law as in effect as of the date
18 that is 6 months before the beginning of
19 the plan year involved.

20 (ii) ABORTIONS FOR WHICH PUBLIC
21 FUNDING IS ALLOWED.—The services de-
22 scribed in this clause are abortions for
23 which the expenditure of Federal funds ap-
24 propriated for the Department of Health
25 and Human Services is permitted, based

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

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

7 (i) DETERMINATION BY SEC-
8 RETARY.—The Secretary may not deter-
9 mine, in accordance with subparagraph
10 (A)(ii), that the community health insur-
11 ance option established under section 1323
12 shall provide coverage of services described
13 in subparagraph (B)(i) as part of benefits
14 for the plan year unless the Secretary—

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

17 (II) assures, in accordance with
18 applicable provisions of generally ac-
19 cepted accounting requirements, circu-
20 lars on funds management of the Of-
21 fice of Management and Budget, and
22 guidance on accounting of the Govern-
23 ment Accountability Office, that no
24 Federal funds are used for such cov-
25 erage; and

1 (III) notwithstanding section
2 1323(e)(1)(C) or any other provision
3 of this title, takes all necessary steps
4 to assure that the United States does
5 not bear the insurance risk for a com-
6 munity health insurance option's cov-
7 erage of services described in subpara-
8 graph (B)(i).

9 (ii) STATE REQUIREMENT.—If a State
10 requires, in addition to the essential health
11 benefits required under section 1323(b)(3)
12 (A), coverage of services described in sub-
13 paragraph (B)(i) for enrollees of a commu-
14 nity health insurance option offered in
15 such State, the State shall assure that no
16 funds flowing through or from the commu-
17 nity health insurance option, and no other
18 Federal funds, pay or defray the cost of
19 providing coverage of services described in
20 subparagraph (B)(i). The United States
21 shall not bear the insurance risk for a
22 State's required coverage of services de-
23 scribed in subparagraph (B)(i).

24 (iii) EXCEPTIONS.—Nothing in this
25 subparagraph shall apply to coverage of

1 services described in subparagraph (B)(ii)
2 by the community health insurance option.
3 Services described in subparagraph (B)(ii)
4 shall be covered to the same extent as such
5 services are covered under title XIX of the
6 Social Security Act.

7 (D) ASSURED AVAILABILITY OF VARIED
8 COVERAGE THROUGH EXCHANGES.—

9 (i) IN GENERAL.—The Secretary shall
10 assure that with respect to qualified health
11 plans offered in any Exchange established
12 pursuant to this title—

13 (I) there is at least one such plan
14 that provides coverage of services de-
15 scribed in clauses (i) and (ii) of sub-
16 paragraph (B); and

17 (II) there is at least one such
18 plan that does not provide coverage of
19 services described in subparagraph
20 (B)(i).

21 (ii) SPECIAL RULES.—For purposes of
22 clause (i)—

23 (I) a plan shall be treated as de-
24 scribed in clause (i)(II) if the plan
25 does not provide coverage of services

1 described in either subparagraph
2 (B)(i) or (B)(ii); and

3 (II) if a State has one Exchange
4 covering more than 1 insurance mar-
5 ket, the Secretary shall meet the re-
6 quirements of clause (i) separately
7 with respect to each such market.

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

10 (A) IN GENERAL.—If a qualified health
11 plan provides coverage of services described in
12 paragraph (1)(B)(i), the issuer of the plan shall
13 not use any amount attributable to any of the
14 following for purposes of paying for such serv-
15 ices:

16 (i) The credit under section 36B of
17 the Internal Revenue Code of 1986 (and
18 the amount (if any) of the advance pay-
19 ment of the credit under section 1412 of
20 the Patient Protection and Affordable Care
21 Act).

22 (ii) Any cost-sharing reduction under
23 section 1402 of the Patient Protection and
24 Affordable Care Act (and the amount (if
25 any) of the advance payment of the reduc-

1 tion under section 1412 of the Patient
2 Protection and Affordable Care Act).

3 (B) SEGREGATION OF FUNDS.—In the case
4 of a plan to which subparagraph (A) applies,
5 the issuer of the plan shall, out of amounts not
6 described in subparagraph (A), segregate an
7 amount equal to the actuarial amounts deter-
8 mined under subparagraph (C) for all enrollees
9 from the amounts described in subparagraph
10 (A).

11 (C) ACTUARIAL VALUE OF OPTIONAL
12 SERVICE COVERAGE.—

13 (i) IN GENERAL.—The Secretary shall
14 estimate the basic per enrollee, per month
15 cost, determined on an average actuarial
16 basis, for including coverage under a quali-
17 fied health plan of the services described in
18 paragraph (1)(B)(i).

19 (ii) CONSIDERATIONS.—In making
20 such estimate, the Secretary—

21 (I) may take into account the im-
22 pact on overall costs of the inclusion
23 of such coverage, but may not take
24 into account any cost reduction esti-
25 mated to result from such services, in-

1 including prenatal care, delivery, or
2 postnatal care;

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

6 (III) may not estimate such a
7 cost at less than \$1 per enrollee, per
8 month.

9 (3) PROVIDER CONSCIENCE PROTECTIONS.—No
10 individual health care provider or health care facility
11 may be discriminated against because of a willing-
12 ness or an unwillingness, if doing so is contrary to
13 the religious or moral beliefs of the provider or facil-
14 ity, to provide, pay for, provide coverage of, or refer
15 for abortions.

16 (b) APPLICATION OF STATE AND FEDERAL LAWS
17 REGARDING ABORTION.—

18 (1) NO PREEMPTION OF STATE LAWS REGARD-
19 ING ABORTION.—Nothing in this Act shall be con-
20 strued to preempt or otherwise have any effect on
21 State laws regarding the prohibition of (or require-
22 ment of) coverage, funding, or procedural require-
23 ments on abortions, including parental notification
24 or consent for the performance of an abortion on a
25 minor.

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

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

6 (i) conscience protection;

7 (ii) willingness or refusal to provide
8 abortion; and

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

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

17 (c) APPLICATION OF EMERGENCY SERVICES
18 LAWS.—Nothing in this Act shall be construed to relieve
19 any health care provider from providing emergency serv-
20 ices as required by State or Federal law, including section
21 1867 of the Social Security Act (popularly known as
22 “EMTALA”).

23 **SEC. 1304. RELATED DEFINITIONS.**

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

1 (1) GROUP MARKET.—The term “group mar-
2 ket” means the health insurance market under
3 which individuals obtain health insurance coverage
4 (directly or through any arrangement) on behalf of
5 themselves (and their dependents) through a group
6 health plan maintained by an employer.

7 (2) INDIVIDUAL MARKET.—The term “indi-
8 vidual market” means the market for health insur-
9 ance coverage offered to individuals other than in
10 connection with a group health plan.

11 (3) LARGE AND SMALL GROUP MARKETS.—The
12 terms “large group market” and “small group mar-
13 ket” mean the health insurance market under which
14 individuals obtain health insurance coverage (directly
15 or through any arrangement) on behalf of them-
16 selves (and their dependents) through a group health
17 plan maintained by a large employer (as defined in
18 subsection (b)(1)) or by a small employer (as defined
19 in subsection (b)(2)), respectively.

20 (b) EMPLOYERS.—In this title:

21 (1) LARGE EMPLOYER.—The term “large em-
22 ployer” means, in connection with a group health
23 plan with respect to a calendar year and a plan year,
24 an employer who employed an average of at least
25 101 employees on business days during the pre-

1 ceding calendar year and who employs at least 1 em-
2 ployee on the first day of the plan year.

3 (2) SMALL EMPLOYER.—The term “small em-
4 ployer” means, in connection with a group health
5 plan with respect to a calendar year and a plan year,
6 an employer who employed an average of at least 1
7 but not more than 100 employees on business days
8 during the preceding calendar year and who employs
9 at least 1 employee on the first day of the plan year.

10 (3) STATE OPTION TO TREAT 50 EMPLOYEES AS
11 SMALL.—In the case of plan years beginning before
12 January 1, 2016, a State may elect to apply this
13 subsection by substituting “51 employees” for “101
14 employees” in paragraph (1) and by substituting
15 “50 employees” for “100 employees” in paragraph
16 (2).

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

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

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

1 which was not in existence throughout the pre-
2 ceding calendar year, the determination of
3 whether such employer is a small or large em-
4 ployer shall be based on the average number of
5 employees that it is reasonably expected such
6 employer will employ on business days in the
7 current calendar year.

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

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

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

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

21 the employer shall continue to be treated as a
22 small employer for purposes of this subtitle for
23 the period beginning with the increase and end-
24 ing with the first day on which the employer

1 does not make such enrollment available to its
2 employees.

3 (c) SECRETARY.—In this title, the term “Secretary”
4 means the Secretary of Health and Human Services.

5 (d) STATE.—In this title, the term “State” means
6 each of the 50 States and the District of Columbia.

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

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

12 (a) ASSISTANCE TO STATES TO ESTABLISH AMER-
13 ICAN HEALTH BENEFIT EXCHANGES.—

14 (1) PLANNING AND ESTABLISHMENT
15 GRANTS.—There shall be appropriated to the Sec-
16 retary, out of any moneys in the Treasury not other-
17 wise appropriated, an amount necessary to enable
18 the Secretary to make awards, not later than 1 year
19 after the date of enactment of this Act, to States in
20 the amount specified in paragraph (2) for the uses
21 described in paragraph (3).

22 (2) AMOUNT SPECIFIED.—For each fiscal year,
23 the Secretary shall determine the total amount that
24 the Secretary will make available to each State for
25 grants under this subsection.

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

6 (4) RENEWABILITY OF GRANT.—

7 (A) IN GENERAL.—Subject to subsection
8 (d)(4), the Secretary may renew a grant award-
9 ed under paragraph (1) if the State recipient of
10 such grant—

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

13 (I) establishing an Exchange;

14 and

15 (II) implementing the reforms
16 described in subtitles A and C (and
17 the amendments made by such sub-
18 titles); and

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

21 (B) LIMITATION.—No grant shall be
22 awarded under this subsection after January 1,
23 2015.

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

1 retary shall provide technical assistance to States to
2 facilitate the participation of qualified small busi-
3 nesses in such States in SHOP Exchanges.

4 (b) AMERICAN HEALTH BENEFIT EXCHANGES.—

5 (1) IN GENERAL.—Each State shall, not later
6 than January 1, 2014, establish an American Health
7 Benefit Exchange (referred to in this title as an
8 “Exchange”) for the State that—

9 (A) facilitates the purchase of qualified
10 health plans;

11 (B) provides for the establishment of a
12 Small Business Health Options Program (in
13 this title referred to as a “SHOP Exchange”)
14 that is designed to assist qualified employers in
15 the State who are small employers in facili-
16 tating the enrollment of their employees in
17 qualified health plans offered in the small group
18 market in the State; and

19 (C) meets the requirements of subsection

20 (d).

21 (2) MERGER OF INDIVIDUAL AND SHOP EX-
22 CHANGES.—A State may elect to provide only one
23 Exchange in the State for providing both Exchange
24 and SHOP Exchange services to both qualified indi-
25 viduals and qualified small employers, but only if the

1 Exchange has adequate resources to assist such indi-
2 viduals and employers.

3 (c) RESPONSIBILITIES OF THE SECRETARY.—

4 (1) IN GENERAL.—The Secretary shall, by reg-
5 ulation, establish criteria for the certification of
6 health plans as qualified health plans. Such criteria
7 shall require that, to be certified, a plan shall, at a
8 minimum—

9 (A) meet marketing requirements, and not
10 employ marketing practices or benefit designs
11 that have the effect of discouraging the enroll-
12 ment in such plan by individuals with signifi-
13 cant health needs;

14 (B) ensure a sufficient choice of providers
15 (in a manner consistent with applicable network
16 adequacy provisions under section 2702(c) of
17 the Public Health Service Act), and provide in-
18 formation to enrollees and prospective enrollees
19 on the availability of in-network and out-of-net-
20 work providers;

21 (C) include within health insurance plan
22 networks those essential community providers,
23 where available, that serve predominately low-
24 income, medically-underserved individuals, such
25 as health care providers defined in section

1 340B(a)(4) of the Public Health Service Act
2 and providers described in section
3 1927(c)(1)(D)(i)(IV) of the Social Security Act
4 as set forth by section 221 of Public Law 111-
5 8, except that nothing in this subparagraph
6 shall be construed to require any health plan to
7 provide coverage for any specific medical proce-
8 dure;

9 (D)(i) be accredited with respect to local
10 performance on clinical quality measures such
11 as the Healthcare Effectiveness Data and Infor-
12 mation Set, patient experience ratings on a
13 standardized Consumer Assessment of
14 Healthcare Providers and Systems survey, as
15 well as consumer access, utilization manage-
16 ment, quality assurance, provider credentialing,
17 complaints and appeals, network adequacy and
18 access, and patient information programs by
19 any entity recognized by the Secretary for the
20 accreditation of health insurance issuers or
21 plans (so long as any such entity has trans-
22 parent and rigorous methodological and scoring
23 criteria); or

24 (ii) receive such accreditation within a pe-
25 riod established by an Exchange for such ac-

1 creditation that is applicable to all qualified
2 health plans;

3 (E) implement a quality improvement
4 strategy described in subsection (g)(1);

5 (F) utilize a uniform enrollment form that
6 qualified individuals and qualified employers
7 may use (either electronically or on paper) in
8 enrolling in qualified health plans offered
9 through such Exchange, and that takes into ac-
10 count criteria that the National Association of
11 Insurance Commissioners develops and submits
12 to the Secretary;

13 (G) utilize the standard format established
14 for presenting health benefits plan options; and

15 (H) provide information to enrollees and
16 prospective enrollees, and to each Exchange in
17 which the plan is offered, on any quality meas-
18 ures for health plan performance endorsed
19 under section 399JJ of the Public Health Serv-
20 ice Act, as applicable.

21 (2) RULE OF CONSTRUCTION.—Nothing in
22 paragraph (1)(C) shall be construed to require a
23 qualified health plan to contract with a provider de-
24 scribed in such paragraph if such provider refuses to

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

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

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

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

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

1 ings) regarding qualified health plans offered
2 through an Exchange to assist consumers in
3 making easy health insurance choices.

4 Such template shall include, with respect to each
5 qualified health plan offered through the Exchange
6 in each rating area, access to the uniform outline of
7 coverage the plan is required to provide under sec-
8 tion 2716 of the Public Health Service Act and to
9 a copy of the plan's written policy.

10 (5) ENROLLMENT PERIODS.—The Secretary
11 shall require an Exchange to provide for—

12 (A) an initial open enrollment, as deter-
13 mined by the Secretary (such determination to
14 be made not later than July 1, 2012);

15 (B) annual open enrollment periods, as de-
16 termined by the Secretary for calendar years
17 after the initial enrollment period;

18 (C) special enrollment periods specified in
19 section 9801 of the Internal Revenue Code of
20 1986 and other special enrollment periods
21 under circumstances similar to such periods
22 under part D of title XVIII of the Social Secu-
23 rity Act; and

1 (D) special monthly enrollment periods for
2 Indians (as defined in section 4 of the Indian
3 Health Care Improvement Act).

4 (d) REQUIREMENTS.—

5 (1) IN GENERAL.—An Exchange shall be a gov-
6 ernmental agency or nonprofit entity that is estab-
7 lished by a State.

8 (2) OFFERING OF COVERAGE.—

9 (A) IN GENERAL.—An Exchange shall
10 make available qualified health plans to quali-
11 fied individuals and qualified employers.

12 (B) LIMITATION.—

13 (i) IN GENERAL.—An Exchange may
14 not make available any health plan that is
15 not a qualified health plan.

16 (ii) OFFERING OF STAND-ALONE DEN-
17 TAL BENEFITS.—Each Exchange within a
18 State shall allow an issuer of a plan that
19 only provides limited scope dental benefits
20 meeting the requirements of section
21 9832(c)(2)(A) of the Internal Revenue
22 Code of 1986 to offer the plan through the
23 Exchange (either separately or in conjunc-
24 tion with a qualified health plan) if the
25 plan provides pediatric dental benefits

1 meeting the requirements of section
2 1302(b)(1)(J)).

3 (3) RULES RELATING TO ADDITIONAL RE-
4 QUIRED BENEFITS.—

5 (A) IN GENERAL.—Except as provided in
6 subparagraph (B), an Exchange may make
7 available a qualified health plan notwith-
8 standing any provision of law that may require
9 benefits other than the essential health benefits
10 specified under section 1302(b).

11 (B) STATES MAY REQUIRE ADDITIONAL
12 BENEFITS.—

13 (i) IN GENERAL.—Subject to the re-
14 quirements of clause (ii), a State may re-
15 quire that a qualified health plan offered
16 in such State offer benefits in addition to
17 the essential health benefits specified
18 under section 1302(b).

19 (ii) STATE MUST ASSUME COST.—A
20 State shall make payments to or on behalf
21 of an individual eligible for the premium
22 tax credit under section 36B of the Inter-
23 nal Revenue Code of 1986 and any cost-
24 sharing reduction under section 1402 to
25 defray the cost to the individual of any ad-

1 ditional benefits described in clause (i)
2 which are not eligible for such credit or re-
3 duction under section 36B(b)(3)(D) of
4 such Code and section 1402(c)(4).

5 (4) FUNCTIONS.—An Exchange shall, at a min-
6 imum—

7 (A) implement procedures for the certifi-
8 cation, recertification, and decertification, con-
9 sistent with guidelines developed by the Sec-
10 retary under subsection (c), of health plans as
11 qualified health plans;

12 (B) provide for the operation of a toll-free
13 telephone hotline to respond to requests for as-
14 sistance;

15 (C) maintain an Internet website through
16 which enrollees and prospective enrollees of
17 qualified health plans may obtain standardized
18 comparative information on such plans;

19 (D) assign a rating to each qualified health
20 plan offered through such Exchange in accord-
21 ance with the criteria developed by the Sec-
22 retary under subsection (c)(3);

23 (E) utilize a standardized format for pre-
24 senting health benefits plan options in the Ex-
25 change, including the use of the uniform outline

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

3 (F) in accordance with section 1413, in-
4 form individuals of eligibility requirements for
5 the medicaid program under title XIX of the
6 Social Security Act, the CHIP program under
7 title XXI of such Act, or any applicable State
8 or local public program and if through screen-
9 ing of the application by the Exchange, the Ex-
10 change determines that such individuals are eli-
11 gible for any such program, enroll such individ-
12 uals in such program;

13 (G) establish and make available by elec-
14 tronic means a calculator to determine the ac-
15 tual cost of coverage after the application of
16 any premium tax credit under section 36B of
17 the Internal Revenue Code of 1986 and any
18 cost-sharing reduction under section 1402;

19 (H) subject to section 1411, grant a cer-
20 tification attesting that, for purposes of the in-
21 dividual responsibility penalty under section
22 5000A of the Internal Revenue Code of 1986,
23 an individual is exempt from the individual re-
24 quirement or from the penalty imposed by such
25 section because—

1 (i) there is no affordable qualified
2 health plan available through the Ex-
3 change, or the individual's employer, cov-
4 ering the individual; or

5 (ii) the individual meets the require-
6 ments for any other such exemption from
7 the individual responsibility requirement or
8 penalty;

9 (I) transfer to the Secretary of the Treas-
10 ury—

11 (i) a list of the individuals who are
12 issued a certification under subparagraph
13 (H), including the name and taxpayer
14 identification number of each individual;

15 (ii) the name and taxpayer identifica-
16 tion number of each individual who was an
17 employee of an employer but who was de-
18 termined to be eligible for the premium tax
19 credit under section 36B of the Internal
20 Revenue Code of 1986 because—

21 (I) the employer did not provide
22 minimum essential coverage; or

23 (II) the employer provided such
24 minimum essential coverage but it
25 was determined under section

1 36B(c)(2)(C) of such Code to either
2 be unaffordable to the employee or
3 not provide the required minimum ac-
4 tuarial value; and

5 (iii) the name and taxpayer identifica-
6 tion number of each individual who notifies
7 the Exchange under section 1411(b)(4)
8 that they have changed employers and of
9 each individual who ceases coverage under
10 a qualified health plan during a plan year
11 (and the effective date of such cessation);

12 (J) provide to each employer the name of
13 each employee of the employer described in sub-
14 paragraph (I)(ii) who ceases coverage under a
15 qualified health plan during a plan year (and
16 the effective date of such cessation); and

17 (K) establish the Navigator program de-
18 scribed in subsection (i).

19 (5) FUNDING LIMITATIONS.—

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

1 participating health insurance issuers, or to
2 otherwise generate funding, to support its oper-
3 ations.

4 (B) PROHIBITING WASTEFUL USE OF
5 FUNDS.—In carrying out activities under this
6 subsection, an Exchange shall not utilize any
7 funds intended for the administrative and oper-
8 ational expenses of the Exchange for staff re-
9 treats, promotional giveaways, excessive execu-
10 tive compensation, or promotion of Federal or
11 State legislative and regulatory modifications.

12 (6) CONSULTATION.—An Exchange shall con-
13 sult with stakeholders relevant to carrying out the
14 activities under this section, including—

15 (A) health care consumers who are enroll-
16 ees in qualified health plans;

17 (B) individuals and entities with experience
18 in facilitating enrollment in qualified health
19 plans;

20 (C) representatives of small businesses and
21 self-employed individuals;

22 (D) State Medicaid offices; and

23 (E) advocates for enrolling hard to reach
24 populations.

1 (7) PUBLICATION OF COSTS.—An Exchange
2 shall publish the average costs of licensing, regu-
3 latory fees, and any other payments required by the
4 Exchange, and the administrative costs of such Ex-
5 change, on an Internet website to educate consumers
6 on such costs. Such information shall also include
7 monies lost to waste, fraud, and abuse.

8 (e) CERTIFICATION.—

9 (1) IN GENERAL.—An Exchange may certify a
10 health plan as a qualified health plan if—

11 (A) such health plan meets the require-
12 ments for certification as promulgated by the
13 Secretary under subsection (c)(1); and

14 (B) the Exchange determines that making
15 available such health plan through such Ex-
16 change is in the interests of qualified individ-
17 uals and qualified employers in the State or
18 States in which such Exchange operates, except
19 that the Exchange may not exclude a health
20 plan—

21 (i) on the basis that such plan is a
22 fee-for-service plan;

23 (ii) through the imposition of pre-
24 mium price controls; or

1 (iii) on the basis that the plan pro-
2 vides treatments necessary to prevent pa-
3 tients' deaths in circumstances the Ex-
4 change determines are inappropriate or too
5 costly.

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

24 (f) FLEXIBILITY.—

1 (1) REGIONAL OR OTHER INTERSTATE EX-
2 CHANGES.—An Exchange may operate in more than
3 one State if—

4 (A) each State in which such Exchange op-
5 erates permits such operation; and

6 (B) the Secretary approves such regional
7 or interstate Exchange.

8 (2) SUBSIDIARY EXCHANGES.—A State may es-
9 tablish one or more subsidiary Exchanges if—

10 (A) each such Exchange serves a geo-
11 graphically distinct area; and

12 (B) the area served by each such Exchange
13 is at least as large as a rating area described
14 in section 2701(a) of the Public Health Service
15 Act.

16 (3) AUTHORITY TO CONTRACT.—

17 (A) IN GENERAL.—A State may elect to
18 authorize an Exchange established by the State
19 under this section to enter into an agreement
20 with an eligible entity to carry out 1 or more
21 responsibilities of the Exchange.

22 (B) ELIGIBLE ENTITY.—In this para-
23 graph, the term “eligible entity” means—

24 (i) a person—

1 (I) incorporated under, and sub-
 2 ject to the laws of, 1 or more States;

3 (II) that has demonstrated expe-
 4 rience on a State or regional basis in
 5 the individual and small group health
 6 insurance markets and in benefits cov-
 7 erage; and

8 (III) that is not a health insur-
 9 ance issuer or that is treated under
 10 subsection (a) or (b) of section 52 of
 11 the Internal Revenue Code of 1986 as
 12 a member of the same controlled
 13 group of corporations (or under com-
 14 mon control with) as a health insur-
 15 ance issuer; or

16 (ii) the State medicaid agency under
 17 title XIX of the Social Security Act.

18 (g) REWARDING QUALITY THROUGH MARKET-
 19 BASED INCENTIVES.—

20 (1) STRATEGY DESCRIBED.—A strategy de-
 21 scribed in this paragraph is a payment structure
 22 that provides increased reimbursement or other in-
 23 centives for—

24 (A) improving health outcomes through the
 25 implementation of activities that shall include

1 quality reporting, effective case management,
2 care coordination, chronic disease management,
3 medication and care compliance initiatives, in-
4 cluding through the use of the medical home
5 model, for treatment or services under the plan
6 or coverage;

7 (B) the implementation of activities to pre-
8 vent hospital readmissions through a com-
9 prehensive program for hospital discharge that
10 includes patient-centered education and coun-
11 seling, comprehensive discharge planning, and
12 post discharge reinforcement by an appropriate
13 health care professional;

14 (C) the implementation of activities to im-
15 prove patient safety and reduce medical errors
16 through the appropriate use of best clinical
17 practices, evidence based medicine, and health
18 information technology under the plan or cov-
19 erage; and

20 (D) the implementation of wellness and
21 health promotion activities.

22 (2) GUIDELINES.—The Secretary, in consulta-
23 tion with experts in health care quality and stake-
24 holders, shall develop guidelines concerning the mat-
25 ters described in paragraph (1).

1 (3) REQUIREMENTS.—The guidelines developed
2 under paragraph (2) shall require the periodic re-
3 porting to the applicable Exchange of the activities
4 that a qualified health plan has conducted to imple-
5 ment a strategy described in paragraph (1).

6 (h) QUALITY IMPROVEMENT.—

7 (1) ENHANCING PATIENT SAFETY.—Beginning
8 on January 1, 2015, a qualified health plan may
9 contract with—

10 (A) a hospital with greater than 50 beds
11 only if such hospital—

12 (i) utilizes a patient safety evaluation
13 system as described in part C of title IX
14 of the Public Health Service Act; and

15 (ii) implements a mechanism to en-
16 sure that each patient receives a com-
17 prehensive program for hospital discharge
18 that includes patient-centered education
19 and counseling, comprehensive discharge
20 planning, and post discharge reinforcement
21 by an appropriate health care professional;
22 or

23 (B) a health care provider only if such pro-
24 vider implements such mechanisms to improve

1 health care quality as the Secretary may by reg-
2 ulation require.

3 (2) EXCEPTIONS.—The Secretary may establish
4 reasonable exceptions to the requirements described
5 in paragraph (1).

6 (3) ADJUSTMENT.—The Secretary may by reg-
7 ulation adjust the number of beds described in para-
8 graph (1)(A).

9 (i) NAVIGATORS.—

10 (1) IN GENERAL.—An Exchange shall establish
11 a program under which it awards grants to entities
12 described in paragraph (2) to carry out the duties
13 described in paragraph (3).

14 (2) ELIGIBILITY.—

15 (A) IN GENERAL.—To be eligible to receive
16 a grant under paragraph (1), an entity shall
17 demonstrate to the Exchange involved that the
18 entity has existing relationships, or could read-
19 ily establish relationships, with employers and
20 employees, consumers (including uninsured and
21 underinsured consumers), or self-employed indi-
22 viduals likely to be qualified to enroll in a quali-
23 fied health plan.

24 (B) TYPES.—Entities described in sub-
25 paragraph (A) may include trade, industry, and

1 professional associations, commercial fishing in-
2 dustry organizations, ranching and farming or-
3 ganizations, community and consumer-focused
4 nonprofit groups, chambers of commerce,
5 unions, small business development centers,
6 other licensed insurance agents and brokers,
7 and other entities that—

8 (i) are capable of carrying out the du-
9 ties described in paragraph (3);

10 (ii) meet the standards described in
11 paragraph (4); and

12 (iii) provide information consistent
13 with the standards developed under para-
14 graph (5).

15 (3) DUTIES.—An entity that serves as a navi-
16 gator under a grant under this subsection shall—

17 (A) conduct public education activities to
18 raise awareness of the availability of qualified
19 health plans;

20 (B) distribute fair and impartial informa-
21 tion concerning enrollment in qualified health
22 plans, and the availability of premium tax cred-
23 its under section 36B of the Internal Revenue
24 Code of 1986 and cost-sharing reductions under
25 section 1402;

1 (C) facilitate enrollment in qualified health
2 plans;

3 (D) provide referrals to any applicable of-
4 fice of health insurance consumer assistance or
5 health insurance ombudsman established under
6 section 2793 of the Public Health Service Act,
7 or any other appropriate State agency or agen-
8 cies, for any enrollee with a grievance, com-
9 plaint, or question regarding their health plan,
10 coverage, or a determination under such plan or
11 coverage; and

12 (E) provide information in a manner that
13 is culturally and linguistically appropriate to
14 the needs of the population being served by the
15 Exchange or Exchanges.

16 (4) STANDARDS.—

17 (A) IN GENERAL.—The Secretary shall es-
18 tablish standards for navigators under this sub-
19 section, including provisions to ensure that any
20 private or public entity that is selected as a
21 navigator is qualified, and licensed if appro-
22 priate, to engage in the navigator activities de-
23 scribed in this subsection and to avoid conflicts
24 of interest. Under such standards, a navigator
25 shall not—

- 1 (i) be a health insurance issuer; or
2 (ii) receive any consideration directly
3 or indirectly from any health insurance
4 issuer in connection with the enrollment of
5 any qualified individuals or employees of a
6 qualified employer in a qualified health
7 plan.

8 (5) FAIR AND IMPARTIAL INFORMATION AND
9 SERVICES.—The Secretary, in collaboration with
10 States, shall develop standards to ensure that infor-
11 mation made available by navigators is fair, accu-
12 rate, and impartial.

13 (6) FUNDING.—Grants under this subsection
14 shall be made from the operational funds of the Ex-
15 change and not Federal funds received by the State
16 to establish the Exchange.

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

22 (k) CONFLICT.—An Exchange may not establish
23 rules that conflict with or prevent the application of regu-
24 lations promulgated by the Secretary under this subtitle.

1 **SEC. 1312. CONSUMER CHOICE.**

2 (a) CHOICE.—

3 (1) QUALIFIED INDIVIDUALS.—A qualified indi-
4 vidual may enroll in any qualified health plan avail-
5 able to such individual.

6 (2) QUALIFIED EMPLOYERS.—

7 (A) EMPLOYER MAY SPECIFY LEVEL.—A
8 qualified employer may provide support for cov-
9 erage of employees under a qualified health
10 plan by selecting any level of coverage under
11 section 1302(d) to be made available to employ-
12 ees through an Exchange.

13 (B) EMPLOYEE MAY CHOOSE PLANS WITH-
14 IN A LEVEL.—Each employee of a qualified em-
15 ployer that elects a level of coverage under sub-
16 paragraph (A) may choose to enroll in a quali-
17 fied health plan that offers coverage at that
18 level.

19 (b) PAYMENT OF PREMIUMS BY QUALIFIED INDIVID-
20 UALS.—A qualified individual enrolled in any qualified
21 health plan may pay any applicable premium owed by such
22 individual to the health insurance issuer issuing such
23 qualified health plan.

24 (c) SINGLE RISK POOL.—

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

1 (other than grandfathered health plans) offered by
2 such issuer in the individual market, including those
3 enrollees who do not enroll in such plans through
4 the Exchange, to be members of a single risk pool.

5 (2) SMALL GROUP MARKET.—A health insurance
6 issuer shall consider all enrollees in all health
7 plans (other than grandfathered health plans) offered
8 by such issuer in the small group market, including
9 those enrollees who do not enroll in such
10 plans through the Exchange, to be members of a
11 single risk pool.

12 (3) MERGER OF MARKETS.—A State may require
13 the individual and small group insurance markets
14 within a State to be merged if the State determines
15 appropriate.

16 (4) STATE LAW.—A State law requiring grandfathered
17 health plans to be included in a pool described in
18 paragraph (1) or (2) shall not apply.

19 (d) EMPOWERING CONSUMER CHOICE.—

20 (1) CONTINUED OPERATION OF MARKET OUTSIDE
21 EXCHANGES.—Nothing in this title shall be
22 construed to prohibit—

23 (A) a health insurance issuer from offering
24 outside of an Exchange a health plan to a
25 qualified individual or qualified employer; and

1 (B) a qualified individual from enrolling in,
2 or a qualified employer from selecting for its
3 employees, a health plan offered outside of an
4 Exchange.

5 (2) CONTINUED OPERATION OF STATE BENEFIT
6 REQUIREMENTS.—Nothing in this title shall be con-
7 strued to terminate, abridge, or limit the operation
8 of any requirement under State law with respect to
9 any policy or plan that is offered outside of an Ex-
10 change to offer benefits.

11 (3) VOLUNTARY NATURE OF AN EXCHANGE.—

12 (A) CHOICE TO ENROLL OR NOT TO EN-
13 ROLL.—Nothing in this title shall be construed
14 to restrict the choice of a qualified individual to
15 enroll or not to enroll in a qualified health plan
16 or to participate in an Exchange.

17 (B) PROHIBITION AGAINST COMPELLED
18 ENROLLMENT.—Nothing in this title shall be
19 construed to compel an individual to enroll in a
20 qualified health plan or to participate in an Ex-
21 change.

22 (C) INDIVIDUALS ALLOWED TO ENROLL IN
23 ANY PLAN.—A qualified individual may enroll
24 in any qualified health plan, except that in the
25 case of a catastrophic plan described in section

1 1302(e), a qualified individual may enroll in the
2 plan only if the individual is eligible to enroll in
3 the plan under section 1302(e)(2).

4 (D) MEMBERS OF CONGRESS IN THE EX-
5 CHANGE.—

6 (i) REQUIREMENT.—Notwithstanding
7 any other provision of law, after the effec-
8 tive date of this subtitle, the only health
9 plans that the Federal Government may
10 make available to Members of Congress
11 and congressional staff with respect to
12 their service as a Member of Congress or
13 congressional staff shall be health plans
14 that are—

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

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

20 (ii) DEFINITIONS.—In this section:

21 (I) MEMBER OF CONGRESS.—

22 The term “Member of Congress”
23 means any member of the House of
24 Representatives or the Senate.

1 (II) CONGRESSIONAL STAFF.—

2 The term “congressional staff” means
3 all full-time and part-time employees
4 employed by the official office of a
5 Member of Congress, whether in
6 Washington, DC or outside of Wash-
7 ington, DC.

8 (4) NO PENALTY FOR TRANSFERRING TO MIN-
9 IMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—

10 An Exchange, or a qualified health plan offered
11 through an Exchange, shall not impose any penalty
12 or other fee on an individual who cancels enrollment
13 in a plan because the individual becomes eligible for
14 minimum essential coverage (as defined in section
15 5000A(f) of the Internal Revenue Code of 1986
16 without regard to paragraph (1)(C) or (D) thereof)
17 or such coverage becomes affordable (within the
18 meaning of section 36B(e)(2)(C) of such Code).

19 (e) ENROLLMENT THROUGH AGENTS OR BRO-
20 KERS.—The Secretary shall establish procedures under
21 which a State may allow agents or brokers—

22 (1) to enroll individuals in any qualified health
23 plans in the individual or small group market as
24 soon as the plan is offered through an Exchange in
25 the State; and

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

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

7 (f) QUALIFIED INDIVIDUALS AND EMPLOYERS; AC-
 8 CESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—

9 (1) QUALIFIED INDIVIDUALS.—In this title:

10 (A) IN GENERAL.—The term “qualified in-
 11 dividual” means, with respect to an Exchange,
 12 an individual who—

13 (i) is seeking to enroll in a qualified
 14 health plan in the individual market of-
 15 fered through the Exchange; and

16 (ii) resides in the State that estab-
 17 lished the Exchange (except with respect to
 18 territorial agreements under section
 19 1312(f)).

20 (B) INCARCERATED INDIVIDUALS EX-
 21 CLUDED.—An individual shall not be treated as
 22 a qualified individual if, at the time of enroll-
 23 ment, the individual is incarcerated, other than
 24 incarceration pending the disposition of
 25 charges.

1 (2) QUALIFIED EMPLOYER.—In this title:

2 (A) IN GENERAL.—The term “qualified
3 employer” means a small employer that elects
4 to make all full-time employees of such em-
5 ployer eligible for 1 or more qualified health
6 plans offered in the small group market
7 through an Exchange that offers qualified
8 health plans.

9 (B) EXTENSION TO LARGE GROUPS.—

10 (i) IN GENERAL.—Beginning in 2017,
11 each State may allow issuers of health in-
12 surance coverage in the large group mar-
13 ket in the State to offer qualified health
14 plans in such market through an Ex-
15 change. Nothing in this subparagraph shall
16 be construed as requiring the issuer to
17 offer such plans through an Exchange.

18 (ii) LARGE EMPLOYERS ELIGIBLE.—If
19 a State under clause (i) allows issuers to
20 offer qualified health plans in the large
21 group market through an Exchange, the
22 term “qualified employer” shall include a
23 large employer that elects to make all full-
24 time employees of such employer eligible
25 for 1 or more qualified health plans offered

1 in the large group market through the Ex-
2 change.

3 (3) ACCESS LIMITED TO LAWFUL RESIDENTS.—

4 If an individual is not, or is not reasonably expected
5 to be for the entire period for which enrollment is
6 sought, a citizen or national of the United States or
7 an alien lawfully present in the United States, the
8 individual shall not be treated as a qualified indi-
9 vidual and may not be covered under a qualified
10 health plan in the individual market that is offered
11 through an Exchange.

12 **SEC. 1313. FINANCIAL INTEGRITY.**

13 (a) ACCOUNTING FOR EXPENDITURES.—

14 (1) IN GENERAL.—An Exchange shall keep an
15 accurate accounting of all activities, receipts, and ex-
16 penditures and shall annually submit to the Sec-
17 retary a report concerning such accountings.

18 (2) INVESTIGATIONS.—The Secretary, in co-
19 ordination with the Inspector General of the Depart-
20 ment of Health and Human Services, may inves-
21 tigate the affairs of an Exchange, may examine the
22 properties and records of an Exchange, and may re-
23 quire periodic reports in relation to activities under-
24 taken by an Exchange. An Exchange shall fully co-

1 operate in any investigation conducted under this
2 paragraph.

3 (3) AUDITS.—An Exchange shall be subject to
4 annual audits by the Secretary.

5 (4) PATTERN OF ABUSE.—If the Secretary de-
6 termines that an Exchange or a State has engaged
7 in serious misconduct with respect to compliance
8 with the requirements of, or carrying out of activi-
9 ties required under, this title, the Secretary may re-
10 scind from payments otherwise due to such State in-
11 volved under this or any other Act administered by
12 the Secretary an amount not to exceed 1 percent of
13 such payments per year until corrective actions are
14 taken by the State that are determined to be ade-
15 quate by the Secretary.

16 (5) PROTECTIONS AGAINST FRAUD AND
17 ABUSE.—With respect to activities carried out under
18 this title, the Secretary shall provide for the efficient
19 and non-discriminatory administration of Exchange
20 activities and implement any measure or procedure
21 that—

22 (A) the Secretary determines is appro-
23 priate to reduce fraud and abuse in the admin-
24 istration of this title; and

1 (B) the Secretary has authority to imple-
2 ment under this title or any other Act.

3 (6) APPLICATION OF THE FALSE CLAIMS
4 ACT.—

5 (A) IN GENERAL.—Payments made by,
6 through, or in connection with an Exchange are
7 subject to the False Claims Act (31 U.S.C.
8 3729 et seq.) if those payments include any
9 Federal funds. Compliance with the require-
10 ments of this Act concerning eligibility for a
11 health insurance issuer to participate in the Ex-
12 change shall be a material condition of an
13 issuer's entitlement to receive payments, includ-
14 ing payments of premium tax credits and cost-
15 sharing reductions, through the Exchange.

16 (B) DAMAGES.—Notwithstanding para-
17 graph (1) of section 3729(a) of title 31, United
18 States Code, and subject to paragraph (2) of
19 such section, the civil penalty assessed under
20 the False Claims Act on any person found liable
21 under such Act as described in subparagraph
22 (A) shall be increased by not less than 3 times
23 and not more than 6 times the amount of dam-
24 ages which the Government sustains because of
25 the act of that person.

1 (b) GAO OVERSIGHT.—Not later than 5 years after
2 the first date on which Exchanges are required to be oper-
3 ational under this title, the Comptroller General shall con-
4 duct an ongoing study of Exchange activities and the en-
5 rollees in qualified health plans offered through Ex-
6 changes. Such study shall review—

7 (1) the operations and administration of Ex-
8 changes, including surveys and reports of qualified
9 health plans offered through Exchanges and on the
10 experience of such plans (including data on enrollees
11 in Exchanges and individuals purchasing health in-
12 surance coverage outside of Exchanges), the ex-
13 penses of Exchanges, claims statistics relating to
14 qualified health plans, complaints data relating to
15 such plans, and the manner in which Exchanges
16 meet their goals;

17 (2) any significant observations regarding the
18 utilization and adoption of Exchanges;

19 (3) where appropriate, recommendations for im-
20 provements in the operations or policies of Ex-
21 changes; and

22 (4) how many physicians, by area and specialty,
23 are not taking or accepting new patients enrolled in
24 Federal Government health care programs, and the

1 adequacy of provider networks of Federal Govern-
2 ment health care programs.

3 **PART III—STATE FLEXIBILITY RELATING TO**
4 **EXCHANGES**

5 **SEC. 1321. STATE FLEXIBILITY IN OPERATION AND EN-**
6 **FORCEMENT OF EXCHANGES AND RELATED**
7 **REQUIREMENTS.**

8 (a) ESTABLISHMENT OF STANDARDS.—

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

14 (A) the establishment and operation of Ex-
15 changes (including SHOP Exchanges);

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

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

21 (D) such other requirements as the Sec-
22 retary determines appropriate.

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

1 Secretary issues regulations under the Public Health
2 Service Act.

3 (2) CONSULTATION.—In issuing the regulations
4 under paragraph (1), the Secretary shall consult
5 with the National Association of Insurance Commis-
6 sioners and its members and with health insurance
7 issuers, consumer organizations, and such other in-
8 dividuals as the Secretary selects in a manner de-
9 signed to ensure balanced representation among in-
10 terested parties.

11 (b) STATE ACTION.—Each State that elects, at such
12 time and in such manner as the Secretary may prescribe,
13 to apply the requirements described in subsection (a)
14 shall, not later than January 1, 2014, adopt and have in
15 effect—

16 (1) the Federal standards established under
17 subsection (a); or

18 (2) a State law or regulation that the Secretary
19 determines implements the standards within the
20 State.

21 (c) FAILURE TO ESTABLISH EXCHANGE OR IMPLE-
22 MENT REQUIREMENTS.—

23 (1) IN GENERAL.—If—

24 (A) a State is not an electing State under
25 subsection (b); or

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

3 (i) will not have any required Ex-
4 change operational by January 1, 2014; or

5 (ii) has not taken the actions the Sec-
6 retary determines necessary to imple-
7 ment—

8 (I) the other requirements set
9 forth in the standards under sub-
10 section (a); or

11 (II) the requirements set forth in
12 subtitles A and C and the amend-
13 ments made by such subtitles;

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

19 (2) ENFORCEMENT AUTHORITY.—The provi-
20 sions of section 2736(b) of the Public Health Serv-
21 ices Act shall apply to the enforcement under para-
22 graph (1) of requirements of subsection (a)(1) (with-
23 out regard to any limitation on the application of
24 those provisions to group health plans).

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

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

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

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

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

4 (a) ESTABLISHMENT OF PROGRAM.—

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

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

15 (b) LOANS AND GRANTS UNDER THE CO-OP PRO-
16 GRAM.—

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

21 (A) loans to provide assistance to such per-
22 son in meeting its start-up costs; and

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

1 (2) REQUIREMENTS FOR AWARDING LOANS AND
2 GRANTS.—

3 (A) IN GENERAL.—In awarding loans and
4 grants under the CO-OP program, the Sec-
5 retary shall—

6 (i) take into account the recommenda-
7 tions of the advisory board established
8 under paragraph (3);

9 (ii) give priority to applicants that will
10 offer qualified health plans on a Statewide
11 basis, will utilize integrated care models,
12 and have significant private support; and

13 (iii) ensure that there is sufficient
14 funding to establish at least 1 qualified
15 nonprofit health insurance issuer in each
16 State, except that nothing in this clause
17 shall prohibit the Secretary from funding
18 the establishment of multiple qualified
19 nonprofit health insurance issuers in any
20 State if the funding is sufficient to do so.

21 (B) STATES WITHOUT ISSUERS IN PRO-
22 GRAM.—If no health insurance issuer applies to
23 be a qualified nonprofit health insurance issuer
24 within a State, the Secretary may use amounts
25 appropriated under this section for the award-

1 ing of grants to encourage the establishment of
2 a qualified nonprofit health insurance issuer
3 within the State or the expansion of a qualified
4 nonprofit health insurance issuer from another
5 State to the State.

6 (C) AGREEMENT.—

7 (i) IN GENERAL.—The Secretary shall
8 require any person receiving a loan or
9 grant under the CO-OP program to enter
10 into an agreement with the Secretary
11 which requires such person to meet (and to
12 continue to meet)—

13 (I) any requirement under this
14 section for such person to be treated
15 as a qualified nonprofit health insur-
16 ance issuer; and

17 (II) any requirements contained
18 in the agreement for such person to
19 receive such loan or grant.

20 (ii) RESTRICTIONS ON USE OF FED-
21 ERAL FUNDS.—The agreement shall in-
22 clude a requirement that no portion of the
23 funds made available by any loan or grant
24 under this section may be used—

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

4 (II) for marketing.

5 Nothing in this clause shall be construed
6 to allow a person to take any action pro-
7 hibited by section 501(c)(29) of the Inter-
8 nal Revenue Code of 1986.

9 (iii) FAILURE TO MEET REQUIRE-
10 MENTS.—If the Secretary determines that
11 a person has failed to meet any require-
12 ment described in clause (i) or (ii) and has
13 failed to correct such failure within a rea-
14 sonable period of time of when the person
15 first knows (or reasonably should have
16 known) of such failure, such person shall
17 repay to the Secretary an amount equal to
18 the sum of—

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

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

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

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

12 (3) ADVISORY BOARD.—

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

19 (B) RULES RELATING TO APPOINT-
20 MENTS.—

21 (i) STANDARDS.—Any individual ap-
22 pointed under subparagraph (A) shall meet
23 ethics and conflict of interest standards
24 protecting against insurance industry in-
25 volvement and interference.

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

6 (C) VACANCY.—Any vacancy on the advi-
7 sory board shall be filled in the same manner
8 as the original appointment.

9 (D) PAY AND REIMBURSEMENT.—

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

16 (ii) TRAVEL EXPENSES.—Each mem-
17 ber shall receive travel expenses, including
18 per diem in lieu of subsistence under sub-
19 chapter I of chapter 57 of title 5, United
20 States Code.

21 (E) APPLICATION OF FACA.—The Federal
22 Advisory Committee Act (5 U.S.C. App.) shall
23 apply to the advisory board, except that section
24 14 of such Act shall not apply.

1 (F) TERMINATION.—The advisory board
2 shall terminate on the earlier of the date that
3 it completes its duties under this section or De-
4 cember 31, 2015.

5 (c) QUALIFIED NONPROFIT HEALTH INSURANCE
6 ISSUER.—For purposes of this section—

7 (1) IN GENERAL.—The term “qualified non-
8 profit health insurance issuer” means a health insur-
9 ance issuer that is an organization—

10 (A) that is organized under State law as a
11 nonprofit, member corporation;

12 (B) substantially all of the activities of
13 which consist of the issuance of qualified health
14 plans in the individual and small group markets
15 in each State in which it is licensed to issue
16 such plans; and

17 (C) that meets the other requirements of
18 this subsection.

19 (2) CERTAIN ORGANIZATIONS PROHIBITED.—
20 An organization shall not be treated as a qualified
21 nonprofit health insurance issuer if—

22 (A) the organization or a related entity (or
23 any predecessor of either) was a health insur-
24 ance issuer on July 16, 2009; or

1 (B) the organization is sponsored by a
2 State or local government, any political subdivi-
3 sion thereof, or any instrumentality of such
4 government or political subdivision.

5 (3) GOVERNANCE REQUIREMENTS.—An organi-
6 zation shall not be treated as a qualified nonprofit
7 health insurance issuer unless—

8 (A) the governance of the organization is
9 subject to a majority vote of its members;

10 (B) its governing documents incorporate
11 ethics and conflict of interest standards pro-
12 tecting against insurance industry involvement
13 and interference; and

14 (C) as provided in regulations promulgated
15 by the Secretary, the organization is required to
16 operate with a strong consumer focus, including
17 timeliness, responsiveness, and accountability to
18 members.

19 (4) PROFITS INURE TO BENEFIT OF MEM-
20 BERS.—An organization shall not be treated as a
21 qualified nonprofit health insurance issuer unless
22 any profits made by the organization are required to
23 be used to lower premiums, to improve benefits, or
24 for other programs intended to improve the quality
25 of health care delivered to its members.

1 (5) COMPLIANCE WITH STATE INSURANCE
2 LAWS.—An organization shall not be treated as a
3 qualified nonprofit health insurance issuer unless the
4 organization meets all the requirements that other
5 issuers of qualified health plans are required to meet
6 in any State where the issuer offers a qualified
7 health plan, including solvency and licensure require-
8 ments, rules on payments to providers, and compli-
9 ance with network adequacy rules, rate and form fil-
10 ing rules, any applicable State premium assessments
11 and any other State law described in section
12 1324(b).

13 (6) COORDINATION WITH STATE INSURANCE
14 REFORMS.—An organization shall not be treated as
15 a qualified nonprofit health insurance issuer unless
16 the organization does not offer a health plan in a
17 State until that State has in effect (or the Secretary
18 has implemented for the State) the market reforms
19 required by part A of title XXVII of the Public
20 Health Service Act (as amended by subtitles A and
21 C of this Act).

22 (d) ESTABLISHMENT OF PRIVATE PURCHASING
23 COUNCIL.—

24 (1) IN GENERAL.—Qualified nonprofit health
25 insurance issuers participating in the CO-OP pro-

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

7 (2) COUNCIL MAY NOT SET PAYMENT RATES.—

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

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

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

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

1 5 of the Federal Trade Commission Act (15
2 U.S.C. 45) to the extent that such section 5 ap-
3 plies to unfair methods of competition.

4 (e) LIMITATION ON PARTICIPATION.—No representa-
5 tive of any Federal, State, or local government (or of any
6 political subdivision or instrumentality thereof), and no
7 representative of a person described in subsection
8 (c)(2)(A), may serve on the board of directors of a quali-
9 fied nonprofit health insurance issuer or with a private
10 purchasing council established under subsection (d).

11 (f) LIMITATIONS ON SECRETARY.—

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

13 (A) participate in any negotiations between
14 1 or more qualified nonprofit health insurance
15 issuers (or a private purchasing council estab-
16 lished under subsection (d)) and any health
17 care facilities or providers, including any drug
18 manufacturer, pharmacy, or hospital; and

19 (B) establish or maintain a price structure
20 for reimbursement of any health benefits cov-
21 ered by such issuers.

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

1 health benefits through qualified nonprofit health in-
2 surance issuers.

3 (g) APPROPRIATIONS.—There are hereby appro-
4 priated, out of any funds in the Treasury not otherwise
5 appropriated, \$6,000,000,000 to carry out this section.

6 (h) TAX EXEMPTION FOR QUALIFIED NONPROFIT
7 HEALTH INSURANCE ISSUER.—

8 (1) IN GENERAL.—Section 501(c) of the Inter-
9 nal Revenue Code of 1986 (relating to list of exempt
10 organizations) is amended by adding at the end the
11 following:

12 “(29) CO-OP HEALTH INSURANCE ISSUERS.—

13 “(A) IN GENERAL.—A qualified nonprofit
14 health insurance issuer (within the meaning of
15 section 1322 of the Patient Protection and Af-
16 fordable Care Act) which has received a loan or
17 grant under the CO-OP program under such
18 section, but only with respect to periods for
19 which the issuer is in compliance with the re-
20 quirements of such section and any agreement
21 with respect to the loan or grant.

22 “(B) CONDITIONS FOR EXEMPTION.—Sub-
23 paragraph (A) shall apply to an organization
24 only if—

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

6 “(ii) except as provided in section
7 1322(c)(4) of the Patient Protection and
8 Affordable Care Act, no part of the net
9 earnings of which inures to the benefit of
10 any private shareholder or individual,

11 “(iii) no substantial part of the activi-
12 ties of which is carrying on propaganda, or
13 otherwise attempting, to influence legisla-
14 tion, and

15 “(iv) the organization does not par-
16 ticipate in, or intervene in (including the
17 publishing or distributing of statements),
18 any political campaign on behalf of (or in
19 opposition to) any candidate for public of-
20 fice.”.

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

1 “(m) ADDITIONAL INFORMATION REQUIRED FROM
2 CO-OP INSURERS.—An organization described in section
3 501(c)(29) shall include on the return required under sub-
4 section (a) the following information:

5 “(1) The amount of the reserves required by
6 each State in which the organization is licensed to
7 issue qualified health plans.

8 “(2) The amount of reserves on hand.”.

9 (3) APPLICATION OF TAX ON EXCESS BENEFIT
10 TRANSACTIONS.—Section 4958(e)(1) of such Code
11 (defining applicable tax-exempt organization) is
12 amended by striking “paragraph (3) or (4)” and in-
13 sserting “paragraph (3), (4), or (29)”.

14 (i) GAO STUDY AND REPORT.—

15 (1) STUDY.—The Comptroller General of the
16 General Accountability Office shall conduct an ongo-
17 ing study on competition and market concentration
18 in the health insurance market in the United States
19 after the implementation of the reforms in such
20 market under the provisions of, and the amendments
21 made by, this Act. Such study shall include an anal-
22 ysis of new issuers of health insurance in such mar-
23 ket.

24 (2) REPORT.—The Comptroller General shall,
25 not later than December 31 of each even-numbered

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

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

9 (a) VOLUNTARY NATURE.—

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

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

20 (3) STATE OPT OUT.—

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

1 (B) TERMINATION OF OPT OUT.—A State
2 may repeal a law described in subparagraph (A)
3 and provide for the offering of such an option
4 through the Exchange.

5 (b) ESTABLISHMENT OF COMMUNITY HEALTH IN-
6 SURANCE OPTION.—

7 (1) ESTABLISHMENT.—The Secretary shall es-
8 tablish a community health insurance option to
9 offer, through the Exchanges established under this
10 title (other than Exchanges in States that elect to
11 opt out as provided for in subsection (a)(3)), health
12 care coverage that provides value, choice, competi-
13 tion, and stability of affordable, high quality cov-
14 erage throughout the United States.

15 (2) COMMUNITY HEALTH INSURANCE OP-
16 TION.—In this section, the term “community health
17 insurance option” means health insurance coverage
18 that—

19 (A) except as specifically provided for in
20 this section, complies with the requirements for
21 being a qualified health plan;

22 (B) provides high value for the premium
23 charged;

1 (C) reduces administrative costs and pro-
2 motes administrative simplification for bene-
3 ficiaries;

4 (D) promotes high quality clinical care;

5 (E) provides high quality customer service
6 to beneficiaries;

7 (F) offers a sufficient choice of providers;
8 and

9 (G) complies with State laws (if any), ex-
10 cept as otherwise provided for in this title, re-
11 lating to the laws described in section 1324(b).

12 (3) ESSENTIAL HEALTH BENEFITS.—

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

18 (B) STATES MAY OFFER ADDITIONAL BEN-
19 EFITS.—Nothing in this section shall preclude a
20 State from requiring that benefits in addition to
21 the essential health benefits required under sub-
22 paragraph (A) be provided to enrollees of a
23 community health insurance option offered in
24 such State.

25 (C) CREDITS.—

1 (i) IN GENERAL.—An individual en-
2 rolled in a community health insurance op-
3 tion under this section shall be eligible for
4 credits under section 36B of the Internal
5 Revenue Code of 1986 in the same manner
6 as an individual who is enrolled in a quali-
7 fied health plan.

8 (ii) NO ADDITIONAL FEDERAL
9 COST.—A requirement by a State under
10 subparagraph (B) that benefits in addition
11 to the essential health benefits required
12 under subparagraph (A) be provided to en-
13 rollees of a community health insurance
14 option shall not affect the amount of a pre-
15 mium tax credit provided under section
16 36B of the Internal Revenue Code of 1986
17 with respect to such plan.

18 (D) STATE MUST ASSUME COST.—A State
19 shall make payments to or on behalf of an eligi-
20 ble individual to defray the cost of any addi-
21 tional benefits described in subparagraph (B).

22 (E) ENSURING ACCESS TO ALL SERV-
23 ICES.—Nothing in this Act shall prohibit an in-
24 dividual enrolled in a community health insur-
25 ance option from paying out-of-pocket the full

1 cost of any item or service not included as an
2 essential health benefit or otherwise covered as
3 a benefit by a health plan. Nothing in subpara-
4 graph (B) shall prohibit any type of medical
5 provider from accepting an out-of-pocket pay-
6 ment from an individual enrolled in a commu-
7 nity health insurance option for a service other-
8 wise not included as an essential health benefit.

9 (F) PROTECTING ACCESS TO END OF LIFE
10 CARE.—A community health insurance option
11 offered under this section shall be prohibited
12 from limiting access to end of life care.

13 (4) COST SHARING.—A community health in-
14 surance option shall offer coverage at each of the
15 levels of coverage described in section 1302(d).

16 (5) PREMIUMS.—

17 (A) PREMIUMS SUFFICIENT TO COVER
18 COSTS.—The Secretary shall establish geo-
19 graphically adjusted premium rates in an
20 amount sufficient to cover expected costs (in-
21 cluding claims and administrative costs) using
22 methods in general use by qualified health
23 plans.

24 (B) APPLICABLE RULES.—The provisions
25 of title XXVII of the Public Health Service Act

1 relating to premiums shall apply to community
2 health insurance options under this section, in-
3 cluding modified community rating provisions
4 under section 2701 of such Act.

5 (C) COLLECTION OF DATA.—The Sec-
6 retary shall collect data as necessary to set pre-
7 mium rates under subparagraph (A).

8 (D) NATIONAL POOLING.—Notwith-
9 standing any other provision of law, the Sec-
10 retary may treat all enrollees in community
11 health insurance options as members of a single
12 pool.

13 (E) CONTINGENCY MARGIN.—In estab-
14 lishing premium rates under subparagraph (A),
15 the Secretary shall include an appropriate
16 amount for a contingency margin.

17 (6) REIMBURSEMENT RATES.—

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

22 (B) LIMITATION.—The rates described in
23 subparagraph (A) shall not be higher, in aggre-
24 gate, than the average reimbursement rates

1 paid by health insurance issuers offering quali-
2 fied health plans through the Exchange.

3 (C) INNOVATION.—Subject to the limits
4 contained in subparagraph (A), a State Advi-
5 sory Council established or designated under
6 subsection (d) may develop or encourage the
7 use of innovative payment policies that promote
8 quality, efficiency and savings to consumers.

9 (7) SOLVENCY AND CONSUMER PROTECTION.—

10 (A) SOLVENCY.—The Secretary shall es-
11 tablish a Federal solvency standard to be ap-
12 plied with respect to a community health insur-
13 ance option. A community health insurance op-
14 tion shall also be subject to the solvency stand-
15 ard of each State in which such community
16 health insurance option is offered.

17 (B) MINIMUM REQUIRED.—In establishing
18 the standard described under subparagraph
19 (A), the Secretary shall require a reserve fund
20 that shall be equal to at least the dollar value
21 of the incurred but not reported claims of a
22 community health insurance option.

23 (C) CONSUMER PROTECTIONS.—The con-
24 sumer protection laws of a State shall apply to
25 a community health insurance option.

1 (8) REQUIREMENTS ESTABLISHED IN PARTNER-
2 SHIP WITH INSURANCE COMMISSIONERS.—

3 (A) IN GENERAL.—The Secretary, in col-
4 laboration with the National Association of In-
5 surance Commissioners (in this paragraph re-
6 ferred to as the “NAIC”), may promulgate reg-
7 ulations to establish additional requirements for
8 a community health insurance option.

9 (B) APPLICABILITY.—Any requirement
10 promulgated under subparagraph (A) shall be
11 applicable to such option beginning 90 days
12 after the date on which the regulation involved
13 becomes final.

14 (c) START-UP FUND.—

15 (1) ESTABLISHMENT OF FUND.—

16 (A) IN GENERAL.—There is established in
17 the Treasury of the United States a trust fund
18 to be known as the “Health Benefit Plan Start-
19 Up Fund” (referred to in this section as the
20 “Start-Up Fund”), that shall consist of such
21 amounts as may be appropriated or credited to
22 the Start-Up Fund as provided for in this sub-
23 section to provide loans for the initial oper-
24 ations of a community health insurance option.

1 Such amounts shall remain available until ex-
2 pended.

3 (B) FUNDING.—There is hereby appro-
4 priated to the Start-Up Fund, out of any mon-
5 eys in the Treasury not otherwise appropriated
6 an amount requested by the Secretary of
7 Health and Human Services as necessary to—

8 (i) pay the start-up costs associated
9 with the initial operations of a community
10 health insurance option; and

11 (ii) pay the costs of making payments
12 on claims submitted during the period that
13 is not more than 90 days from the date on
14 which such option is offered.

15 (2) USE OF START-UP FUND.—The Secretary
16 shall use amounts contained in the Start-Up Fund
17 to make payments (subject to the repayment re-
18 quirements in paragraph (4)) for the purposes de-
19 scribed in paragraph (1)(B).

20 (3) PASS THROUGH OF REBATES.—The Sec-
21 retary may establish procedures for reducing the
22 amount of payments to a contracting administrator
23 to take into account any rebates or price conces-
24 sions.

25 (4) REPAYMENT.—

1 (A) IN GENERAL.—A community health in-
2 insurance option shall be required to repay the
3 Secretary of the Treasury (on such terms as the
4 Secretary may require) for any payments made
5 under paragraph (1)(B) by the date that is not
6 later than 9 years after the date on which the
7 payment is made. The Secretary may require
8 the payment of interest with respect to such re-
9 payments at rates that do not exceed the mar-
10 ket interest rate (as determined by the Sec-
11 retary).

12 (B) SANCTIONS IN CASE OF FOR-PROFIT
13 CONVERSION.—In any case in which the Sec-
14 retary enters into a contract with a qualified
15 entity for the offering of a community health
16 insurance option and such entity is determined
17 to be a for-profit entity by the Secretary, such
18 entity shall be—

19 (i) immediately liable to the Secretary
20 for any payments received by such entity
21 from the Start-Up Fund; and

22 (ii) permanently ineligible to offer a
23 qualified health plan.

24 (d) STATE ADVISORY COUNCIL.—

1 (1) ESTABLISHMENT.—A State (other than a
2 State that elects to opt out as provided for in sub-
3 section (a)(3)) shall establish or designate a public
4 or non-profit private entity to serve as the State Ad-
5 visory Council to provide recommendations to the
6 Secretary on the operations and policies of a com-
7 munity health insurance option in the State. Such
8 Council shall provide recommendations on at least
9 the following:

10 (A) policies and procedures to integrate
11 quality improvement and cost containment
12 mechanisms into the health care delivery sys-
13 tem;

14 (B) mechanisms to facilitate public aware-
15 ness of the availability of a community health
16 insurance option; and

17 (C) alternative payment structures under a
18 community health insurance option for health
19 care providers that encourage quality improve-
20 ment and cost control.

21 (2) MEMBERS.—The members of the State Ad-
22 visory Council shall be representatives of the public
23 and shall include health care consumers and pro-
24 viders.

1 (3) APPLICABILITY OF RECOMMENDATIONS.—

2 The Secretary may apply the recommendations of a
3 State Advisory Council to a community health insur-
4 ance option in that State, in any other State, or in
5 all States.

6 (e) AUTHORITY TO CONTRACT; TERMS OF CON-
7 TRACT.—

8 (1) AUTHORITY.—

9 (A) IN GENERAL.—The Secretary may
10 enter into a contract or contracts with one or
11 more qualified entities for the purpose of per-
12 forming administrative functions (including
13 functions described in subsection (a)(4) of sec-
14 tion 1874A of the Social Security Act) with re-
15 spect to a community health insurance option in
16 the same manner as the Secretary may enter
17 into contracts under subsection (a)(1) of such
18 section. The Secretary shall have the same au-
19 thority with respect to a community health in-
20 surance option under this section as the Sec-
21 retary has under subsections (a)(1) and (b) of
22 section 1874A of the Social Security Act with
23 respect to title XVIII of such Act.

24 (B) REQUIREMENTS APPLY.—If the Sec-
25 retary enters into a contract with a qualified

1 entity to offer a community health insurance
2 option, under such contract such entity—

3 (i) shall meet the criteria established
4 under paragraph (2); and

5 (ii) shall receive an administrative fee
6 under paragraph (7).

7 (C) LIMITATION.—Contracts under this
8 subsection shall not involve the transfer of in-
9 surance risk to the contracting administrator.

10 (D) REFERENCE.—An entity with which
11 the Secretary has entered into a contract under
12 this paragraph shall be referred to as a “con-
13 tracting administrator”.

14 (2) QUALIFIED ENTITY.—To be qualified to be
15 selected by the Secretary to offer a community
16 health insurance option, an entity shall—

17 (A) meet the criteria established under sec-
18 tion 1874A(a)(2) of the Social Security Act;

19 (B) be a nonprofit entity for purposes of
20 offering such option;

21 (C) meet the solvency standards applicable
22 under subsection (b)(7);

23 (D) be eligible to offer health insurance or
24 health benefits coverage;

1 (E) meet quality standards specified by the
2 Secretary;

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

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

7 Procedures described under subparagraph (F) shall
8 include the implementation of procedures to use ben-
9 efitary identifiers to identify individuals entitled to
10 benefits so that such an individual's social security
11 account number is not used, and shall also include
12 procedures for the use of technology (including
13 front-end, prepayment intelligent data-matching
14 technology similar to that used by hedge funds, in-
15 vestment funds, and banks) to provide real-time
16 data analysis of claims for payment under this title
17 to identify and investigate unusual billing or order
18 practices under this title that could indicate fraud or
19 abuse.

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

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

3 (4) LIMITATION.—A contract may not be re-
4 newed under this subsection unless the Secretary de-
5 termines that the contracting administrator has met
6 performance requirements established by the Sec-
7 retary in the areas described in paragraph (7)(B).

8 (5) AUDITS.—The Inspector General shall con-
9 duct periodic audits with respect to contracting ad-
10 ministrators under this subsection to ensure that the
11 administrator involved is in compliance with this sec-
12 tion.

13 (6) REVOCATION.—A contract awarded under
14 this subsection shall be revoked by the Secretary,
15 upon the recommendation of the Inspector General,
16 only after notice to the contracting administrator in-
17 volved and an opportunity for a hearing. The Sec-
18 retary may revoke such contract if the Secretary de-
19 termines that such administrator has engaged in
20 fraud, deception, waste, abuse of power, negligence,
21 mismanagement of taxpayer dollars, or gross mis-
22 management. An entity that has had a contract re-
23 voked under this paragraph shall not be qualified to
24 enter into a subsequent contract under this sub-
25 section.

1 (7) FEE FOR ADMINISTRATION.—

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

6 (B) REQUIREMENT FOR HIGH QUALITY
7 ADMINISTRATION.—The Secretary may increase
8 the fee described in subparagraph (A) by not
9 more than 10 percent, or reduce the fee de-
10 scribed in subparagraph (A) by not more than
11 50 percent, based on the extent to which the
12 contracting administrator, in the determination
13 of the Secretary, meets performance require-
14 ments established by the Secretary, in at least
15 the following areas:

16 (i) Maintaining low premium costs
17 and low cost sharing requirements, pro-
18 vided that such requirements are con-
19 sistent with section 1302.

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

23 (iii) Promoting high quality clinical
24 care.

1 (iv) Providing high quality customer
2 service to beneficiaries.

3 (C) NON-RENEWAL.—The Secretary may
4 not renew a contract to offer a community
5 health insurance option under this section with
6 any contracting entity that has been assessed
7 more than one reduction under subparagraph
8 (B) during the contract period.

9 (8) LIMITATION.—Notwithstanding the terms
10 of a contract under this subsection, the Secretary
11 shall negotiate the reimbursement rates for purposes
12 of subsection (b)(6).

13 (f) REPORT BY HHS AND INSOLVENCY WARN-
14 INGS.—

15 (1) IN GENERAL.—On an annual basis, the Sec-
16 retary shall conduct a study on the solvency of a
17 community health insurance option and submit to
18 Congress a report describing the results of such
19 study.

20 (2) RESULT.—If, in any year, the result of the
21 study under paragraph (1) is that a community
22 health insurance option is insolvent, such result shall
23 be treated as a community health insurance option
24 solvency warning.

25 (3) SUBMISSION OF PLAN AND PROCEDURE.—

1 (A) IN GENERAL.—If there is a community
2 health insurance option solvency warning under
3 paragraph (2) made in a year, the President
4 shall submit to Congress, within the 15-day pe-
5 riod beginning on the date of the budget sub-
6 mission to Congress under section 1105(a) of
7 title 31, United States Code, for the succeeding
8 year, proposed legislation to respond to such
9 warning.

10 (B) PROCEDURE.—In the case of a legisla-
11 tive proposal submitted by the President pursu-
12 ant to subparagraph (A), such proposal shall be
13 considered by Congress using the same proce-
14 dures described under sections 803 and 804 of
15 the Medicare Prescription Drug, Improvement,
16 and Modernization Act of 2003 that shall be
17 used for a medicare funding warning.

18 (g) MARKETING PARITY.—In a facility controlled by
19 the Federal Government, or by a State, where marketing
20 or promotional materials related to a community health
21 insurance option are made available to the public, making
22 available marketing or promotional materials relating to
23 private health insurance plans shall not be prohibited.
24 Such materials include informational pamphlets, guide-

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

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

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

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

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

- 19 (1) guaranteed renewal;
- 20 (2) rating;
- 21 (3) preexisting conditions;
- 22 (4) non-discrimination;
- 23 (5) quality improvement and reporting;
- 24 (6) fraud and abuse;
- 25 (7) solvency and financial requirements;

- 1 (8) market conduct;
- 2 (9) prompt payment;
- 3 (10) appeals and grievances;
- 4 (11) privacy and confidentiality;
- 5 (12) licensure; and
- 6 (13) benefit plan material or information.

7 **PART IV—STATE FLEXIBILITY TO ESTABLISH**
8 **ALTERNATIVE PROGRAMS**

9 **SEC. 1331. STATE FLEXIBILITY TO ESTABLISH BASIC**
10 **HEALTH PROGRAMS FOR LOW-INCOME INDI-**
11 **VIDUALS NOT ELIGIBLE FOR MEDICAID.**

12 (a) ESTABLISHMENT OF PROGRAM.—

13 (1) IN GENERAL.—The Secretary shall establish
14 a basic health program meeting the requirements of
15 this section under which a State may enter into con-
16 tracts to offer 1 or more standard health plans pro-
17 viding at least the essential health benefits described
18 in section 1302(b) to eligible individuals in lieu of
19 offering such individuals coverage through an Ex-
20 change.

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

1 satisfaction of the Secretary, and the Secretary cer-
2 tifies, that—

3 (A) in the case of an eligible individual en-
4 rolled in a standard health plan offered through
5 the program, the State provides—

6 (i) that the amount of the monthly
7 premium an eligible individual is required
8 to pay for coverage under the standard
9 health plan for the individual and the indi-
10 vidual's dependents does not exceed the
11 amount of the monthly premium that the
12 eligible individual would have been required
13 to pay (in the rating area in which the in-
14 dividual resides) if the individual had en-
15 rolled in the applicable second lowest cost
16 silver plan (as defined in section
17 36B(b)(3)(B) of the Internal Revenue
18 Code of 1986) offered to the individual
19 through an Exchange; and

20 (ii) that the cost-sharing an eligible
21 individual is required to pay under the
22 standard health plan does not exceed—

23 (I) the cost-sharing required
24 under a platinum plan in the case of
25 an eligible individual with household

1 income not in excess of 150 percent of
2 the poverty line for the size of the
3 family involved; and

4 (II) the cost-sharing required
5 under a gold plan in the case of an el-
6 igible individual not described in sub-
7 clause (I); and

8 (B) the benefits provided under the stand-
9 ard health plans offered through the program
10 cover at least the essential health benefits de-
11 scribed in section 1302(b).

12 For purposes of subparagraph (A)(i), the amount of
13 the monthly premium an individual is required to
14 pay under either the standard health plan or the ap-
15 plicable second lowest cost silver plan shall be deter-
16 mined after reduction for any premium tax credits
17 and cost-sharing reductions allowable with respect to
18 either plan.

19 (b) STANDARD HEALTH PLAN.—In this section, the
20 term “standard health plan” means a health benefits plan
21 that the State contracts with under this section—

22 (1) under which the only individuals eligible to
23 enroll are eligible individuals;

24 (2) that provides at least the essential health
25 benefits described in section 1302(b); and

1 (3) in the case of a plan that provides health
2 insurance coverage offered by a health insurance
3 issuer, that has a medical loss ratio of at least 85
4 percent.

5 (c) CONTRACTING PROCESS.—

6 (1) IN GENERAL.—A State basic health pro-
7 gram shall establish a competitive process for enter-
8 ing into contracts with standard health plans under
9 subsection (a), including negotiation of premiums
10 and cost-sharing and negotiation of benefits in addi-
11 tion to the essential health benefits described in sec-
12 tion 1302(b).

13 (2) SPECIFIC ITEMS TO BE CONSIDERED.—A
14 State shall, as part of its competitive process under
15 paragraph (1), include at least the following:

16 (A) INNOVATION.—Negotiation with
17 offerors of a standard health plan for the inclu-
18 sion of innovative features in the plan, includ-
19 ing—

20 (i) care coordination and care man-
21 agement for enrollees, especially for those
22 with chronic health conditions;

23 (ii) incentives for use of preventive
24 services; and

1 (iii) the establishment of relationships
2 between providers and patients that maxi-
3 mize patient involvement in health care de-
4 cision-making, including providing incen-
5 tives for appropriate utilization under the
6 plan.

7 (B) HEALTH AND RESOURCE DIF-
8 FERENCES.—Consideration of, and the making
9 of suitable allowances for, differences in health
10 care needs of enrollees and differences in local
11 availability of, and access to, health care pro-
12 viders. Nothing in this subparagraph shall be
13 construed as allowing discrimination on the
14 basis of pre-existing conditions or other health
15 status-related factors.

16 (C) MANAGED CARE.—Contracting with
17 managed care systems, or with systems that
18 offer as many of the attributes of managed care
19 as are feasible in the local health care market.

20 (D) PERFORMANCE MEASURES.—Estab-
21 lishing specific performance measures and
22 standards for issuers of standard health plans
23 that focus on quality of care and improved
24 health outcomes, requiring such plans to report
25 to the State with respect to the measures and

1 standards, and making the performance and
2 quality information available to enrollees in a
3 useful form.

4 (3) ENHANCED AVAILABILITY.—

5 (A) MULTIPLE PLANS.—A State shall, to
6 the maximum extent feasible, seek to make
7 multiple standard health plans available to eligi-
8 ble individuals within a State to ensure individ-
9 uals have a choice of such plans.

10 (B) REGIONAL COMPACTS.—A State may
11 negotiate a regional compact with other States
12 to include coverage of eligible individuals in all
13 such States in agreements with issuers of
14 standard health plans.

15 (4) COORDINATION WITH OTHER STATE PRO-
16 GRAMS.—A State shall seek to coordinate the admin-
17 istration of, and provision of benefits under, its pro-
18 gram under this section with the State medicaid pro-
19 gram under title XIX of the Social Security Act, the
20 State child health plan under title XXI of such Act,
21 and other State-administered health programs to
22 maximize the efficiency of such programs and to im-
23 prove the continuity of care.

24 (d) TRANSFER OF FUNDS TO STATES.—

1 (1) IN GENERAL.—If the Secretary determines
2 that a State electing the application of this section
3 meets the requirements of the program established
4 under subsection (a), the Secretary shall transfer to
5 the State for each fiscal year for which 1 or more
6 standard health plans are operating within the State
7 the amount determined under paragraph (3).

8 (2) USE OF FUNDS.—A State shall establish a
9 trust for the deposit of the amounts received under
10 paragraph (1) and amounts in the trust fund shall
11 only be used to reduce the premiums and cost-shar-
12 ing of, or to provide additional benefits for, eligible
13 individuals enrolled in standard health plans within
14 the State. Amounts in the trust fund, and expendi-
15 tures of such amounts, shall not be included in de-
16 termining the amount of any non-Federal funds for
17 purposes of meeting any matching or expenditure re-
18 quirement of any federally-funded program.

19 (3) AMOUNT OF PAYMENT.—

20 (A) SECRETARIAL DETERMINATION.—

21 (i) IN GENERAL.—The amount deter-
22 mined under this paragraph for any fiscal
23 year is the amount the Secretary deter-
24 mines is equal to 85 percent of the pre-
25 mium tax credits under section 36B of the

1 Internal Revenue Code of 1986, and the
2 cost-sharing reductions under section
3 1402, that would have been provided for
4 the fiscal year to eligible individuals en-
5 rolled in standard health plans in the State
6 if such eligible individuals were allowed to
7 enroll in qualified health plans through an
8 Exchange established under this subtitle.

9 (ii) SPECIFIC REQUIREMENTS.—The
10 Secretary shall make the determination
11 under clause (i) on a per enrollee basis and
12 shall take into account all relevant factors
13 necessary to determine the value of the
14 premium tax credits and cost-sharing re-
15 ductions that would have been provided to
16 eligible individuals described in clause (i),
17 including the age and income of the en-
18 rollee, whether the enrollment is for self-
19 only or family coverage, geographic dif-
20 ferences in average spending for health
21 care across rating areas, the health status
22 of the enrollee for purposes of determining
23 risk adjustment payments and reinsurance
24 payments that would have been made if
25 the enrollee had enrolled in a qualified

1 health plan through an Exchange, and
2 whether any reconciliation of the credit or
3 cost-sharing reductions would have oc-
4 curred if the enrollee had been so enrolled.
5 This determination shall take into consid-
6 eration the experience of other States with
7 respect to participation in an Exchange
8 and such credits and reductions provided
9 to residents of the other States, with a spe-
10 cial focus on enrollees with income below
11 200 percent of poverty.

12 (iii) CERTIFICATION.—The Chief Ac-
13 tuary of the Centers for Medicare & Med-
14 icaid Services, in consultation with the Of-
15 fice of Tax Analysis of the Department of
16 the Treasury, shall certify whether the
17 methodology used to make determinations
18 under this subparagraph, and such deter-
19 minations, meet the requirements of clause
20 (ii). Such certifications shall be based on
21 sufficient data from the State and from
22 comparable States about their experience
23 with programs created by this Act.

24 (B) CORRECTIONS.—The Secretary shall
25 adjust the payment for any fiscal year to reflect

1 any error in the determinations under subpara-
2 graph (A) for any preceding fiscal year.

3 (4) APPLICATION OF SPECIAL RULES.—The
4 provisions of section 1303 shall apply to a State
5 basic health program, and to standard health plans
6 offered through such program, in the same manner
7 as such rules apply to qualified health plans.

8 (e) ELIGIBLE INDIVIDUAL.—

9 (1) IN GENERAL.—In this section, the term “el-
10 igible individual” means, with respect to any State,
11 an individual—

12 (A) who a resident of the State who is not
13 eligible to enroll in the State’s medicaid pro-
14 gram under title XIX of the Social Security Act
15 for benefits that at a minimum consist of the
16 essential health benefits described in section
17 1302(b);

18 (B) whose household income exceeds 133
19 percent but does not exceed 200 percent of the
20 poverty line for the size of the family involved;

21 (C) who is not eligible for minimum essen-
22 tial coverage (as defined in section 5000A(f) of
23 the Internal Revenue Code of 1986) or is eligi-
24 ble for an employer-sponsored plan that is not

1 affordable coverage (as determined under sec-
2 tion 5000A(e)(2) of such Code); and

3 (D) who has not attained age 65 as of the
4 beginning of the plan year.

5 Such term shall not include any individual who is
6 not a qualified individual under section 1312 who is
7 eligible to be covered by a qualified health plan of-
8 fered through an Exchange.

9 (2) ELIGIBLE INDIVIDUALS MAY NOT USE EX-
10 CHANGE.—An eligible individual shall not be treated
11 as a qualified individual under section 1312 eligible
12 for enrollment in a qualified health plan offered
13 through an Exchange established under section
14 1311.

15 (f) SECRETARIAL OVERSIGHT.—The Secretary shall
16 each year conduct a review of each State program to en-
17 sure compliance with the requirements of this section, in-
18 cluding ensuring that the State program meets—

19 (1) eligibility verification requirements for par-
20 ticipation in the program;

21 (2) the requirements for use of Federal funds
22 received by the program; and

23 (3) the quality and performance standards
24 under this section.

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

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

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

13 (a) APPLICATION.—

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

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

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

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

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

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

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

9 (2) REQUIREMENTS.—The requirements de-
10 scribed in this paragraph with respect to health in-
11 surance coverage within the State for plan years be-
12 ginning on or after January 1, 2014, are as follows:

13 (A) Part I of subtitle D.

14 (B) Part II of subtitle D.

15 (C) Section 1402.

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

18 (3) PASS THROUGH OF FUNDING.—With re-
19 spect to a State waiver under paragraph (1), under
20 which, due to the structure of the State plan, indi-
21 viduals and small employers in the State would not
22 qualify for the premium tax credits, cost-sharing re-
23 ductions, or small business credits under sections
24 36B of the Internal Revenue Code of 1986 or under
25 part I of subtitle E for which they would otherwise

1 be eligible, the Secretary shall provide for an alter-
2 native means by which the aggregate amount of such
3 credits or reductions that would have been paid on
4 behalf of participants in the Exchanges established
5 under this title had the State not received such waiv-
6 er, shall be paid to the State for purposes of imple-
7 menting the State plan under the waiver. Such
8 amount shall be determined annually by the Sec-
9 retary, taking into consideration the experience of
10 other States with respect to participation in an Ex-
11 change and credits and reductions provided under
12 such provisions to residents of the other States.

13 (4) WAIVER CONSIDERATION AND TRANS-
14 PARENCY.—

15 (A) IN GENERAL.—An application for a
16 waiver under this section shall be considered by
17 the Secretary in accordance with the regula-
18 tions described in subparagraph (B).

19 (B) REGULATIONS.—Not later than 180
20 days after the date of enactment of this Act,
21 the Secretary shall promulgate regulations re-
22 lating to waivers under this section that pro-
23 vide—

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

1 lic hearings, sufficient to ensure a mean-
2 ingful level of public input;

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

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

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

10 (iii) a process for providing public no-
11 tice and comment after the application is
12 received by the Secretary, that is sufficient
13 to ensure a meaningful level of public
14 input and that does not impose require-
15 ments that are in addition to, or duplica-
16 tive of, requirements imposed under the
17 Administrative Procedures Act, or require-
18 ments that are unreasonable or unneces-
19 sarily burdensome with respect to State
20 compliance;

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

1 (v) a process for the periodic evalua-
2 tion by the Secretary of the program under
3 the waiver.

4 (C) REPORT.—The Secretary shall annu-
5 ally report to Congress concerning actions
6 taken by the Secretary with respect to applica-
7 tions for waivers under this section.

8 (5) COORDINATED WAIVER PROCESS.—The Sec-
9 retary shall develop a process for coordinating and
10 consolidating the State waiver processes applicable
11 under the provisions of this section, and the existing
12 waiver processes applicable under titles XVIII, XIX,
13 and XXI of the Social Security Act, and any other
14 Federal law relating to the provision of health care
15 items or services. Such process shall permit a State
16 to submit a single application for a waiver under any
17 or all of such provisions.

18 (6) DEFINITION.—In this section, the term
19 “Secretary” means—

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

1 (B) the Secretary of the Treasury with re-
2 spect to waivers relating to the provisions de-
3 scribed in paragraph (2)(D).

4 (b) GRANTING OF WAIVERS.—

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

8 (A) will provide coverage that is at least as
9 comprehensive as the coverage defined in sec-
10 tion 1302(b) and offered through Exchanges es-
11 tablished under this title as certified by Office
12 of the Actuary of the Centers for Medicare &
13 Medicaid Services based on sufficient data from
14 the State and from comparable States about
15 their experience with programs created by this
16 Act and the provisions of this Act that would
17 be waived;

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

22 (C) will provide coverage to at least a com-
23 parable number of its residents as the provi-
24 sions of this title would provide; and

25 (D) will not increase the Federal deficit.

1 (2) REQUIREMENT TO ENACT A LAW.—

2 (A) IN GENERAL.—A law described in this
3 paragraph is a State law that provides for State
4 actions under a waiver under this section, in-
5 cluding the implementation of the State plan
6 under subsection (a)(1)(B).

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

11 (c) SCOPE OF WAIVER.—

12 (1) IN GENERAL.—The Secretary shall deter-
13 mine the scope of a waiver of a requirement de-
14 scribed in subsection (a)(2) granted to a State under
15 subsection (a)(1).

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

19 (d) DETERMINATIONS BY SECRETARY.—

20 (1) TIME FOR DETERMINATION.—The Sec-
21 retary shall make a determination under subsection
22 (a)(1) not later than 180 days after the receipt of
23 an application from a State under such subsection.

24 (2) EFFECT OF DETERMINATION.—

1 (A) GRANTING OF WAIVERS.—If the Sec-
2 retary determines to grant a waiver under sub-
3 section (a)(1), the Secretary shall notify the
4 State involved of such determination and the
5 terms and effectiveness of such waiver.

6 (B) DENIAL OF WAIVER.—If the Secretary
7 determines a waiver should not be granted
8 under subsection (a)(1), the Secretary shall no-
9 tify the State involved, and the appropriate
10 committees of Congress of such determination
11 and the reasons therefore.

12 (e) TERM OF WAIVER.—No waiver under this section
13 may extend over a period of longer than 5 years unless
14 the State requests continuation of such waiver, and such
15 request shall be deemed granted unless the Secretary,
16 within 90 days after the date of its submission to the Sec-
17 retary, either denies such request in writing or informs
18 the State in writing with respect to any additional infor-
19 mation which is needed in order to make a final deter-
20 mination with respect to the request.

21 **SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS**

22 **IN MORE THAN ONE STATE.**

23 (a) HEALTH CARE CHOICE COMPACTS.—

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

1 Association of Insurance Commissioners, issue regu-
2 lations for the creation of health care choice com-
3 pacts under which 2 or more States may enter into
4 an agreement under which—

5 (A) 1 or more qualified health plans could
6 be offered in the individual markets in all such
7 States but, except as provided in subparagraph
8 (B), only be subject to the laws and regulations
9 of the State in which the plan was written or
10 issued;

11 (B) the issuer of any qualified health plan
12 to which the compact applies—

13 (i) would continue to be subject to
14 market conduct, unfair trade practices,
15 network adequacy, and consumer protec-
16 tion standards (including standards relat-
17 ing to rating), including addressing dis-
18 putes as to the performance of the con-
19 tract, of the State in which the purchaser
20 resides;

21 (ii) would be required to be licensed in
22 each State in which it offers the plan
23 under the compact or to submit to the ju-
24 risdiction of each such State with regard to
25 the standards described in clause (i) (in-

1 cluding allowing access to records as if the
2 insurer were licensed in the State); and

3 (iii) must clearly notify consumers
4 that the policy may not be subject to all
5 the laws and regulations of the State in
6 which the purchaser resides.

7 (2) STATE AUTHORITY.—A State may not enter
8 into an agreement under this subsection unless the
9 State enacts a law after the date of the enactment
10 of this title that specifically authorizes the State to
11 enter into such agreements.

12 (3) APPROVAL OF COMPACTS.—The Secretary
13 may approve interstate health care choice compacts
14 under paragraph (1) only if the Secretary deter-
15 mines that such health care choice compact—

16 (A) will provide coverage that is at least as
17 comprehensive as the coverage defined in sec-
18 tion 1302(b) and offered through Exchanges es-
19 tablished under this title;

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

1 (C) will provide coverage to at least a com-
2 parable number of its residents as the provi-
3 sions of this title would provide;

4 (D) will not increase the Federal deficit;
5 and

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

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

13 (b) AUTHORITY FOR NATIONWIDE PLANS.—

14 (1) IN GENERAL.—Except as provided in para-
15 graph (2), if an issuer (including a group of health
16 insurance issuers affiliated either by common owner-
17 ship and control or by the common use of a nation-
18 ally licensed service mark) of a qualified health plan
19 in the individual or small group market meets the
20 requirements of this subsection (in this subsection a
21 “nationwide qualified health plan”)—

22 (A) the issuer of the plan may offer the
23 nationwide qualified health plan in the indi-
24 vidual or small group market in more than 1
25 State; and

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

6 (2) STATE OPT-OUT.—A State may, by specific
7 reference in a law enacted after the date of enact-
8 ment of this title, provide that this subsection shall
9 not apply to that State. Such opt-out shall be effec-
10 tive until such time as the State by law revokes it.

11 (3) PLAN REQUIREMENTS.—An issuer meets
12 the requirements of this subsection with respect to
13 a nationwide qualified health plan if, in the deter-
14 mination of the Secretary—

15 (A) the plan offers a benefits package that
16 is uniform in each State in which the plan is of-
17 fered and meets the requirements set forth in
18 paragraphs (4) through (6);

19 (B) the issuer is licensed in each State in
20 which it offers the plan and is subject to all re-
21 quirements of State law not inconsistent with
22 this section, including but not limited to, the
23 standards and requirements that a State im-
24 poses that do not prevent the application of a
25 requirement of part A of title XXVII of the

1 Public Health Service Act or a requirement of
2 this title;

3 (C) the issuer meets all requirements of
4 this title with respect to a qualified health plan,
5 including the requirement to offer the silver and
6 gold levels of the plan in each Exchange in the
7 State for the market in which the plan is of-
8 fered;

9 (D) the issuer determines the premiums
10 for the plan in any State on the basis of the
11 rating rules in effect in that State for the rat-
12 ing areas in which it is offered;

13 (E) the issuer offers the nationwide quali-
14 fied health plan in at least 60 percent of the
15 participating States in the first year in which
16 the plan is offered, 65 percent of such States
17 in the second year, 70 percent of such States in
18 the third year, 75 percent of such States in the
19 fourth year, and 80 percent of such States in
20 the fifth and subsequent years;

21 (F) the issuer shall offer the plan in par-
22 ticipating States across the country, in all geo-
23 graphic regions, and in all States that have
24 adopted adjusted community rating before the
25 date of enactment of this Act; and

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

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

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

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

1 under this subsection shall include at least the es-
 2 sential benefits package described in section 1302.

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

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

17 **SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR**

18 **INDIVIDUAL AND SMALL GROUP MARKETS IN**

19 **EACH STATE.**

20 (a) IN GENERAL.—Each State shall, not later than
 21 January 1, 2014—

22 (1) include in the Federal standards or State
 23 law or regulation the State adopts and has in effect
 24 under section 1321(b) the provisions described in
 25 subsection (b); and

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

4 (b) MODEL REGULATION.—

5 (1) IN GENERAL.—In establishing the Federal
6 standards under section 1321(a), the Secretary, in
7 consultation with the National Association of Insur-
8 ance Commissioners (the “NAIC”), shall include
9 provisions that enable States to establish and main-
10 tain a program under which—

11 (A) health insurance issuers, and third
12 party administrators on behalf of group health
13 plans, are required to make payments to an ap-
14 plicable reinsurance entity for any plan year be-
15 ginning in the 3-year period beginning January
16 1, 2014 (as specified in paragraph (3)); and

17 (B) the applicable reinsurance entity col-
18 lects payments under subparagraph (A) and
19 uses amounts so collected to make reinsurance
20 payments to health insurance issuers described
21 in subparagraph (A) that cover high risk indi-
22 viduals in the individual market (excluding
23 grandfathered health plans) for any plan year
24 beginning in such 3-year period.

1 (2) HIGH-RISK INDIVIDUAL; PAYMENT
2 AMOUNTS.—The Secretary shall include the fol-
3 lowing in the provisions under paragraph (1):

4 (A) DETERMINATION OF HIGH-RISK INDI-
5 VIDUALS.—The method by which individuals
6 will be identified as high risk individuals for
7 purposes of the reinsurance program estab-
8 lished under this section. Such method shall
9 provide for identification of individuals as high-
10 risk individuals on the basis of—

11 (i) a list of at least 50 but not more
12 than 100 medical conditions that are iden-
13 tified as high-risk conditions and that may
14 be based on the identification of diagnostic
15 and procedure codes that are indicative of
16 individuals with pre-existing, high-risk con-
17 ditions; or

18 (ii) any other comparable objective
19 method of identification recommended by
20 the American Academy of Actuaries.

21 (B) PAYMENT AMOUNT.—The formula for
22 determining the amount of payments that will
23 be paid to health insurance issuers described in
24 paragraph (1)(A) that insure high-risk individ-
25 uals. Such formula shall provide for the equi-

1 table allocation of available funds through rec-
2 onciliation and may be designed—

3 (i) to provide a schedule of payments
4 that specifies the amount that will be paid
5 for each of the conditions identified under
6 subparagraph (A); or

7 (ii) to use any other comparable meth-
8 od for determining payment amounts that
9 is recommended by the American Academy
10 of Actuaries and that encourages the use
11 of care coordination and care management
12 programs for high risk conditions.

13 (3) DETERMINATION OF REQUIRED CONTRIBU-
14 TIONS.—

15 (A) IN GENERAL.—The Secretary shall in-
16 clude in the provisions under paragraph (1) the
17 method for determining the amount each health
18 insurance issuer and group health plan de-
19 scribed in paragraph (1)(A) contributing to the
20 reinsurance program under this section is re-
21 quired to contribute under such paragraph for
22 each plan year beginning in the 36-month pe-
23 riod beginning January 1, 2014. The contribu-
24 tion amount for any plan year may be based on
25 the percentage of revenue of each issuer and

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

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

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

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

20 (iii) the aggregate contribution
21 amounts for all States shall, based on the
22 best estimates of the NAIC and without
23 regard to amounts described in clause (ii),
24 equal \$10,000,000,000 for plan years be-
25 ginning in 2014, \$6,000,000,000 for plan

1 years beginning 2015, and \$4,000,000,000
2 for plan years beginning in 2016; and

3 (iv) in addition to the aggregate con-
4 tribution amounts under clause (iii), each
5 issuer's contribution amount for any cal-
6 endar year under clause (iii) reflects its
7 proportionate share of an additional
8 \$2,000,000,000 for 2014, an additional
9 \$2,000,000,000 for 2015, and an addi-
10 tional \$1,000,000,000 for 2016.

11 Nothing in this subparagraph shall be con-
12 strued to preclude a State from collecting addi-
13 tional amounts from issuers on a voluntary
14 basis.

15 (4) EXPENDITURE OF FUNDS.—The provisions
16 under paragraph (1) shall provide that—

17 (A) the contribution amounts collected for
18 any calendar year may be allocated and used in
19 any of the three calendar years for which
20 amounts are collected based on the reinsurance
21 needs of a particular period or to reflect experi-
22 ence in a prior period; and

23 (B) amounts remaining unexpended as of
24 December, 2016, may be used to make pay-
25 ments under any reinsurance program of a

1 State in the individual market in effect in the
2 2-year period beginning on January 1, 2017.

3 Notwithstanding the preceding sentence, any con-
4 tribution amounts described in paragraph (3)(B)(iv)
5 shall be deposited into the general fund of the
6 Treasury of the United States and may not be used
7 for the program established under this section.

8 (c) APPLICABLE REINSURANCE ENTITY.—For pur-
9 poses of this section—

10 (1) IN GENERAL.—The term “applicable rein-
11 surance entity” means a not-for-profit organiza-
12 tion—

13 (A) the purpose of which is to help sta-
14 bilize premiums for coverage in the individual
15 and small group markets in a State during the
16 first 3 years of operation of an Exchange for
17 such markets within the State when the risk of
18 adverse selection related to new rating rules
19 and market changes is greatest; and

20 (B) the duties of which shall be to carry
21 out the reinsurance program under this section
22 by coordinating the funding and operation of
23 the risk-spreading mechanisms designed to im-
24 plement the reinsurance program.

1 2014, 2015, and 2016 under which a qualified health plan
2 offered in the individual or small group market shall par-
3 ticipate in a payment adjustment system based on the
4 ratio of the allowable costs of the plan to the plan's aggre-
5 gate premiums. Such program shall be based on the pro-
6 gram for regional participating provider organizations
7 under part D of title XVIII of the Social Security Act.

8 (b) PAYMENT METHODOLOGY.—

9 (1) PAYMENTS OUT.—The Secretary shall pro-
10 vide under the program established under subsection

11 (a) that if—

12 (A) a participating plan's allowable costs
13 for any plan year are more than 103 percent
14 but not more than 108 percent of the target
15 amount, the Secretary shall pay to the plan an
16 amount equal to 50 percent of the target
17 amount in excess of 103 percent of the target
18 amount; and

19 (B) a participating plan's allowable costs
20 for any plan year are more than 108 percent of
21 the target amount, the Secretary shall pay to
22 the plan an amount equal to the sum of 2.5
23 percent of the target amount plus 80 percent of
24 allowable costs in excess of 108 percent of the
25 target amount.

1 (2) PAYMENTS IN.—The Secretary shall provide
2 under the program established under subsection (a)
3 that if—

4 (A) a participating plan’s allowable costs
5 for any plan year are less than 97 percent but
6 not less than 92 percent of the target amount,
7 the plan shall pay to the Secretary an amount
8 equal to 50 percent of the excess of 97 percent
9 of the target amount over the allowable costs;
10 and

11 (B) a participating plan’s allowable costs
12 for any plan year are less than 92 percent of
13 the target amount, the plan shall pay to the
14 Secretary an amount equal to the sum of 2.5
15 percent of the target amount plus 80 percent of
16 the excess of 92 percent of the target amount
17 over the allowable costs.

18 (c) DEFINITIONS.—In this section:

19 (1) ALLOWABLE COSTS.—

20 (A) IN GENERAL.—The amount of allow-
21 able costs of a plan for any year is an amount
22 equal to the total costs (other than administra-
23 tive costs) of the plan in providing benefits cov-
24 ered by the plan.

1 (B) REDUCTION FOR RISK ADJUSTMENT
2 AND REINSURANCE PAYMENTS.—Allowable
3 costs shall reduced by any risk adjustment and
4 reinsurance payments received under section
5 1341 and 1343.

6 (2) TARGET AMOUNT.—The target amount of a
7 plan for any year is an amount equal to the total
8 premiums (including any premium subsidies under
9 any governmental program), reduced by the adminis-
10 trative costs of the plan.

11 **SEC. 1343. RISK ADJUSTMENT.**

12 (a) IN GENERAL.—

13 (1) LOW ACTUARIAL RISK PLANS.—Using the
14 criteria and methods developed under subsection (b),
15 each State shall assess a charge on health plans and
16 health insurance issuers (with respect to health in-
17 surance coverage) described in subsection (c) if the
18 actuarial risk of the enrollees of such plans or cov-
19 erage for a year is less than the average actuarial
20 risk of all enrollees in all plans or coverage in such
21 State for such year that are not self-insured group
22 health plans (which are subject to the provisions of
23 the Employee Retirement Income Security Act of
24 1974).

1 (2) HIGH ACTUARIAL RISK PLANS.—Using the
2 criteria and methods developed under subsection (b),
3 each State shall provide a payment to health plans
4 and health insurance issuers (with respect to health
5 insurance coverage) described in subsection (c) if the
6 actuarial risk of the enrollees of such plans or cov-
7 erage for a year is greater than the average actu-
8 arial risk of all enrollees in all plans and coverage
9 in such State for such year that are not self-insured
10 group health plans (which are subject to the provi-
11 sions of the Employee Retirement Income Security
12 Act of 1974).

13 (b) CRITERIA AND METHODS.—The Secretary, in
14 consultation with States, shall establish criteria and meth-
15 ods to be used in carrying out the risk adjustment activi-
16 ties under this section. The Secretary may utilize criteria
17 and methods similar to the criteria and methods utilized
18 under part C or D of title XVIII of the Social Security
19 Act. Such criteria and methods shall be included in the
20 standards and requirements the Secretary prescribes
21 under section 1321.

22 (c) SCOPE.—A health plan or a health insurance
23 issuer is described in this subsection if such health plan
24 or health insurance issuer provides coverage in the indi-
25 vidual or small group market within the State. This sub-

1 section shall not apply to a grandfathered health plan or
 2 the issuer of a grandfathered health plan with respect to
 3 that plan.

4 **Subtitle E—Affordable Coverage**
 5 **Choices for All Americans**

6 **PART I—PREMIUM TAX CREDITS AND COST-**
 7 **SHARING REDUCTIONS**

8 **Subpart A—Premium Tax Credits and Cost-sharing**
 9 **Reductions**

10 **SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM**
 11 **ASSISTANCE FOR COVERAGE UNDER A**
 12 **QUALIFIED HEALTH PLAN.**

13 (a) IN GENERAL.—Subpart C of part IV of sub-
 14 chapter A of chapter 1 of the Internal Revenue Code of
 15 1986 (relating to refundable credits) is amended by insert-
 16 ing after section 36A the following new section:

17 **“SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A**
 18 **QUALIFIED HEALTH PLAN.**

19 “(a) IN GENERAL.—In the case of an applicable tax-
 20 payer, there shall be allowed as a credit against the tax
 21 imposed by this subtitle for any taxable year an amount
 22 equal to the premium assistance credit amount of the tax-
 23 payer for the taxable year.

24 “(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For
 25 purposes of this section—

1 “(1) IN GENERAL.—The term ‘premium assist-
2 ance credit amount’ means, with respect to any tax-
3 able year, the sum of the premium assistance
4 amounts determined under paragraph (2) with re-
5 spect to all coverage months of the taxpayer occur-
6 ring during the taxable year.

7 “(2) PREMIUM ASSISTANCE AMOUNT.—The pre-
8 mium assistance amount determined under this sub-
9 section with respect to any coverage month is the
10 amount equal to the lesser of—

11 “(A) the monthly premiums for such
12 month for 1 or more qualified health plans of-
13 fered in the individual market within a State
14 which cover the taxpayer, the taxpayer’s spouse,
15 or any dependent (as defined in section 152) of
16 the taxpayer and which were enrolled in
17 through an Exchange established by the State
18 under 1311 of the Patient Protection and Af-
19 fordable Care Act, or

20 “(B) the excess (if any) of—

21 “(i) the adjusted monthly premium
22 for such month for the applicable second
23 lowest cost silver plan with respect to the
24 taxpayer, over

1 “(ii) an amount equal to 1/12 of the
2 product of the applicable percentage and
3 the taxpayer’s household income for the
4 taxable year.

5 “(3) OTHER TERMS AND RULES RELATING TO
6 PREMIUM ASSISTANCE AMOUNTS.—For purposes of
7 paragraph (2)—

8 “(A) APPLICABLE PERCENTAGE.—

9 “(i) IN GENERAL.—Except as pro-
10 vided in clause (ii), the applicable percent-
11 age with respect to any taxpayer for any
12 taxable year is equal to 2.8 percent, in-
13 creased by the number of percentage
14 points (not greater than 7) which bears the
15 same ratio to 7 percentage points as—

16 “(I) the taxpayer’s household in-
17 come for the taxable year in excess of
18 100 percent of the poverty line for a
19 family of the size involved, bears to

20 “(II) an amount equal to 200
21 percent of the poverty line for a fam-
22 ily of the size involved.

23 “(ii) SPECIAL RULE FOR TAXPAYERS
24 UNDER 133 PERCENT OF POVERTY LINE.—

25 If a taxpayer’s household income for the

1 taxable year is in excess of 100 percent,
2 but not more than 133 percent, of the pov-
3 erty line for a family of the size involved,
4 the taxpayer's applicable percentage shall
5 be 2 percent.

6 “(iii) INDEXING.—In the case of tax-
7 able years beginning in any calendar year
8 after 2014, the Secretary shall adjust the
9 initial and final applicable percentages
10 under clause (i), and the 2 percent under
11 clause (ii), for the calendar year to reflect
12 the excess of the rate of premium growth
13 between the preceding calendar year and
14 2013 over the rate of income growth for
15 such period.

16 “(B) APPLICABLE SECOND LOWEST COST
17 SILVER PLAN.—The applicable second lowest
18 cost silver plan with respect to any applicable
19 taxpayer is the second lowest cost silver plan of
20 the individual market in the rating area in
21 which the taxpayer resides which—

22 “(i) is offered through the same Ex-
23 change through which the qualified health
24 plans taken into account under paragraph
25 (2)(A) were offered, and

1 “(ii) provides—

2 “(I) self-only coverage in the case
3 of an applicable taxpayer—

4 “(aa) whose tax for the tax-
5 able year is determined under
6 section 1(c) (relating to unmar-
7 ried individuals other than sur-
8 viving spouses and heads of
9 households) and who is not al-
10 lowed a deduction under section
11 151 for the taxable year with re-
12 spect to a dependent, or

13 “(bb) who is not described
14 in item (aa) but who purchases
15 only self-only coverage, and

16 “(II) family coverage in the case
17 of any other applicable taxpayer.

18 If a taxpayer files a joint return and no credit
19 is allowed under this section with respect to 1
20 of the spouses by reason of subsection (e), the
21 taxpayer shall be treated as described in clause
22 (ii)(I) unless a deduction is allowed under sec-
23 tion 151 for the taxable year with respect to a
24 dependent other than either spouse and sub-
25 section (e) does not apply to the dependent.

1 “(C) ADJUSTED MONTHLY PREMIUM.—

2 The adjusted monthly premium for an applica-
3 ble second lowest cost silver plan is the monthly
4 premium which would have been charged (for
5 the rating area with respect to which the pre-
6 miums under paragraph (2)(A) were deter-
7 mined) for the plan if each individual covered
8 under a qualified health plan taken into account
9 under paragraph (2)(A) were covered by such
10 silver plan and the premium was adjusted only
11 for the age of each such individual in the man-
12 ner allowed under section 2701 of the Public
13 Health Service Act. In the case of a State par-
14 ticipating in the wellness discount demonstra-
15 tion project under section 2705(d) of the Public
16 Health Service Act, the adjusted monthly pre-
17 mium shall be determined without regard to
18 any premium discount or rebate under such
19 project.

20 “(D) ADDITIONAL BENEFITS.—If—

21 “(i) a qualified health plan under sec-
22 tion 1302(b)(5) of the Patient Protection
23 and Affordable Care Act offers benefits in
24 addition to the essential health benefits re-
25 quired to be provided by the plan, or

1 “(ii) a State requires a qualified
2 health plan under section 1311(d)(3)(B) of
3 such Act to cover benefits in addition to
4 the essential health benefits required to be
5 provided by the plan,
6 the portion of the premium for the plan prop-
7 erly allocable (under rules prescribed by the
8 Secretary of Health and Human Services) to
9 such additional benefits shall not be taken into
10 account in determining either the monthly pre-
11 mium or the adjusted monthly premium under
12 paragraph (2).

13 “(E) SPECIAL RULE FOR PEDIATRIC DEN-
14 TAL COVERAGE.—For purposes of determining
15 the amount of any monthly premium, if an indi-
16 vidual enrolls in both a qualified health plan
17 and a plan described in section
18 1311(d)(2)(B)(ii)(I) of the Patient Protection
19 and Affordable Care Act for any plan year, the
20 portion of the premium for the plan described
21 in such section that (under regulations pre-
22 scribed by the Secretary) is properly allocable
23 to pediatric dental benefits which are included
24 in the essential health benefits required to be
25 provided by a qualified health plan under sec-

1 tion 1302(b)(1)(J) of such Act shall be treated
2 as a premium payable for a qualified health
3 plan.

4 “(c) DEFINITION AND RULES RELATING TO APPLI-
5 CABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED
6 HEALTH PLAN.—For purposes of this section—

7 “(1) APPLICABLE TAXPAYER.—

8 “(A) IN GENERAL.—The term ‘applicable
9 taxpayer’ means, with respect to any taxable
10 year, a taxpayer whose household income for
11 the taxable year exceeds 100 percent but does
12 not exceed 400 percent of an amount equal to
13 the poverty line for a family of the size in-
14 volved.

15 “(B) SPECIAL RULE FOR CERTAIN INDI-
16 VIDUALS LAWFULLY PRESENT IN THE UNITED
17 STATES.—If—

18 “(i) a taxpayer has a household in-
19 come which is not greater than 100 per-
20 cent of an amount equal to the poverty line
21 for a family of the size involved, and

22 “(ii) the taxpayer is an alien lawfully
23 present in the United States, but is not eli-
24 gible for the medicaid program under title

1 XIX of the Social Security Act by reason
2 of such alien status,
3 the taxpayer shall, for purposes of the credit
4 under this section, be treated as an applicable
5 taxpayer with a household income which is
6 equal to 100 percent of the poverty line for a
7 family of the size involved.

8 “(C) MARRIED COUPLES MUST FILE JOINT
9 RETURN.—If the taxpayer is married (within
10 the meaning of section 7703) at the close of the
11 taxable year, the taxpayer shall be treated as an
12 applicable taxpayer only if the taxpayer and the
13 taxpayer’s spouse file a joint return for the tax-
14 able year.

15 “(D) DENIAL OF CREDIT TO DEPEND-
16 ENTS.—No credit shall be allowed under this
17 section to any individual with respect to whom
18 a deduction under section 151 is allowable to
19 another taxpayer for a taxable year beginning
20 in the calendar year in which such individual’s
21 taxable year begins.

22 “(2) COVERAGE MONTH.—For purposes of this
23 subsection—

1 “(A) IN GENERAL.—The term ‘coverage
2 month’ means, with respect to an applicable
3 taxpayer, any month if—

4 “(i) as of the first day of such month
5 the taxpayer, the taxpayer’s spouse, or any
6 dependent of the taxpayer is covered by a
7 qualified health plan described in sub-
8 section (b)(2)(A) that was enrolled in
9 through an Exchange established by the
10 State under section 1311 of the Patient
11 Protection and Affordable Care Act, and

12 “(ii) the premium for coverage under
13 such plan for such month is paid by the
14 taxpayer (or through advance payment of
15 the credit under subsection (a) under sec-
16 tion 1412 of the Patient Protection and
17 Affordable Care Act).

18 “(B) EXCEPTION FOR MINIMUM ESSEN-
19 TIAL COVERAGE.—

20 “(i) IN GENERAL.—The term ‘cov-
21 erage month’ shall not include any month
22 with respect to an individual if for such
23 month the individual is eligible for min-
24 imum essential coverage other than eligi-
25 bility for coverage described in section

1 5000A(f)(1)(C) (relating to coverage in the
2 individual market).

3 “(ii) MINIMUM ESSENTIAL COV-
4 ERAGE.—The term ‘minimum essential
5 coverage’ has the meaning given such term
6 by section 5000A(f).

7 “(C) SPECIAL RULE FOR EMPLOYER-SPON-
8 SORED MINIMUM ESSENTIAL COVERAGE.—For
9 purposes of subparagraph (B)—

10 “(i) COVERAGE MUST BE AFFORD-
11 ABLE.—Except as provided in clause (iii),
12 an employee shall not be treated as eligible
13 for minimum essential coverage if such
14 coverage—

15 “(I) consists of an eligible em-
16 ployer-sponsored plan (as defined in
17 section 5000A(f)(2)), and

18 “(II) the employee’s required
19 contribution (within the meaning of
20 section 5000A(e)(1)(B)) with respect
21 to the plan exceeds 9.8 percent of the
22 applicable taxpayer’s household in-
23 come.

24 This clause shall also apply to an indi-
25 vidual who is eligible to enroll in the plan

1 by reason of a relationship the individual
2 bears to the employee.

3 “(ii) COVERAGE MUST PROVIDE MIN-
4 IMUM VALUE.—Except as provided in
5 clause (iii), an employee shall not be treat-
6 ed as eligible for minimum essential cov-
7 erage if such coverage consists of an eligi-
8 ble employer-sponsored plan (as defined in
9 section 5000A(f)(2)) and the plan’s share
10 of the total allowed costs of benefits pro-
11 vided under the plan is less than 60 per-
12 cent of such costs.

13 “(iii) EMPLOYEE OR FAMILY MUST
14 NOT BE COVERED UNDER EMPLOYER
15 PLAN.—Clauses (i) and (ii) shall not apply
16 if the employee (or any individual de-
17 scribed in the last sentence of clause (i)) is
18 covered under the eligible employer-spon-
19 sored plan or the grandfathered health
20 plan.

21 “(iv) INDEXING.—In the case of plan
22 years beginning in any calendar year after
23 2014, the Secretary shall adjust the 9.8
24 percent under clause (i)(II) in the same

1 manner as the percentages are adjusted
2 under subsection (b)(3)(A)(ii).

3 “(3) DEFINITIONS AND OTHER RULES.—

4 “(A) QUALIFIED HEALTH PLAN.—The
5 term ‘qualified health plan’ has the meaning
6 given such term by section 1301(a) of the Pa-
7 tient Protection and Affordable Care Act, ex-
8 cept that such term shall not include a qualified
9 health plan which is a catastrophic plan de-
10 scribed in section 1302(e) of such Act.

11 “(B) GRANDFATHERED HEALTH PLAN.—
12 The term ‘grandfathered health plan’ has the
13 meaning given such term by section 1251 of the
14 Patient Protection and Affordable Care Act.

15 “(d) TERMS RELATING TO INCOME AND FAMILIES.—
16 For purposes of this section—

17 “(1) FAMILY SIZE.—The family size involved
18 with respect to any taxpayer shall be equal to the
19 number of individuals for whom the taxpayer is al-
20 lowed a deduction under section 151 (relating to al-
21 lowance of deduction for personal exemptions) for
22 the taxable year.

23 “(2) HOUSEHOLD INCOME.—

1 “(A) HOUSEHOLD INCOME.—The term
2 ‘household income’ means, with respect to any
3 taxpayer, an amount equal to the sum of—

4 “(i) the modified gross income of the
5 taxpayer, plus

6 “(ii) the aggregate modified gross in-
7 comes of all other individuals who—

8 “(I) were taken into account in
9 determining the taxpayer’s family size
10 under paragraph (1), and

11 “(II) were required to file a re-
12 turn of tax imposed by section 1 for
13 the taxable year.

14 “(B) MODIFIED GROSS INCOME.—The
15 term ‘modified gross income’ means gross in-
16 come—

17 “(i) decreased by the amount of any
18 deduction allowable under paragraph (1),
19 (3), (4), or (10) of section 62(a),

20 “(ii) increased by the amount of inter-
21 est received or accrued during the taxable
22 year which is exempt from tax imposed by
23 this chapter, and

24 “(iii) determined without regard to
25 sections 911, 931, and 933.

1 “(3) POVERTY LINE.—

2 “(A) IN GENERAL.—The term ‘poverty
3 line’ has the meaning given that term in section
4 2110(c)(5) of the Social Security Act (42
5 U.S.C. 1397jj(c)(5)).

6 “(B) POVERTY LINE USED.—In the case of
7 any qualified health plan offered through an
8 Exchange for coverage during a taxable year
9 beginning in a calendar year, the poverty line
10 used shall be the most recently published pov-
11 erty line as of the 1st day of the regular enroll-
12 ment period for coverage during such calendar
13 year.

14 “(e) RULES FOR INDIVIDUALS NOT LAWFULLY
15 PRESENT.—

16 “(1) IN GENERAL.—If 1 or more individuals for
17 whom a taxpayer is allowed a deduction under sec-
18 tion 151 (relating to allowance of deduction for per-
19 sonal exemptions) for the taxable year (including the
20 taxpayer or his spouse) are individuals who are not
21 lawfully present—

22 “(A) the aggregate amount of premiums
23 otherwise taken into account under clauses (i)
24 and (ii) of subsection (b)(2)(A) shall be reduced

1 by the portion (if any) of such premiums which
2 is attributable to such individuals, and

3 “(B) for purposes of applying this section,
4 the determination as to what percentage a tax-
5 payer’s household income bears to the poverty
6 level for a family of the size involved shall be
7 made under one of the following methods:

8 “(i) A method under which—

9 “(I) the taxpayer’s family size is
10 determined by not taking such indi-
11 viduals into account, and

12 “(II) the taxpayer’s household in-
13 come is equal to the product of the
14 taxpayer’s household income (deter-
15 mined without regard to this sub-
16 section) and a fraction—

17 “(aa) the numerator of
18 which is the poverty line for the
19 taxpayer’s family size determined
20 after application of subclause (I),
21 and

22 “(bb) the denominator of
23 which is the poverty line for the
24 taxpayer’s family size determined
25 without regard to subclause (I).

1 “(ii) A comparable method reaching
2 the same result as the method under
3 clause (i).

4 “(2) LAWFULLY PRESENT.—For purposes of
5 this section, an individual shall be treated as law-
6 fully present only if the individual is, and is reason-
7 ably expected to be for the entire period of enroll-
8 ment for which the credit under this section is being
9 claimed, a citizen or national of the United States
10 or an alien lawfully present in the United States.

11 “(3) SECRETARIAL AUTHORITY.—The Secretary
12 of Health and Human Services, in consultation with
13 the Secretary, shall prescribe rules setting forth the
14 methods by which calculations of family size and
15 household income are made for purposes of this sub-
16 section. Such rules shall be designed to ensure that
17 the least burden is placed on individuals enrolling in
18 qualified health plans through an Exchange and tax-
19 payers eligible for the credit allowable under this
20 section.

21 “(f) RECONCILIATION OF CREDIT AND ADVANCE
22 CREDIT.—

23 “(1) IN GENERAL.—The amount of the credit
24 allowed under this section for any taxable year shall
25 be reduced (but not below zero) by the amount of

1 any advance payment of such credit under section
2 1412 of the Patient Protection and Affordable Care
3 Act.

4 “(2) EXCESS ADVANCE PAYMENTS.—

5 “(A) IN GENERAL.—If the advance pay-
6 ments to a taxpayer under section 1412 of the
7 Patient Protection and Affordable Care Act for
8 a taxable year exceed the credit allowed by this
9 section (determined without regard to para-
10 graph (1)), the tax imposed by this chapter for
11 the taxable year shall be increased by the
12 amount of such excess.

13 “(B) LIMITATION ON INCREASE WHERE
14 INCOME LESS THAN 400 PERCENT OF POVERTY
15 LINE.—

16 “(i) IN GENERAL.—In the case of an
17 applicable taxpayer whose household in-
18 come is less than 400 percent of the pov-
19 erty line for the size of the family involved
20 for the taxable year, the amount of the in-
21 crease under subparagraph (A) shall in no
22 event exceed \$400 (\$250 in the case of a
23 taxpayer whose tax is determined under
24 section 1(c) for the taxable year).

1 “(ii) INDEXING OF AMOUNT.—In the
2 case of any calendar year beginning after
3 2014, each of the dollar amounts under
4 clause (i) shall be increased by an amount
5 equal to—

6 “(I) such dollar amount, multi-
7 plied by

8 “(II) the cost-of-living adjust-
9 ment determined under section 1(f)(3)
10 for the calendar year, determined by
11 substituting ‘calendar year 2013’ for
12 ‘calendar year 1992’ in subparagraph
13 (B) thereof.

14 If the amount of any increase under clause
15 (i) is not a multiple of \$50, such increase
16 shall be rounded to the next lowest mul-
17 tiple of \$50.

18 “(g) REGULATIONS.—The Secretary shall prescribe
19 such regulations as may be necessary to carry out the pro-
20 visions of this section, including regulations which provide
21 for—

22 “(1) the coordination of the credit allowed
23 under this section with the program for advance
24 payment of the credit under section 1412 of the Pa-
25 tient Protection and Affordable Care Act, and

1 “(2) the application of subsection (f) where the
2 filing status of the taxpayer for a taxable year is dif-
3 ferent from such status used for determining the ad-
4 vance payment of the credit.”.

5 (b) DISALLOWANCE OF DEDUCTION.—Section 280C
6 of the Internal Revenue Code of 1986 is amended by add-
7 ing at the end the following new subsection:

8 “(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—
9 No deduction shall be allowed for the portion of the pre-
10 miums paid by the taxpayer for coverage of 1 or more
11 individuals under a qualified health plan which is equal
12 to the amount of the credit determined for the taxable
13 year under section 36B(a) with respect to such pre-
14 miums.”.

15 (c) STUDY ON AFFORDABLE COVERAGE.—

16 (1) STUDY AND REPORT.—

17 (A) IN GENERAL.—Not later than 5 years
18 after the date of the enactment of this Act, the
19 Comptroller General shall conduct a study on
20 the affordability of health insurance coverage,
21 including—

22 (i) the impact of the tax credit for
23 qualified health insurance coverage of indi-
24 viduals under section 36B of the Internal
25 Revenue Code of 1986 and the tax credit

1 for employee health insurance expenses of
2 small employers under section 45R of such
3 Code on maintaining and expanding the
4 health insurance coverage of individuals;

5 (ii) the availability of affordable
6 health benefits plans, including a study of
7 whether the percentage of household in-
8 come used for purposes of section
9 36B(c)(2)(C) of the Internal Revenue Code
10 of 1986 (as added by this section) is the
11 appropriate level for determining whether
12 employer-provided coverage is affordable
13 for an employee and whether such level
14 may be lowered without significantly in-
15 creasing the costs to the Federal Govern-
16 ment and reducing employer-provided cov-
17 erage; and

18 (iii) the ability of individuals to main-
19 tain essential health benefits coverage (as
20 defined in section 5000A(f) of the Internal
21 Revenue Code of 1986).

22 (B) REPORT.—The Comptroller General
23 shall submit to the appropriate committees of
24 Congress a report on the study conducted under
25 subparagraph (A), together with legislative rec-

1 (1) the Secretary shall notify the issuer of the
2 plan of such eligibility; and

3 (2) the issuer shall reduce the cost-sharing
4 under the plan at the level and in the manner speci-
5 fied in subsection (c).

6 (b) ELIGIBLE INSURED.—In this section, the term
7 “eligible insured” means an individual—

8 (1) who enrolls in a qualified health plan in the
9 silver level of coverage in the individual market of-
10 fered through an Exchange; and

11 (2) whose household income exceeds 100 per-
12 cent but does not exceed 400 percent of the poverty
13 line for a family of the size involved.

14 In the case of an individual described in section
15 36B(c)(1)(B) of the Internal Revenue Code of 1986, the
16 individual shall be treated as having household income
17 equal to 100 percent for purposes of applying this section.

18 (c) DETERMINATION OF REDUCTION IN COST-SHAR-
19 ING.—

20 (1) REDUCTION IN OUT-OF-POCKET LIMIT.—

21 (A) IN GENERAL.—The reduction in cost-
22 sharing under this subsection shall first be
23 achieved by reducing the applicable out-of-pock-
24 et limit under section 1302(c)(1) in the case
25 of—

1 (i) an eligible insured whose household
2 income is more than 100 percent but not
3 more than 200 percent of the poverty line
4 for a family of the size involved, by two-
5 thirds;

6 (ii) an eligible insured whose house-
7 hold income is more than 200 percent but
8 not more than 300 percent of the poverty
9 line for a family of the size involved, by
10 one-half; and

11 (iii) an eligible insured whose house-
12 hold income is more than 300 percent but
13 not more than 400 percent of the poverty
14 line for a family of the size involved, by
15 one-third.

16 (B) COORDINATION WITH ACTUARIAL
17 VALUE LIMITS.—

18 (i) IN GENERAL.—The Secretary shall
19 ensure the reduction under this paragraph
20 shall not result in an increase in the plan's
21 share of the total allowed costs of benefits
22 provided under the plan above—

23 (I) 90 percent in the case of an
24 eligible insured described in para-
25 graph (2)(A);

1 (II) 80 percent in the case of an
2 eligible insured described in para-
3 graph (2)(B); and

4 (III) 70 percent in the case of an
5 eligible insured described in clause (ii)
6 or (iii) of subparagraph (A).

7 (ii) ADJUSTMENT.—The Secretary
8 shall adjust the out-of pocket limits under
9 paragraph (1) if necessary to ensure that
10 such limits do not cause the respective ac-
11 tuarial values to exceed the levels specified
12 in clause (i).

13 (2) ADDITIONAL REDUCTION FOR LOWER IN-
14 COME INSUREDS.—The Secretary shall establish pro-
15 cedures under which the issuer of a qualified health
16 plan to which this section applies shall further re-
17 duce cost-sharing under the plan in a manner suffi-
18 cient to—

19 (A) in the case of an eligible insured whose
20 household income is not less than 100 percent
21 but not more than 150 percent of the poverty
22 line for a family of the size involved, increase
23 the plan's share of the total allowed costs of
24 benefits provided under the plan to 90 percent
25 of such costs; and

1 (B) in the case of an eligible insured whose
2 household income is more than 150 percent but
3 not more than 200 percent of the poverty line
4 for a family of the size involved, increase the
5 plan's share of the total allowed costs of bene-
6 fits provided under the plan to 80 percent of
7 such costs.

8 (3) METHODS FOR REDUCING COST-SHARING.—

9 (A) IN GENERAL.—An issuer of a qualified
10 health plan making reductions under this sub-
11 section shall notify the Secretary of such reduc-
12 tions and the Secretary shall make periodic and
13 timely payments to the issuer equal to the value
14 of the reductions.

15 (B) CAPITATED PAYMENTS.—The Sec-
16 retary may establish a capitated payment sys-
17 tem to carry out the payment of cost-sharing
18 reductions under this section. Any such system
19 shall take into account the value of the reduc-
20 tions and make appropriate risk adjustments to
21 such payments.

22 (4) ADDITIONAL BENEFITS.—If a qualified
23 health plan under section 1302(b)(5) offers benefits
24 in addition to the essential health benefits required
25 to be provided by the plan, or a State requires a

1 qualified health plan under section 1311(d)(3)(B) to
2 cover benefits in addition to the essential health ben-
3 efits required to be provided by the plan, the reduc-
4 tions in cost-sharing under this section shall not
5 apply to such additional benefits.

6 (5) SPECIAL RULE FOR PEDIATRIC DENTAL
7 PLANS.—If an individual enrolls in both a qualified
8 health plan and a plan described in section
9 1311(d)(2)(B)(ii)(I) for any plan year, subsection
10 (a) shall not apply to that portion of any reduction
11 in cost-sharing under subsection (c) that (under reg-
12 ulations prescribed by the Secretary) is properly al-
13 locable to pediatric dental benefits which are in-
14 cluded in the essential health benefits required to be
15 provided by a qualified health plan under section
16 1302(b)(1)(J).

17 (d) SPECIAL RULES FOR INDIANS.—

18 (1) INDIANS UNDER 300 PERCENT OF POV-
19 ERTY.—If an individual enrolled in any qualified
20 health plan in the individual market through an Ex-
21 change is an Indian (as defined in section 4(d) of
22 the Indian Self-Determination and Education Assist-
23 ance Act (25 U.S.C. 450b(d))) whose household in-
24 come is not more than 300 percent of the poverty

1 line for a family of the size involved, then, for pur-
2 poses of this section—

3 (A) such individual shall be treated as an
4 eligible insured; and

5 (B) the issuer of the plan shall eliminate
6 any cost-sharing under the plan.

7 (2) ITEMS OR SERVICES FURNISHED THROUGH
8 INDIAN HEALTH PROVIDERS.—If an Indian (as so
9 defined) enrolled in a qualified health plan is fur-
10 nished an item or service directly by the Indian
11 Health Service, an Indian Tribe, Tribal Organiza-
12 tion, or Urban Indian Organization or through refer-
13 ral under contract health services—

14 (A) no cost-sharing under the plan shall be
15 imposed under the plan for such item or serv-
16 ice; and

17 (B) the issuer of the plan shall not reduce
18 the payment to any such entity for such item
19 or service by the amount of any cost-sharing
20 that would be due from the Indian but for sub-
21 paragraph (A).

22 (3) PAYMENT.—The Secretary shall pay to the
23 issuer of a qualified health plan the amount nec-
24 essary to reflect the increase in actuarial value of
25 the plan required by reason of this subsection.

1 (e) RULES FOR INDIVIDUALS NOT LAWFULLY
2 PRESENT.—

3 (1) IN GENERAL.—If an individual who is an el-
4 igible insured is not lawfully present—

5 (A) no cost-sharing reduction under this
6 section shall apply with respect to the indi-
7 vidual; and

8 (B) for purposes of applying this section,
9 the determination as to what percentage a tax-
10 payer's household income bears to the poverty
11 level for a family of the size involved shall be
12 made under one of the following methods:

13 (i) A method under which—

14 (I) the taxpayer's family size is
15 determined by not taking such indi-
16 viduals into account, and

17 (II) the taxpayer's household in-
18 come is equal to the product of the
19 taxpayer's household income (deter-
20 mined without regard to this sub-
21 section) and a fraction—

22 (aa) the numerator of which
23 is the poverty line for the tax-
24 payer's family size determined

1 after application of subclause (I),
2 and

3 (bb) the denominator of
4 which is the poverty line for the
5 taxpayer's family size determined
6 without regard to subclause (I).

7 (ii) A comparable method reaching the
8 same result as the method under clause (i).

9 (2) **LAWFULLY PRESENT.**—For purposes of this
10 section, an individual shall be treated as lawfully
11 present only if the individual is, and is reasonably
12 expected to be for the entire period of enrollment for
13 which the cost-sharing reduction under this section
14 is being claimed, a citizen or national of the United
15 States or an alien lawfully present in the United
16 States.

17 (3) **SECRETARIAL AUTHORITY.**—The Secretary,
18 in consultation with the Secretary of the Treasury,
19 shall prescribe rules setting forth the methods by
20 which calculations of family size and household in-
21 come are made for purposes of this subsection. Such
22 rules shall be designed to ensure that the least bur-
23 den is placed on individuals enrolling in qualified
24 health plans through an Exchange and taxpayers eli-
25 gible for the credit allowable under this section.

1 (f) DEFINITIONS AND SPECIAL RULES.—In this sec-
2 tion:

3 (1) IN GENERAL.—Any term used in this sec-
4 tion which is also used in section 36B of the Inter-
5 nal Revenue Code of 1986 shall have the meaning
6 given such term by such section.

7 (2) LIMITATIONS ON REDUCTION.—No cost-
8 sharing reduction shall be allowed under this section
9 with respect to coverage for any month unless the
10 month is a coverage month with respect to which a
11 credit is allowed to the insured (or an applicable tax-
12 payer on behalf of the insured) under section 36B
13 of such Code.

14 (3) DATA USED FOR ELIGIBILITY.—Any deter-
15 mination under this section shall be made on the
16 basis of the taxable year for which the advance de-
17 termination is made under section 1412 and not the
18 taxable year for which the credit under section 36B
19 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 1312(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;

1 (3) whether an individual’s coverage under an
2 employer-sponsored health benefits plan is treated as
3 unaffordable under sections 36B(c)(2)(C) and
4 5000A(e)(2); and

5 (4) whether to grant a certification under sec-
6 tion 1311(d)(4)(H) attesting that, for purposes of
7 the individual responsibility requirement under sec-
8 tion 5000A of the Internal Revenue Code of 1986,
9 an individual is entitled to an exemption from either
10 the individual responsibility requirement or the pen-
11 alty imposed by such section.

12 (b) INFORMATION REQUIRED TO BE PROVIDED BY
13 APPLICANTS.—

14 (1) IN GENERAL.—An applicant for enrollment
15 in a qualified health plan offered through an Ex-
16 change in the individual market shall provide—

17 (A) the name, address, and date of birth of
18 each individual who is to be covered by the plan
19 (in this subsection referred to as an “enrollee”);
20 and

21 (B) the information required by any of the
22 following paragraphs that is applicable to an
23 enrollee.

1 (2) CITIZENSHIP OR IMMIGRATION STATUS.—

2 The following information shall be provided with re-
3 spect to every enrollee:

4 (A) In the case of an enrollee whose eligi-
5 bility is based on an attestation of citizenship of
6 the enrollee, the enrollee's social security num-
7 ber.

8 (B) In the case of an individual whose eli-
9 gibility is based on an attestation of the enroll-
10 ee's immigration status, the enrollee's social se-
11 curity number (if applicable) and such identi-
12 fying information with respect to the enrollee's
13 immigration status as the Secretary, after con-
14 sultation with the Secretary of Homeland Secu-
15 rity, determines appropriate.

16 (3) ELIGIBILITY AND AMOUNT OF TAX CREDIT
17 OR REDUCED COST-SHARING.—In the case of an en-
18 rollee with respect to whom a premium tax credit or
19 reduced cost-sharing under section 36B of such
20 Code or section 1402 is being claimed, the following
21 information:

22 (A) INFORMATION REGARDING INCOME
23 AND FAMILY SIZE.—The information described
24 in section 6103(l)(21) for the taxable year end-
25 ing with or within the second calendar year pre-

1 ceding the calendar year in which the plan year
2 begins.

3 (B) CHANGES IN CIRCUMSTANCES.—The
4 information described in section 1412(b)(2), in-
5 cluding information with respect to individuals
6 who were not required to file an income tax re-
7 turn for the taxable year described in subpara-
8 graph (A) or individuals who experienced
9 changes in marital status or family size or sig-
10 nificant reductions in income.

11 (4) EMPLOYER-SPONSORED COVERAGE.—In the
12 case of an enrollee with respect to whom eligibility
13 for a premium tax credit under section 36B of such
14 Code or cost-sharing reduction under section 1402 is
15 being established on the basis that the enrollee's (or
16 related individual's) employer is not treated under
17 section 36B(c)(2)(C) of such Code as providing min-
18 imum essential coverage or affordable minimum es-
19 sential coverage, the following information:

20 (A) The name, address, and employer iden-
21 tification number (if available) of the employer.

22 (B) Whether the enrollee or individual is a
23 full-time employee and whether the employer
24 provides such minimum essential coverage.

1 (C) If the employer provides such min-
2 imum essential coverage, the lowest cost option
3 for the enrollee's or individual's enrollment sta-
4 tus and the enrollee's or individual's required
5 contribution (within the meaning of section
6 5000A(e)(1)(B) of such Code) under the em-
7 ployer-sponsored plan.

8 (D) If an enrollee claims an employer's
9 minimum essential coverage is unaffordable, the
10 information described in paragraph (3).

11 If an enrollee changes employment or obtains addi-
12 tional employment while enrolled in a qualified
13 health plan for which such credit or reduction is al-
14 lowed, the enrollee shall notify the Exchange of such
15 change or additional employment and provide the in-
16 formation described in this paragraph with respect
17 to the new employer.

18 (5) EXEMPTIONS FROM INDIVIDUAL RESPONSI-
19 BILITY REQUIREMENTS.—In the case of an indi-
20 vidual who is seeking an exemption certificate under
21 section 1311(d)(4)(H) from any requirement or pen-
22 alty imposed by section 5000A, the following infor-
23 mation:

24 (A) In the case of an individual seeking ex-
25 emption based on the individual's status as a

1 member of an exempt religious sect or division,
2 as a member of a health care sharing ministry,
3 as an Indian, or as an individual eligible for a
4 hardship exemption, such information as the
5 Secretary shall prescribe.

6 (B) In the case of an individual seeking ex-
7 emption based on the lack of affordable cov-
8 erage or the individual's status as a taxpayer
9 with household income less than 100 percent of
10 the poverty line, the information described in
11 paragraphs (3) and (4), as applicable.

12 (c) VERIFICATION OF INFORMATION CONTAINED IN
13 RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

14 (1) INFORMATION TRANSFERRED TO SEC-
15 RETARY.—An Exchange shall submit the informa-
16 tion provided by an applicant under subsection (b)
17 to the Secretary for verification in accordance with
18 the requirements of this subsection and subsection
19 (d).

20 (2) CITIZENSHIP OR IMMIGRATION STATUS.—

21 (A) COMMISSIONER OF SOCIAL SECUR-
22 ITY.—The Secretary shall submit to the Com-
23 missioner of Social Security the following infor-
24 mation for a determination as to whether the

1 information provided is consistent with the in-
2 formation in the records of the Commissioner:

3 (i) The name, date of birth, and social
4 security number of each individual for
5 whom such information was provided
6 under subsection (b)(2).

7 (ii) The attestation of an individual
8 that the individual is a citizen.

9 (B) SECRETARY OF HOMELAND SECU-
10 RITY.—

11 (i) IN GENERAL.—In the case of an
12 individual—

13 (I) who attests that the indi-
14 vidual is an alien lawfully present in
15 the United States; or

16 (II) who attests that the indi-
17 vidual is a citizen but with respect to
18 whom the Commissioner of Social Se-
19 curity has notified the Secretary
20 under subsection (e)(3) that the attes-
21 tation is inconsistent with information
22 in the records maintained by the
23 Commissioner;

24 the Secretary shall submit to the Secretary
25 of Homeland Security the information de-

1 scribed in clause (ii) for a determination as
2 to whether the information provided is con-
3 sistent with the information in the records
4 of the Secretary of Homeland Security.

5 (ii) INFORMATION.—The information
6 described in clause (ii) is the following:

7 (I) The name, date of birth, and
8 any identifying information with re-
9 spect to the individual's immigration
10 status provided under subsection
11 (b)(2).

12 (II) The attestation that the indi-
13 vidual is an alien lawfully present in
14 the United States or in the case of an
15 individual described in clause (i)(II),
16 the attestation that the individual is a
17 citizen.

18 (3) ELIGIBILITY FOR TAX CREDIT AND COST-
19 SHARING REDUCTION.—The Secretary shall submit
20 the information described in subsection (b)(3)(A)
21 provided under paragraph (3), (4), or (5) of sub-
22 section (b) to the Secretary of the Treasury for
23 verification of household income and family size for
24 purposes of eligibility.

25 (4) METHODS.—

1 (A) IN GENERAL.—The Secretary, in con-
2 sultation with the Secretary of the Treasury,
3 the Secretary of Homeland Security, and the
4 Commissioner of Social Security, shall provide
5 that verifications and determinations under this
6 subsection shall be done—

7 (i) through use of an on-line system
8 or otherwise for the electronic submission
9 of, and response to, the information sub-
10 mitted under this subsection with respect
11 to an applicant; or

12 (ii) by determining the consistency of
13 the information submitted with the infor-
14 mation maintained in the records of the
15 Secretary of the Treasury, the Secretary of
16 Homeland Security, or the Commissioner
17 of Social Security through such other
18 method as is approved by the Secretary.

19 (B) FLEXIBILITY.—The Secretary may
20 modify the methods used under the program es-
21 tablished by this section for the Exchange and
22 verification of information if the Secretary de-
23 termines such modifications would reduce the
24 administrative costs and burdens on the appli-
25 cant, including allowing an applicant to request

1 the Secretary of the Treasury to provide the in-
2 formation described in paragraph (3) directly to
3 the Exchange or to the Secretary. The Sec-
4 retary shall not make any such modification un-
5 less the Secretary determines that any applica-
6 ble requirements under this section and section
7 6103 of the Internal Revenue Code of 1986
8 with respect to the confidentiality, disclosure,
9 maintenance, or use of information will be met.

10 (d) VERIFICATION BY SECRETARY.—In the case of
11 information provided under subsection (b) that is not re-
12 quired under subsection (c) to be submitted to another
13 person for verification, the Secretary shall verify the accu-
14 racy of such information in such manner as the Secretary
15 determines appropriate, including delegating responsibility
16 for verification to the Exchange.

17 (e) ACTIONS RELATING TO VERIFICATION.—

18 (1) IN GENERAL.—Each person to whom the
19 Secretary provided information under subsection (c)
20 shall report to the Secretary under the method es-
21 tablished under subsection (c)(4) the results of its
22 verification and the Secretary shall notify the Ex-
23 change of such results. Each person to whom the
24 Secretary provided information under subsection (d)

1 shall report to the Secretary in such manner as the
2 Secretary determines appropriate.

3 (2) VERIFICATION.—

4 (A) ELIGIBILITY FOR ENROLLMENT AND
5 PREMIUM TAX CREDITS AND COST-SHARING RE-
6 Ductions.—If information provided by an ap-
7 plicant under paragraphs (1), (2), (3), and (4)
8 of subsection (b) is verified under subsections
9 (c) and (d)—

10 (i) the individual's eligibility to enroll
11 through the Exchange and to apply for
12 premium tax credits and cost-sharing re-
13 ductions shall be satisfied; and

14 (ii) the Secretary shall, if applicable,
15 notify the Secretary of the Treasury under
16 section 1412(e) of the amount of any ad-
17 vance payment to be made.

18 (B) EXEMPTION FROM INDIVIDUAL RE-
19 sponsibility.—If information provided by an
20 applicant under subsection (b)(5) is verified
21 under subsections (c) and (d), the Secretary
22 shall issue the certification of exemption de-
23 scribed in section 1311(d)(4)(H).

24 (3) INCONSISTENCIES INVOLVING ATTESTATION
25 OF CITIZENSHIP OR LAWFUL PRESENCE.—If the in-

1 formation provided by any applicant under sub-
2 section (b)(2) is inconsistent with information in the
3 records maintained by the Commissioner of Social
4 Security or Secretary of Homeland Security, which-
5 ever is applicable, the applicant's eligibility will be
6 determined in the same manner as an individual's
7 eligibility under the medicaid program is determined
8 under section 1902(ee) of the Social Security Act (as
9 in effect on January 1, 2010).

10 (4) INCONSISTENCIES INVOLVING OTHER IN-
11 FORMATION.—

12 (A) IN GENERAL.—If the information pro-
13 vided by an applicant under subsection (b)
14 (other than subsection (b)(2)) is inconsistent
15 with information in the records maintained by
16 persons under subsection (c) or is not verified
17 under subsection (d), the Secretary shall notify
18 the Exchange and the Exchange shall take the
19 following actions:

20 (i) REASONABLE EFFORT.—The Ex-
21 change shall make a reasonable effort to
22 identify and address the causes of such in-
23 consistency, including through typo-
24 graphical or other clerical errors, by con-
25 tacting the applicant to confirm the accu-

1 racy of the information, and by taking
2 such additional actions as the Secretary,
3 through regulation or other guidance, may
4 identify.

5 (ii) NOTICE AND OPPORTUNITY TO
6 CORRECT.—In the case the inconsistency
7 or inability to verify is not resolved under
8 subparagraph (A), the Exchange shall—

9 (I) notify the applicant of such
10 fact;

11 (II) provide the applicant an op-
12 portunity to either present satisfac-
13 tory documentary evidence or resolve
14 the inconsistency with the person
15 verifying the information under sub-
16 section (c) or (d) during the 90-day
17 period beginning the date on which
18 the notice required under subclause
19 (I) is sent to the applicant.

20 The Secretary may extend the 90-day pe-
21 riod under subclause (II) for enrollments
22 occurring during 2014.

23 (B) SPECIFIC ACTIONS NOT INVOLVING
24 CITIZENSHIP OR LAWFUL PRESENCE.—

1 (i) IN GENERAL.—Except as provided
2 in paragraph (3), the Exchange shall, dur-
3 ing any period before the close of the pe-
4 riod under subparagraph (A)(ii)(II), make
5 any determination under paragraphs (2),
6 (3), and (4) of subsection (a) on the basis
7 of the information contained on the appli-
8 cation.

9 (ii) ELIGIBILITY OR AMOUNT OF
10 CREDIT OR REDUCTION.—If an inconsis-
11 tency involving the eligibility for, or amount
12 of, any premium tax credit or cost-sharing
13 reduction is unresolved under this sub-
14 section as of the close of the period under
15 subparagraph (A)(ii)(II), the Exchange
16 shall notify the applicant of the amount (if
17 any) of the credit or reduction that is de-
18 termined on the basis of the records main-
19 tained by persons under subsection (c).

20 (iii) EMPLOYER AFFORDABILITY.—If
21 the Secretary notifies an Exchange that an
22 enrollee is eligible for a premium tax credit
23 under section 36B of such Code or cost-
24 sharing reduction under section 1402 be-
25 cause the enrollee's (or related individ-

1 ual's) employer does not provide minimum
2 essential coverage through an employer-
3 sponsored plan or that the employer does
4 provide that coverage but it is not afford-
5 able coverage, the Exchange shall notify
6 the employer of such fact and that the em-
7 ployer may be liable for the payment as-
8 sessed under section 4980H of such Code.

9 (iv) EXEMPTION.—In any case where
10 the inconsistency involving, or inability to
11 verify, information provided under sub-
12 section (b)(5) is not resolved as of the
13 close of the period under subparagraph
14 (A)(ii)(II), the Exchange shall notify an
15 applicant that no certification of exemption
16 from any requirement or payment under
17 section 5000A of such Code will be issued.

18 (C) APPEALS PROCESS.—The Exchange
19 shall also notify each person receiving notice
20 under this paragraph of the appeals processes
21 established under subsection (f).

22 (f) APPEALS AND REDETERMINATIONS.—

23 (1) IN GENERAL.—The Secretary, in consulta-
24 tion with the Secretary of the Treasury, the Sec-
25 retary of Homeland Security, and the Commissioner

1 of Social Security, shall establish procedures by
2 which the Secretary or one of such other Federal of-
3 ficers—

4 (A) hears and makes decisions with respect
5 to appeals of any determination under sub-
6 section (e); and

7 (B) redetermines eligibility on a periodic
8 basis in appropriate circumstances.

9 (2) EMPLOYER LIABILITY.—

10 (A) IN GENERAL.—The Secretary shall es-
11 tablish a separate appeals process for employers
12 who are notified under subsection (e)(4)(C) that
13 the employer may be liable for a tax imposed by
14 section 4980H of the Internal Revenue Code of
15 1986 with respect to an employee because of a
16 determination that the employer does not pro-
17 vide minimum essential coverage through an
18 employer-sponsored plan or that the employer
19 does provide that coverage but it is not afford-
20 able coverage with respect to an employee. Such
21 process shall provide an employer the oppor-
22 tunity to—

23 (i) present information to the Ex-
24 change for review of the determination ei-
25 ther by the Exchange or the person mak-

1 ing the determination, including evidence
2 of the employer-sponsored plan and em-
3 ployer contributions to the plan; and

4 (ii) have access to the data used to
5 make the determination to the extent al-
6 lowable by law.

7 Such process shall be in addition to any rights
8 of appeal the employer may have under subtitle
9 F of such Code.

10 (B) CONFIDENTIALITY.—Notwithstanding
11 any provision of this title (or the amendments
12 made by this title) or section 6103 of the Inter-
13 nal Revenue Code of 1986, an employer shall
14 not be entitled to any taxpayer return informa-
15 tion with respect to an employee for purposes of
16 determining whether the employer is subject to
17 the penalty under section 4980H of such Code
18 with respect to the employee, except that—

19 (i) the employer may be notified as to
20 the name of an employee and whether or
21 not the employee's income is above or
22 below the threshold by which the afford-
23 ability of an employer's health insurance
24 coverage is measured; and

1 (ii) this subparagraph shall not apply
2 to an employee who provides a waiver (at
3 such time and in such manner as the Sec-
4 retary may prescribe) authorizing an em-
5 ployer to have access to the employee's tax-
6 payer return information.

7 (g) CONFIDENTIALITY OF APPLICANT INFORMA-
8 TION.—

9 (1) IN GENERAL.—An applicant for insurance
10 coverage or for a premium tax credit or cost-sharing
11 reduction shall be required to provide only the infor-
12 mation strictly necessary to authenticate identity,
13 determine eligibility, and determine the amount of
14 the credit or reduction.

15 (2) RECEIPT OF INFORMATION.—Any person
16 who receives information provided by an applicant
17 under subsection (b) (whether directly or by another
18 person at the request of the applicant), or receives
19 information from a Federal agency under subsection
20 (c), (d), or (e), shall—

21 (A) use the information only for the pur-
22 poses of, and to the extent necessary in, ensur-
23 ing the efficient operation of the Exchange, in-
24 cluding verifying the eligibility of an individual
25 to enroll through an Exchange or to claim a

1 premium tax credit or cost-sharing reduction or
2 the amount of the credit or reduction; and

3 (B) not disclose the information to any
4 other person except as provided in this section.

5 (h) PENALTIES.—

6 (1) FALSE OR FRAUDULENT INFORMATION.—

7 (A) CIVIL PENALTY.—

8 (i) IN GENERAL.—If—

9 (I) any person fails to provides
10 correct information under subsection
11 (b); and

12 (II) such failure is attributable to
13 negligence or disregard of any rules or
14 regulations of the Secretary,

15 such person shall be subject, in addition to
16 any other penalties that may be prescribed
17 by law, to a civil penalty of not more than
18 \$25,000 with respect to any failures involv-
19 ing an application for a plan year. For
20 purposes of this subparagraph, the terms
21 “negligence” and “disregard” shall have
22 the same meanings as when used in section
23 6662 of the Internal Revenue Code of
24 1986.

1 (ii) REASONABLE CAUSE EXCEP-
2 TION.—No penalty shall be imposed under
3 clause (i) if the Secretary determines that
4 there was a reasonable cause for the fail-
5 ure and that the person acted in good
6 faith.

7 (B) KNOWING AND WILLFUL VIOLA-
8 TIONS.—Any person who knowingly and will-
9 fully provides false or fraudulent information
10 under subsection (b) shall be subject, in addi-
11 tion to any other penalties that may be pre-
12 scribed by law, to a civil penalty of not more
13 than \$250,000.

14 (2) IMPROPER USE OR DISCLOSURE OF INFOR-
15 MATION.—Any person who knowingly and willfully
16 uses or discloses information in violation of sub-
17 section (g) shall be subject, in addition to any other
18 penalties that may be prescribed by law, to a civil
19 penalty of not more than \$25,000.

20 (3) LIMITATIONS ON LIENS AND LEVIES.—The
21 Secretary (or, if applicable, the Attorney General of
22 the United States) shall not—

23 (A) file notice of lien with respect to any
24 property of a person by reason of any failure to
25 pay the penalty imposed by this subsection; or

1 (B) levy on any such property with respect
2 to such failure.

3 (i) STUDY OF ADMINISTRATION OF EMPLOYER RE-
4 SPONSIBILITY.—

5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services shall, in consultation with the Sec-
7 retary of the Treasury, conduct a study of the proce-
8 dures that are necessary to ensure that in the ad-
9 ministration of this title and section 4980H of the
10 Internal Revenue Code of 1986 (as added by section
11 1513) that the following rights are protected:

12 (A) The rights of employees to preserve
13 their right to confidentiality of their taxpayer
14 return information and their right to enroll in
15 a qualified health plan through an Exchange if
16 an employer does not provide affordable cov-
17 erage.

18 (B) The rights of employers to adequate
19 due process and access to information necessary
20 to accurately determine any payment assessed
21 on employers.

22 (2) REPORT.—Not later than January 1, 2013,
23 the Secretary of Health and Human Services shall
24 report the results of the study conducted under
25 paragraph (1), including any recommendations for

1 legislative changes, to the Committees on Finance
2 and Health, Education, Labor and Pensions of the
3 Senate and the Committees of Education and Labor
4 and Ways and Means of the House of Representa-
5 tives.

6 **SEC. 1412. ADVANCE DETERMINATION AND PAYMENT OF**
7 **PREMIUM TAX CREDITS AND COST-SHARING**
8 **REDUCTIONS.**

9 (a) IN GENERAL.—The Secretary, in consultation
10 with the Secretary of the Treasury, shall establish a pro-
11 gram under which—

12 (1) upon request of an Exchange, advance de-
13 terminations are made under section 1411 with re-
14 spect to the income eligibility of individuals enrolling
15 in a qualified health plan in the individual market
16 through the Exchange for the premium tax credit al-
17 lowable under section 36B of the Internal Revenue
18 Code of 1986 and the cost-sharing reductions under
19 section 1402;

20 (2) the Secretary notifies—

21 (A) the Exchange and the Secretary of the
22 Treasury of the advance determinations; and

23 (B) the Secretary of the Treasury of the
24 name and employer identification number of
25 each employer with respect to whom 1 or more

1 employee of the employer were determined to be
2 eligible for the premium tax credit under sec-
3 tion 36B of the Internal Revenue Code of 1986
4 and the cost-sharing reductions under section
5 1402 because—

6 (i) the employer did not provide min-
7 imum essential coverage; or

8 (ii) the employer provided such min-
9 imum essential coverage but it was deter-
10 mined under section 36B(c)(2)(C) of such
11 Code to either be unaffordable to the em-
12 ployee or not provide the required min-
13 imum actuarial value; and

14 (3) the Secretary of the Treasury makes ad-
15 vance payments of such credit or reductions to the
16 issuers of the qualified health plans in order to re-
17 duce the premiums payable by individuals eligible for
18 such credit.

19 (b) ADVANCE DETERMINATIONS.—

20 (1) IN GENERAL.—The Secretary shall provide
21 under the program established under subsection (a)
22 that advance determination of eligibility with respect
23 to any individual shall be made—

24 (A) during the annual open enrollment pe-
25 riod applicable to the individual (or such other

1 enrollment period as may be specified by the
2 Secretary); and

3 (B) on the basis of the individual's house-
4 hold income for the most recent taxable year for
5 which the Secretary, after consultation with the
6 Secretary of the Treasury, determines informa-
7 tion is available.

8 (2) CHANGES IN CIRCUMSTANCES.—The Sec-
9 retary shall provide procedures for making advance
10 determinations on the basis of information other
11 than that described in paragraph (1)(B) in cases
12 where information included with an application form
13 demonstrates substantial changes in income, changes
14 in family size or other household circumstances,
15 change in filing status, the filing of an application
16 for unemployment benefits, or other significant
17 changes affecting eligibility, including—

18 (A) allowing an individual claiming a de-
19 crease of 20 percent or more in income, or fil-
20 ing an application for unemployment benefits,
21 to have eligibility for the credit determined on
22 the basis of household income for a later period
23 or on the basis of the individual's estimate of
24 such income for the taxable year; and

1 (B) the determination of household income
2 in cases where the taxpayer was not required to
3 file a return of tax imposed by this chapter for
4 the second preceding taxable year.

5 (c) PAYMENT OF PREMIUM TAX CREDITS AND COST-
6 SHARING REDUCTIONS.—

7 (1) IN GENERAL.—The Secretary shall notify
8 the Secretary of the Treasury and the Exchange
9 through which the individual is enrolling of the ad-
10 vance determination under section 1411.

11 (2) PREMIUM TAX CREDIT.—

12 (A) IN GENERAL.—The Secretary of the
13 Treasury shall make the advance payment
14 under this section of any premium tax credit al-
15 lowed under section 36B of the Internal Rev-
16 enue Code of 1986 to the issuer of a qualified
17 health plan on a monthly basis (or such other
18 periodic basis as the Secretary may provide).

19 (B) ISSUER RESPONSIBILITIES.—An issuer
20 of a qualified health plan receiving an advance
21 payment with respect to an individual enrolled
22 in the plan shall—

23 (i) reduce the premium charged the
24 insured for any period by the amount of
25 the advance payment for the period;

1 (ii) notify the Exchange and the Sec-
2 retary of such reduction;

3 (iii) include with each billing state-
4 ment the amount by which the premium
5 for the plan has been reduced by reason of
6 the advance payment; and

7 (iv) in the case of any nonpayment of
8 premiums by the insured—

9 (I) notify the Secretary of such
10 nonpayment; and

11 (II) allow a 3-month grace period
12 for nonpayment of premiums before
13 discontinuing coverage.

14 (3) COST-SHARING REDUCTIONS.—The Sec-
15 retary shall also notify the Secretary of the Treasury
16 and the Exchange under paragraph (1) if an ad-
17 vance payment of the cost-sharing reductions under
18 section 1402 is to be made to the issuer of any
19 qualified health plan with respect to any individual
20 enrolled in the plan. The Secretary of the Treasury
21 shall make such advance payment at such time and
22 in such amount as the Secretary specifies in the no-
23 tice.

24 (d) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT
25 LAWFULLY PRESENT.—Nothing in this subtitle or the

1 amendments made by this subtitle allows Federal pay-
2 ments, credits, or cost-sharing reductions for individuals
3 who are not lawfully present in the United States.

4 (e) STATE FLEXIBILITY.—Nothing in this subtitle or
5 the amendments made by this subtitle shall be construed
6 to prohibit a State from making payments to or on behalf
7 of an individual for coverage under a qualified health plan
8 offered through an Exchange that are in addition to any
9 credits or cost-sharing reductions allowable to the indi-
10 vidual under this subtitle and such amendments.

11 **SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLL-**
12 **MENT THROUGH AN EXCHANGE AND STATE**
13 **MEDICAID, CHIP, AND HEALTH SUBSIDY PRO-**
14 **GRAMS.**

15 (a) IN GENERAL.—The Secretary shall establish a
16 system meeting the requirements of this section under
17 which residents of each State may apply for enrollment
18 in, receive a determination of eligibility for participation
19 in, and continue participation in, applicable State health
20 subsidy programs. Such system shall ensure that if an in-
21 dividual applying to an Exchange is found through screen-
22 ing to be eligible for medical assistance under the State
23 medicaid plan under title XIX, or eligible for enrollment
24 under a State children's health insurance program

1 (CHIP) under title XXI of such Act, the individual is en-
2 rolled for assistance under such plan or program.

3 (b) REQUIREMENTS RELATING TO FORMS AND NO-
4 TICE.—

5 (1) REQUIREMENTS RELATING TO FORMS.—

6 (A) IN GENERAL.—The Secretary shall de-
7 velop and provide to each State a single,
8 streamlined form that—

9 (i) may be used to apply for all appli-
10 cable State health subsidy programs within
11 the State;

12 (ii) may be filed online, in person, by
13 mail, or by telephone;

14 (iii) may be filed with an Exchange or
15 with State officials operating one of the
16 other applicable State health subsidy pro-
17 grams; and

18 (iv) is structured to maximize an ap-
19 plicant's ability to complete the form satis-
20 factorily, taking into account the charac-
21 teristics of individuals who qualify for ap-
22 plicable State health subsidy programs.

23 (B) STATE AUTHORITY TO ESTABLISH
24 FORM.—A State may develop and use its own
25 single, streamlined form as an alternative to the

1 form developed under subparagraph (A) if the
 2 alternative form is consistent with standards
 3 promulgated by the Secretary under this sec-
 4 tion.

5 (C) SUPPLEMENTAL ELIGIBILITY
 6 FORMS.—The Secretary may allow a State to
 7 use a supplemental or alternative form in the
 8 case of individuals who apply for eligibility that
 9 is not determined on the basis of the household
 10 income (as defined in section 36B of the Inter-
 11 nal Revenue Code of 1986).

12 (2) NOTICE.—The Secretary shall provide that
 13 an applicant filing a form under paragraph (1) shall
 14 receive notice of eligibility for an applicable State
 15 health subsidy program without any need to provide
 16 additional information or paperwork unless such in-
 17 formation or paperwork is specifically required by
 18 law when information provided on the form is incon-
 19 sistent with data used for the electronic verification
 20 under paragraph (3) or is otherwise insufficient to
 21 determine eligibility.

22 (c) REQUIREMENTS RELATING TO ELIGIBILITY
 23 BASED ON DATA EXCHANGES.—

24 (1) DEVELOPMENT OF SECURE INTERFACES.—
 25 Each State shall develop for all applicable State

1 health subsidy programs a secure, electronic inter-
2 face allowing an exchange of data (including infor-
3 mation contained in the application forms described
4 in subsection (b)) that allows a determination of eli-
5 gibility for all such programs based on a single ap-
6 plication. Such interface shall be compatible with the
7 method established for data verification under sec-
8 tion 1411(c)(4).

9 (2) DATA MATCHING PROGRAM.—Each applica-
10 ble State health subsidy program shall participate in
11 a data matching arrangement for determining eligi-
12 bility for participation in the program under para-
13 graph (3) that—

14 (A) provides access to data described in
15 paragraph (3);

16 (B) applies only to individuals who—

17 (i) receive assistance from an applica-
18 ble State health subsidy program; or

19 (ii) apply for such assistance—

20 (I) by filing a form described in
21 subsection (b); or

22 (II) by requesting a determina-
23 tion of eligibility and authorizing dis-
24 closure of the information described in
25 paragraph (3) to applicable State

1 health coverage subsidy programs for
2 purposes of determining and estab-
3 lishing eligibility; and

4 (C) consistent with standards promulgated
5 by the Secretary, including the privacy and data
6 security safeguards described in section 1942 of
7 the Social Security Act or that are otherwise
8 applicable to such programs.

9 (3) DETERMINATION OF ELIGIBILITY.—

10 (A) IN GENERAL.—Each applicable State
11 health subsidy program shall, to the maximum
12 extent practicable—

13 (i) establish, verify, and update eligi-
14 bility for participation in the program
15 using the data matching arrangement
16 under paragraph (2); and

17 (ii) determine such eligibility on the
18 basis of reliable, third party data, includ-
19 ing information described in sections 1137,
20 453(i), and 1942(a) of the Social Security
21 Act, obtained through such arrangement.

22 (B) EXCEPTION.—This paragraph shall
23 not apply in circumstances with respect to
24 which the Secretary determines that the admin-
25 istrative and other costs of use of the data

1 matching arrangement under paragraph (2)
2 outweigh its expected gains in accuracy, effi-
3 ciency, and program participation.

4 (4) SECRETARIAL STANDARDS.—The Secretary
5 shall, after consultation with persons in possession
6 of the data to be matched and representatives of ap-
7 plicable State health subsidy programs, promulgate
8 standards governing the timing, contents, and proce-
9 dures for data matching described in this subsection.
10 Such standards shall take into account administra-
11 tive and other costs and the value of data matching
12 to the establishment, verification, and updating of
13 eligibility for applicable State health subsidy pro-
14 grams.

15 (d) ADMINISTRATIVE AUTHORITY.—

16 (1) AGREEMENTS.—Subject to section 1411
17 and section 6103(l)(21) of the Internal Revenue
18 Code of 1986 and any other requirement providing
19 safeguards of privacy and data integrity, the Sec-
20 retary may establish model agreements, and enter
21 into agreements, for the sharing of data under this
22 section.

23 (2) AUTHORITY OF EXCHANGE TO CONTRACT
24 OUT.—Nothing in this section shall be construed
25 to—

1 (A) prohibit contractual arrangements
2 through which a State medicaid agency deter-
3 mines eligibility for all applicable State health
4 subsidy programs, but only if such agency com-
5 plies with the Secretary's requirements ensuring
6 reduced administrative costs, eligibility errors,
7 and disruptions in coverage; or

8 (B) change any requirement under title
9 XIX that eligibility for participation in a
10 State's medicaid program must be determined
11 by a public agency.

12 (e) APPLICABLE STATE HEALTH SUBSIDY PRO-
13 GRAM.—In this section, the term “applicable State health
14 subsidy program” means—

15 (1) the program under this title for the enroll-
16 ment in qualified health plans offered through an
17 Exchange, including the premium tax credits under
18 section 36B of the Internal Revenue Code of 1986
19 and cost-sharing reductions under section 1402;

20 (2) a State medicaid program under title XIX
21 of the Social Security Act;

22 (3) a State children's health insurance program
23 (CHIP) under title XXI of such Act; and

24 (4) a State program under section 1331 estab-
25 lishing qualified basic health plans.

1 **SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY RE-**
2 **QUIREMENTS FOR CERTAIN PROGRAMS.**

3 (a) DISCLOSURE OF TAXPAYER RETURN INFORMA-
4 TION AND SOCIAL SECURITY NUMBERS.—

5 (1) TAXPAYER RETURN INFORMATION.—Sub-
6 section (l) of section 6103 of the Internal Revenue
7 Code of 1986 is amended by adding at the end the
8 following new paragraph:

9 “(21) DISCLOSURE OF RETURN INFORMATION
10 TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR
11 CERTAIN PROGRAMS.—

12 “(A) IN GENERAL.—The Secretary, upon
13 written request from the Secretary of Health
14 and Human Services, shall disclose to officers,
15 employees, and contractors of the Department
16 of Health and Human Services return informa-
17 tion of any taxpayer whose income is relevant
18 in determining any premium tax credit under
19 section 36B or any cost-sharing reduction
20 under section 1402 of the Patient Protection
21 and Affordable Care Act or eligibility for par-
22 ticipation in a State medicaid program under
23 title XIX of the Social Security Act, a State’s
24 children’s health insurance program under title
25 XXI of the Social Security Act, or a basic
26 health program under section 1331 of Patient

1 Protection and Affordable Care Act. Such re-
2 turn information shall be limited to—

3 “(i) taxpayer identity information
4 with respect to such taxpayer,

5 “(ii) the filing status of such tax-
6 payer,

7 “(iii) the number of individuals for
8 whom a deduction is allowed under section
9 151 with respect to the taxpayer (including
10 the taxpayer and the taxpayer’s spouse),

11 “(iv) the modified gross income (as
12 defined in section 36B) of such taxpayer
13 and each of the other individuals included
14 under clause (iii) who are required to file
15 a return of tax imposed by chapter 1 for
16 the taxable year,

17 “(v) such other information as is pre-
18 scribed by the Secretary by regulation as
19 might indicate whether the taxpayer is eli-
20 gible for such credit or reduction (and the
21 amount thereof), and

22 “(vi) the taxable year with respect to
23 which the preceding information relates or,
24 if applicable, the fact that such informa-
25 tion is not available.

1 “(B) INFORMATION TO EXCHANGE AND
2 STATE AGENCIES.—The Secretary of Health
3 and Human Services may disclose to an Ex-
4 change established under the Patient Protection
5 and Affordable Care Act or its contractors, or
6 to a State agency administering a State pro-
7 gram described in subparagraph (A) or its con-
8 tractors, any inconsistency between the infor-
9 mation provided by the Exchange or State
10 agency to the Secretary and the information
11 provided to the Secretary under subparagraph
12 (A).

13 “(C) RESTRICTION ON USE OF DISCLOSED
14 INFORMATION.—Return information disclosed
15 under subparagraph (A) or (B) may be used by
16 officers, employees, and contractors of the De-
17 partment of Health and Human Services, an
18 Exchange, or a State agency only for the pur-
19 poses of, and to the extent necessary in—

20 “(i) establishing eligibility for partici-
21 pation in the Exchange, and verifying the
22 appropriate amount of, any credit or re-
23 duction described in subparagraph (A),

1 “(ii) determining eligibility for partici-
2 pation in the State programs described in
3 subparagraph (A).”.

4 (2) SOCIAL SECURITY NUMBERS.—Section
5 205(c)(2)(C) of the Social Security Act is amended
6 by adding at the end the following new clause:

7 “(x) The Secretary of Health and
8 Human Services, and the Exchanges estab-
9 lished under section 1311 of the Patient
10 Protection and Affordable Care Act, are
11 authorized to collect and use the names
12 and social security account numbers of in-
13 dividuals as required to administer the pro-
14 visions of, and the amendments made by,
15 the such Act.”.

16 (b) CONFIDENTIALITY AND DISCLOSURE.—Para-
17 graph (3) of section 6103(a) of such Code is amended by
18 striking “or (20)” and inserting “(20), or (21)”.

19 (c) PROCEDURES AND RECORDKEEPING RELATED
20 TO DISCLOSURES.—Paragraph (4) of section 6103(p) of
21 such Code is amended—

22 (1) by inserting “, or any entity described in
23 subsection (l)(21),” after “or (20)” in the matter
24 preceding subparagraph (A),

1 (2) by inserting “or any entity described in sub-
2 section (l)(21),” after “or (o)(1)(A)” in subpara-
3 graph (F)(ii), and

4 (3) by inserting “or any entity described in sub-
5 section (l)(21),” after “or (20)” both places it ap-
6 pears in the matter after subparagraph (F).

7 (d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—
8 Paragraph (2) of section 7213(a) of such Code is amended
9 by striking “or (20)” and inserting “(20), or (21)”.

10 **SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING RE-**
11 **DUCTION PAYMENTS DISREGARDED FOR**
12 **FEDERAL AND FEDERALLY-ASSISTED PRO-**
13 **GRAMS.**

14 For purposes of determining the eligibility of any in-
15 dividual for benefits or assistance, or the amount or extent
16 of benefits or assistance, under any Federal program or
17 under any State or local program financed in whole or in
18 part with Federal funds—

19 (1) any credit or refund allowed or made to any
20 individual by reason of section 36B of the Internal
21 Revenue Code of 1986 (as added by section 1401)
22 shall not be taken into account as income and shall
23 not be taken into account as resources for the month
24 of receipt and the following 2 months; and

1 (2) any cost-sharing reduction payment or ad-
2 vance payment of the credit allowed under such sec-
3 tion 36B that is made under section 1402 or 1412
4 shall be treated as made to the qualified health plan
5 in which an individual is enrolled and not to that in-
6 dividual.

7 **PART II—SMALL BUSINESS TAX CREDIT**

8 **SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE**
9 **EXPENSES OF SMALL BUSINESSES.**

10 (a) IN GENERAL.—Subpart D of part IV of sub-
11 chapter A of chapter 1 of the Internal Revenue Code of
12 1986 (relating to business-related credits) is amended by
13 inserting after section 45Q the following:

14 **“SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF**
15 **SMALL EMPLOYERS.**

16 “(a) GENERAL RULE.—For purposes of section 38,
17 in the case of an eligible small employer, the small em-
18 ployer health insurance credit determined under this sec-
19 tion for any taxable year in the credit period is the amount
20 determined under subsection (b).

21 “(b) HEALTH INSURANCE CREDIT AMOUNT.—Sub-
22 ject to subsection (c), the amount determined under this
23 subsection with respect to any eligible small employer is
24 equal to 50 percent (35 percent in the case of a tax-exempt
25 eligible small employer) of the lesser of—

1 “(1) the aggregate amount of nonelective con-
2 tributions the employer made on behalf of its em-
3 ployees during the taxable year under the arrange-
4 ment described in subsection (d)(4) for premiums
5 for qualified health plans offered by the employer to
6 its employees through an Exchange, or

7 “(2) the aggregate amount of nonelective con-
8 tributions which the employer would have made dur-
9 ing the taxable year under the arrangement if each
10 employee taken into account under paragraph (1)
11 had enrolled in a qualified health plan which had a
12 premium equal to the average premium (as deter-
13 mined by the Secretary of Health and Human Serv-
14 ices) for the small group market in the rating area
15 in which the employee enrolls for coverage.

16 “(c) PHASEOUT OF CREDIT AMOUNT BASED ON
17 NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The
18 amount of the credit determined under subsection (b)
19 without regard to this subsection shall be reduced (but not
20 below zero) by the sum of the following amounts:

21 “(1) Such amount multiplied by a fraction the
22 numerator of which is the total number of full-time
23 equivalent employees of the employer in excess of 10
24 and the denominator of which is 15.

1 “(2) Such amount multiplied by a fraction the
2 numerator of which is the average annual wages of
3 the employer in excess of the dollar amount in effect
4 under subsection (d)(3)(B) and the denominator of
5 which is such dollar amount.

6 “(d) ELIGIBLE SMALL EMPLOYER.—For purposes of
7 this section—

8 “(1) IN GENERAL.—The term ‘eligible small
9 employer’ means, with respect to any taxable year,
10 an employer—

11 “(A) which has no more than 25 full-time
12 equivalent employees for the taxable year,

13 “(B) the average annual wages of which do
14 not exceed an amount equal to twice the dollar
15 amount in effect under paragraph (3)(B) for
16 the taxable year, and

17 “(C) which has in effect an arrangement
18 described in paragraph (4).

19 “(2) FULL-TIME EQUIVALENT EMPLOYEES.—

20 “(A) IN GENERAL.—The term ‘full-time
21 equivalent employees’ means a number of em-
22 ployees equal to the number determined by di-
23 viding—

24 “(i) the total number of hours of serv-
25 ice for which wages were paid by the em-

1 ployer to employees during the taxable
2 year, by

3 “(ii) 2,080.

4 Such number shall be rounded to the next low-
5 est whole number if not otherwise a whole num-
6 ber.

7 “(B) EXCESS HOURS NOT COUNTED.—If
8 an employee works in excess of 2,080 hours of
9 service during any taxable year, such excess
10 shall not be taken into account under subpara-
11 graph (A).

12 “(C) HOURS OF SERVICE.—The Secretary,
13 in consultation with the Secretary of Labor,
14 shall prescribe such regulations, rules, and
15 guidance as may be necessary to determine the
16 hours of service of an employee, including rules
17 for the application of this paragraph to employ-
18 ees who are not compensated on an hourly
19 basis.

20 “(3) AVERAGE ANNUAL WAGES.—

21 “(A) IN GENERAL.—The average annual
22 wages of an eligible small employer for any tax-
23 able year is the amount determined by divid-
24 ing—

1 “(i) the aggregate amount of wages
2 which were paid by the employer to em-
3 ployees during the taxable year, by

4 “(ii) the number of full-time equiva-
5 lent employees of the employee determined
6 under paragraph (2) for the taxable year.

7 Such amount shall be rounded to the next low-
8 est multiple of \$1,000 if not otherwise such a
9 multiple.

10 “(B) DOLLAR AMOUNT.—For purposes of
11 paragraph (1)(B)—

12 “(i) 2011, 2012, AND 2013.—The dollar
13 amount in effect under this paragraph for
14 taxable years beginning in 2011, 2012, or
15 2013 is \$20,000.

16 “(ii) SUBSEQUENT YEARS.—In the
17 case of a taxable year beginning in a cal-
18 endar year after 2013, the dollar amount
19 in effect under this paragraph shall be
20 equal to \$20,000, multiplied by the cost-of-
21 living adjustment determined under section
22 1(f)(3) for the calendar year, determined
23 by substituting ‘calendar year 2012’ for
24 ‘calendar year 1992’ in subparagraph (B)
25 thereof.

1 “(4) CONTRIBUTION ARRANGEMENT.—An ar-
2 rangement is described in this paragraph if it re-
3 quires an eligible small employer to make a nonelec-
4 tive contribution on behalf of each employee who en-
5 rolls in a qualified health plan offered to employees
6 by the employer through an exchange in an amount
7 equal to a uniform percentage (not less than 50 per-
8 cent) of the premium cost of the qualified health
9 plan.

10 “(5) SEASONAL WORKER HOURS AND WAGES
11 NOT COUNTED.—For purposes of this subsection—

12 “(A) IN GENERAL.—The number of hours
13 of service worked by, and wages paid to, a sea-
14 sonal worker of an employer shall not be taken
15 into account in determining the full-time equiv-
16 alent employees and average annual wages of
17 the employer unless the worker works for the
18 employer on more than 120 days during the
19 taxable year.

20 “(B) DEFINITION OF SEASONAL WORK-
21 ER.—The term ‘seasonal worker’ means a work-
22 er who performs labor or services on a seasonal
23 basis as defined by the Secretary of Labor, in-
24 cluding workers covered by section 500.20(s)(1)
25 of title 29, Code of Federal Regulations and re-

1 tail workers employed exclusively during holiday
2 seasons.

3 “(e) OTHER RULES AND DEFINITIONS.—For pur-
4 poses of this section—

5 “(1) EMPLOYEE.—

6 “(A) CERTAIN EMPLOYEES EXCLUDED.—

7 The term ‘employee’ shall not include—

8 “(i) an employee within the meaning
9 of section 401(c)(1),

10 “(ii) any 2-percent shareholder (as de-
11 fined in section 1372(b)) of an eligible
12 small business which is an S corporation,

13 “(iii) any 5-percent owner (as defined
14 in section 416(i)(1)(B)(i)) of an eligible
15 small business, or

16 “(iv) any individual who bears any of
17 the relationships described in subpara-
18 graphs (A) through (G) of section
19 152(d)(2) to, or is a dependent described
20 in section 152(d)(2)(H) of, an individual
21 described in clause (i), (ii), or (iii).

22 “(B) LEASED EMPLOYEES.—The term
23 ‘employee’ shall include a leased employee with-
24 in the meaning of section 414(n).

1 “(2) CREDIT PERIOD.—The term ‘credit period’
2 means, with respect to any eligible small employer,
3 the 2-consecutive-taxable year period beginning with
4 the 1st taxable year in which the employer (or any
5 predecessor) offers 1 or more qualified health plans
6 to its employees through an Exchange.

7 “(3) NONELECTIVE CONTRIBUTION.—The term
8 ‘nonelective contribution’ means an employer con-
9 tribution other than an employer contribution pursu-
10 ant to a salary reduction arrangement.

11 “(4) WAGES.—The term ‘wages’ has the mean-
12 ing given such term by section 3121(a) (determined
13 without regard to any dollar limitation contained in
14 such section).

15 “(5) AGGREGATION AND OTHER RULES MADE
16 APPLICABLE.—

17 “(A) AGGREGATION RULES.—All employ-
18 ers treated as a single employer under sub-
19 section (b), (c), (m), or (o) of section 414 shall
20 be treated as a single employer for purposes of
21 this section.

22 “(B) OTHER RULES.—Rules similar to the
23 rules of subsections (c), (d), and (e) of section
24 52 shall apply.

1 “(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELI-
2 GIBLE SMALL EMPLOYERS.—

3 “(1) IN GENERAL.—In the case of a tax-exempt
4 eligible small employer, there shall be treated as a
5 credit allowable under subpart C (and not allowable
6 under this subpart) the lesser of—

7 “(A) the amount of the credit determined
8 under this section with respect to such em-
9 ployer, or

10 “(B) the amount of the payroll taxes of the
11 employer during the calendar year in which the
12 taxable year begins.

13 “(2) TAX-EXEMPT ELIGIBLE SMALL EM-
14 PLOYER.—For purposes of this section, the term
15 ‘tax-exempt eligible small employer’ means an eligi-
16 ble small employer which is any organization de-
17 scribed in section 501(c) which is exempt from tax-
18 ation under section 501(a).

19 “(3) PAYROLL TAXES.—For purposes of this
20 subsection—

21 “(A) IN GENERAL.—The term ‘payroll
22 taxes’ means—

23 “(i) amounts required to be withheld
24 from the employees of the tax-exempt eligi-
25 ble small employer under section 3401(a),

1 “(ii) amounts required to be withheld
2 from such employees under section
3 3101(b), and

4 “(iii) amounts of the taxes imposed on
5 the tax-exempt eligible small employer
6 under section 3111(b).

7 “(B) SPECIAL RULE.—A rule similar to
8 the rule of section 24(d)(2)(C) shall apply for
9 purposes of subparagraph (A).

10 “(g) APPLICATION OF SECTION FOR CALENDAR
11 YEARS 2011, 2012, AND 2013.—In the case of any tax-
12 able year beginning in 2011, 2012, or 2013, the following
13 modifications to this section shall apply in determining the
14 amount of the credit under subsection (a):

15 “(1) NO CREDIT PERIOD REQUIRED.—The
16 credit shall be determined without regard to whether
17 the taxable year is in a credit period and for pur-
18 poses of applying this section to taxable years begin-
19 ning after 2013, no credit period shall be treated as
20 beginning with a taxable year beginning before
21 2014.

22 “(2) AMOUNT OF CREDIT.—The amount of the
23 credit determined under subsection (b) shall be de-
24 termined—

1 “(A) by substituting ‘35 percent (25 per-
2 cent in the case of a tax-exempt eligible small
3 employer)’ for ‘50 percent (35 percent in the
4 case of a tax-exempt eligible small employer)’,

5 “(B) by reference to an eligible small em-
6 ployer’s nonelective contributions for premiums
7 paid for health insurance coverage (within the
8 meaning of section 9832(b)(1)) of an employee,
9 and

10 “(C) by substituting for the average pre-
11 mium determined under subsection (b)(2) the
12 amount the Secretary of Health and Human
13 Services determines is the average premium for
14 the small group market in the State in which
15 the employer is offering health insurance cov-
16 erage (or for such area within the State as is
17 specified by the Secretary).

18 “(3) CONTRIBUTION ARRANGEMENT.—An ar-
19 rangement shall not fail to meet the requirements of
20 subsection (d)(4) solely because it provides for the
21 offering of insurance outside of an Exchange.

22 “(h) INSURANCE DEFINITIONS.—Any term used in
23 this section which is also used in the Public Health Service
24 Act or subtitle A of title I of the Patient Protection and

1 Affordable Care Act shall have the meaning given such
2 term by such Act or subtitle.

3 “(i) REGULATIONS.—The Secretary shall prescribe
4 such regulations as may be necessary to carry out the pro-
5 visions of this section, including regulations to prevent the
6 avoidance of the 2-year limit on the credit period through
7 the use of successor entities and the avoidance of the limi-
8 tations under subsection (c) through the use of multiple
9 entities.”.

10 (b) CREDIT TO BE PART OF GENERAL BUSINESS
11 CREDIT.—Section 38(b) of the Internal Revenue Code of
12 1986 (relating to current year business credit) is amended
13 by striking “plus” at the end of paragraph (34), by strik-
14 ing the period at the end of paragraph (35) and inserting
15 “, plus”, and by inserting after paragraph (35) the fol-
16 lowing:

17 “(36) the small employer health insurance cred-
18 it determined under section 45R.”.

19 (c) CREDIT ALLOWED AGAINST ALTERNATIVE MIN-
20 IMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue
21 Code of 1986 (defining specified credits) is amended by
22 redesignating clauses (vi), (vii), and (viii) as clauses (vii),
23 (viii), and (ix), respectively, and by inserting after clause
24 (v) the following new clause:

1 “(vi) the credit determined under sec-
2 tion 45R.”.

3 (d) DISALLOWANCE OF DEDUCTION FOR CERTAIN
4 EXPENSES FOR WHICH CREDIT ALLOWED.—

5 (1) IN GENERAL.—Section 280C of the Internal
6 Revenue Code of 1986 (relating to disallowance of
7 deduction for certain expenses for which credit al-
8 lowed), as amended by section 1401(b), is amended
9 by adding at the end the following new subsection:

10 “(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE
11 EXPENSES OF SMALL EMPLOYERS.—No deduction shall
12 be allowed for that portion of the premiums for qualified
13 health plans (as defined in section 1301(a) of the Patient
14 Protection and Affordable Care Act), or for health insur-
15 ance coverage in the case of taxable years beginning in
16 2011, 2012, or 2013, paid by an employer which is equal
17 to the amount of the credit determined under section
18 45R(a) with respect to the premiums.”.

19 (2) DEDUCTION FOR EXPIRING CREDITS.—Sec-
20 tion 196(c) of such Code is amended by striking
21 “and” at the end of paragraph (12), by striking the
22 period at the end of paragraph (13) and inserting “,
23 and”, and by adding at the end the following new
24 paragraph:

1 “(14) the small employer health insurance cred-
2 it determined under section 45R(a).”.

3 (e) CLERICAL AMENDMENT.—The table of sections
4 for subpart D of part IV of subchapter A of chapter 1
5 of the Internal Revenue Code of 1986 is amended by add-
6 ing at the end the following:

“Sec. 45R. Employee health insurance expenses of small employers.”.

7 (f) EFFECTIVE DATES.—

8 (1) IN GENERAL.—The amendments made by
9 this section shall apply to amounts paid or incurred
10 in taxable years beginning after December 31, 2010.

11 (2) MINIMUM TAX.—The amendments made by
12 subsection (c) shall apply to credits determined
13 under section 45R of the Internal Revenue Code of
14 1986 in taxable years beginning after December 31,
15 2010, and to carrybacks of such credits.

16 **Subtitle F—Shared Responsibility**
17 **for Health Care**

18 **PART I—INDIVIDUAL RESPONSIBILITY**

19 **SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSEN-**
20 **TIAL COVERAGE.**

21 (a) FINDINGS.—Congress makes the following find-
22 ings:

23 (1) IN GENERAL.—The individual responsibility
24 requirement provided for in this section (in this sub-
25 section referred to as the “requirement”) is commer-

1 cial and economic in nature, and substantially af-
2 fects interstate commerce, as a result of the effects
3 described in paragraph (2).

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

7 (A) The requirement regulates activity that
8 is commercial and economic in nature: economic
9 and financial decisions about how and when
10 health care is paid for, and when health insur-
11 ance is purchased.

12 (B) Health insurance and health care serv-
13 ices are a significant part of the national econ-
14 omy. National health spending is projected to
15 increase from \$2,500,000,000,000, or 17.6 per-
16 cent of the economy, in 2009 to
17 \$4,700,000,000,000 in 2019. Private health in-
18 surance spending is projected to be
19 \$854,000,000,000 in 2009, and pays for med-
20 ical supplies, drugs, and equipment that are
21 shipped in interstate commerce. Since most
22 health insurance is sold by national or regional
23 health insurance companies, health insurance is
24 sold in interstate commerce and claims pay-
25 ments flow through interstate commerce.

1 (C) The requirement, together with the
2 other provisions of this Act, will add millions of
3 new consumers to the health insurance market,
4 increasing the supply of, and demand for,
5 health care services. According to the Congres-
6 sional Budget Office, the requirement will in-
7 crease the number and share of Americans who
8 are insured.

9 (D) The requirement achieves near-uni-
10 versal coverage by building upon and strength-
11 ening the private employer-based health insur-
12 ance system, which covers 176,000,000 Ameri-
13 cans nationwide. In Massachusetts, a similar re-
14 quirement has strengthened private employ-
15 er-based coverage: despite the economic downturn,
16 the number of workers offered employer-based
17 coverage has actually increased.

18 (E) Half of all personal bankruptcies are
19 caused in part by medical expenses. By signifi-
20 cantly increasing health insurance coverage, the
21 requirement, together with the other provisions
22 of this Act, will improve financial security for
23 families.

24 (F) Under the Employee Retirement In-
25 come Security Act of 1974 (29 U.S.C. 1001 et

1 seq.), the Public Health Service Act (42 U.S.C.
2 201 et seq.), and this Act, the Federal Govern-
3 ment has a significant role in regulating health
4 insurance which is in interstate commerce.

5 (G) Under sections 2704 and 2705 of the
6 Public Health Service Act (as added by section
7 1201 of this Act), if there were no requirement,
8 many individuals would wait to purchase health
9 insurance until they needed care. By signifi-
10 cantly increasing health insurance coverage, the
11 requirement, together with the other provisions
12 of this Act, will minimize this adverse selection
13 and broaden the health insurance risk pool to
14 include healthy individuals, which will lower
15 health insurance premiums. The requirement is
16 essential to creating effective health insurance
17 markets in which improved health insurance
18 products that are guaranteed issue and do not
19 exclude coverage of pre-existing conditions can
20 be sold.

21 (H) Administrative costs for private health
22 insurance, which were \$90,000,000,000 in
23 2006, are 26 to 30 percent of premiums in the
24 current individual and small group markets. By
25 significantly increasing health insurance cov-

1 erage and the size of purchasing pools, which
 2 will increase economies of scale, the require-
 3 ment, together with the other provisions of this
 4 Act, will significantly reduce administrative
 5 costs and lower health insurance premiums.
 6 The requirement is essential to creating effec-
 7 tive health insurance markets that do not re-
 8 quire underwriting and eliminate its associated
 9 administrative costs.

10 (3) SUPREME COURT RULING.—In United
 11 States v. South-Eastern Underwriters Association
 12 (322 U.S. 533 (1944)), the Supreme Court of the
 13 United States ruled that insurance is interstate com-
 14 merce subject to Federal regulation.

15 (b) IN GENERAL.—Subtitle D of the Internal Rev-
 16 enue Code of 1986 is amended by adding at the end the
 17 following new chapter:

18 **“CHAPTER 48—MAINTENANCE OF**
 19 **MINIMUM ESSENTIAL COVERAGE**

 “Sec. 5000A. Requirement to maintain minimum essential coverage.

20 **“SEC. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ES-**
 21 **SENTIAL COVERAGE.**

22 “(a) REQUIREMENT TO MAINTAIN MINIMUM ESSEN-
 23 TIAL COVERAGE.—An applicable individual shall for each
 24 month beginning after 2013 ensure that the individual,

1 and any dependent of the individual who is an applicable
2 individual, is covered under minimum essential coverage
3 for such month.

4 “(b) SHARED RESPONSIBILITY PAYMENT.—

5 “(1) IN GENERAL.—If an applicable individual
6 fails to meet the requirement of subsection (a) for
7 1 or more months during any calendar year begin-
8 ning after 2013, then, except as provided in sub-
9 section (d), there is hereby imposed a penalty with
10 respect to the individual in the amount determined
11 under subsection (c).

12 “(2) INCLUSION WITH RETURN.—Any penalty
13 imposed by this section with respect to any month
14 shall be included with a taxpayer’s return under
15 chapter 1 for the taxable year which includes such
16 month.

17 “(3) PAYMENT OF PENALTY.—If an individual
18 with respect to whom a penalty is imposed by this
19 section for any month—

20 “(A) is a dependent (as defined in section
21 152) of another taxpayer for the other tax-
22 payer’s taxable year including such month, such
23 other taxpayer shall be liable for such penalty,
24 or

1 “(B) files a joint return for the taxable
2 year including such month, such individual and
3 the spouse of such individual shall be jointly lia-
4 ble for such penalty.

5 “(c) AMOUNT OF PENALTY.—

6 “(1) IN GENERAL.—The penalty determined
7 under this subsection for any month with respect to
8 any individual is an amount equal to $\frac{1}{12}$ of the ap-
9 plicable dollar amount for the calendar year.

10 “(2) DOLLAR LIMITATION.—The amount of the
11 penalty imposed by this section on any taxpayer for
12 any taxable year with respect to all individuals for
13 whom the taxpayer is liable under subsection (b)(3)
14 shall not exceed an amount equal to 300 percent the
15 applicable dollar amount (determined without regard
16 to paragraph (3)(C)) for the calendar year with or
17 within which the taxable year ends.

18 “(3) APPLICABLE DOLLAR AMOUNT.—For pur-
19 poses of paragraph (1)—

20 “(A) IN GENERAL.—Except as provided in
21 subparagraphs (B) and (C), the applicable dol-
22 lar amount is \$750.

23 “(B) PHASE IN.—The applicable dollar
24 amount is \$95 for 2014 and \$350 for 2015.

1 “(C) SPECIAL RULE FOR INDIVIDUALS
2 UNDER AGE 18.—If an applicable individual has
3 not attained the age of 18 as of the beginning
4 of a month, the applicable dollar amount with
5 respect to such individual for the month shall
6 be equal to one-half of the applicable dollar
7 amount for the calendar year in which the
8 month occurs.

9 “(D) INDEXING OF AMOUNT.—In the case
10 of any calendar year beginning after 2016, the
11 applicable dollar amount shall be equal to \$750,
12 increased by an amount equal to—

13 “(i) \$750, multiplied by

14 “(ii) the cost-of-living adjustment de-
15 termined under section 1(f)(3) for the cal-
16 endar year, determined by substituting
17 ‘calendar year 2015’ for ‘calendar year
18 1992’ in subparagraph (B) thereof.

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

22 “(4) TERMS RELATING TO INCOME AND FAMI-
23 LIES.—For purposes of this section—

24 “(A) FAMILY SIZE.—The family size in-
25 volved with respect to any taxpayer shall be

1 equal to the number of individuals for whom
2 the taxpayer is allowed a deduction under sec-
3 tion 151 (relating to allowance of deduction for
4 personal exemptions) for the taxable year.

5 “(B) HOUSEHOLD INCOME.—The term
6 ‘household income’ means, with respect to any
7 taxpayer for any taxable year, an amount equal
8 to the sum of—

9 “(i) the modified gross income of the
10 taxpayer, plus

11 “(ii) the aggregate modified gross in-
12 comes of all other individuals who—

13 “(I) were taken into account in
14 determining the taxpayer’s family size
15 under paragraph (1), and

16 “(II) were required to file a re-
17 turn of tax imposed by section 1 for
18 the taxable year.

19 “(C) MODIFIED GROSS INCOME.—The
20 term ‘modified gross income’ means gross in-
21 come—

22 “(i) decreased by the amount of any
23 deduction allowable under paragraph (1),
24 (3), (4), or (10) of section 62(a),

1 “(ii) increased by the amount of inter-
2 est received or accrued during the taxable
3 year which is exempt from tax imposed by
4 this chapter, and

5 “(iii) determined without regard to
6 sections 911, 931, and 933.

7 “(D) POVERTY LINE.—

8 “(i) IN GENERAL.—The term ‘poverty
9 line’ has the meaning given that term in
10 section 2110(c)(5) of the Social Security
11 Act (42 U.S.C. 1397jj(c)(5)).

12 “(ii) POVERTY LINE USED.—In the
13 case of any taxable year ending with or
14 within a calendar year, the poverty line
15 used shall be the most recently published
16 poverty line as of the 1st day of such cal-
17 endar year.

18 “(d) APPLICABLE INDIVIDUAL.—For purposes of this
19 section—

20 “(1) IN GENERAL.—The term ‘applicable indi-
21 vidual’ means, with respect to any month, an indi-
22 vidual other than an individual described in para-
23 graph (2), (3), or (4).

24 “(2) RELIGIOUS EXEMPTIONS.—

1 “(A) RELIGIOUS CONSCIENCE EXEMP-
2 TION.—Such term shall not include any indi-
3 vidual for any month if such individual has in
4 effect an exemption under section
5 1311(d)(4)(H) of the Patient Protection and
6 Affordable Care Act which certifies that such
7 individual is a member of a recognized religious
8 sect or division thereof described in section
9 1402(g)(1) and an adherent of established te-
10 nets or teachings of such sect or division as de-
11 scribed in such section.

12 “(B) HEALTH CARE SHARING MINISTRY.—

13 “(i) IN GENERAL.—Such term shall
14 not include any individual for any month if
15 such individual is a member of a health
16 care sharing ministry for the month.

17 “(ii) HEALTH CARE SHARING MIN-
18 ISTRY.—The term ‘health care sharing
19 ministry’ means an organization—

20 “(I) which is described in section
21 501(c)(3) and is exempt from taxation
22 under section 501(a),

23 “(II) members of which share a
24 common set of ethical or religious be-
25 liefs and share medical expenses

1 among members in accordance with
2 those beliefs and without regard to
3 the State in which a member resides
4 or is employed,

5 “(III) members of which retain
6 membership even after they develop a
7 medical condition,

8 “(IV) which (or a predecessor of
9 which) has been in existence at all
10 times since December 31, 1999, and
11 medical expenses of its members have
12 been shared continuously and without
13 interruption since at least December
14 31, 1999, and

15 “(V) which conducts an annual
16 audit which is performed by an inde-
17 pendent certified public accounting
18 firm in accordance with generally ac-
19 cepted accounting principles and
20 which is made available to the public
21 upon request.

22 “(3) INDIVIDUALS NOT LAWFULLY PRESENT.—

23 Such term shall not include an individual for any
24 month if for the month the individual is not a citizen

1 or national of the United States or an alien lawfully
2 present in the United States.

3 “(4) INCARCERATED INDIVIDUALS.—Such term
4 shall not include an individual for any month if for
5 the month the individual is incarcerated, other than
6 incarceration pending the disposition of charges.

7 “(e) EXEMPTIONS.—No penalty shall be imposed
8 under subsection (a) with respect to—

9 “(1) INDIVIDUALS WHO CANNOT AFFORD COV-
10 ERAGE.—

11 “(A) IN GENERAL.—Any applicable indi-
12 vidual for any month if the applicable individ-
13 ual’s required contribution (determined on an
14 annual basis) for coverage for the month ex-
15 ceeds 8 percent of such individual’s household
16 income for the taxable year described in section
17 1412(b)(1)(B) of the Patient Protection and
18 Affordable Care Act. For purposes of applying
19 this subparagraph, the taxpayer’s household in-
20 come shall be increased by any exclusion from
21 gross income for any portion of the required
22 contribution made through a salary reduction
23 arrangement.

1 “(B) REQUIRED CONTRIBUTION.—For
2 purposes of this paragraph, the term ‘required
3 contribution’ means—

4 “(i) in the case of an individual eligi-
5 ble to purchase minimum essential cov-
6 erage consisting of coverage through an el-
7 igible-employer-sponsored plan, the portion
8 of the annual premium which would be
9 paid by the individual (without regard to
10 whether paid through salary reduction or
11 otherwise) for self-only coverage, or

12 “(ii) in the case of an individual eligi-
13 ble only to purchase minimum essential
14 coverage described in subsection (f)(1)(C),
15 the annual premium for the lowest cost
16 bronze plan available in the individual
17 market through the Exchange in the State
18 in the rating area in which the individual
19 resides (without regard to whether the in-
20 dividual purchased a qualified health plan
21 through the Exchange), reduced by the
22 amount of the credit allowable under sec-
23 tion 36B for the taxable year (determined
24 as if the individual was covered by a quali-

1 fied health plan offered through the Ex-
2 change for the entire taxable year).

3 “(C) SPECIAL RULES FOR INDIVIDUALS
4 RELATED TO EMPLOYEES.—For purposes of
5 subparagraph (B)(i), if an applicable individual
6 is eligible for minimum essential coverage
7 through an employer by reason of a relationship
8 to an employee, the determination shall be
9 made by reference to the affordability of the
10 coverage to the employee.

11 “(D) INDEXING.—In the case of plan years
12 beginning in any calendar year after 2014, sub-
13 paragraph (A) shall be applied by substituting
14 for ‘8 percent’ the percentage the Secretary of
15 Health and Human Services determines reflects
16 the excess of the rate of premium growth be-
17 tween the preceding calendar year and 2013
18 over the rate of income growth for such period.

19 “(2) TAXPAYERS WITH INCOME UNDER 100
20 PERCENT OF POVERTY LINE.—Any applicable indi-
21 vidual for any month during a calendar year if the
22 individual’s household income for the taxable year
23 described in section 1412(b)(1)(B) of the Patient
24 Protection and Affordable Care Act is less than 100
25 percent of the poverty line for the size of the family

1 involved (determined in the same manner as under
2 subsection (b)(4)).

3 “(3) MEMBERS OF INDIAN TRIBES.—Any appli-
4 cable individual for any month during which the in-
5 dividual is a member of an Indian tribe (as defined
6 in section 45A(c)(6)).

7 “(4) MONTHS DURING SHORT COVERAGE
8 GAPS.—

9 “(A) IN GENERAL.—Any month the last
10 day of which occurred during a period in which
11 the applicable individual was not covered by
12 minimum essential coverage for a continuous
13 period of less than 3 months.

14 “(B) SPECIAL RULES.—For purposes of
15 applying this paragraph—

16 “(i) the length of a continuous period
17 shall be determined without regard to the
18 calendar years in which months in such pe-
19 riod occur,

20 “(ii) if a continuous period is greater
21 than the period allowed under subpara-
22 graph (A), no exception shall be provided
23 under this paragraph for any month in the
24 period, and

1 “(iii) if there is more than 1 contin-
 2 uous period described in subparagraph (A)
 3 covering months in a calendar year, the ex-
 4 ception provided by this paragraph shall
 5 only apply to months in the first of such
 6 periods.

7 The Secretary shall prescribe rules for the col-
 8 lection of the penalty imposed by this section in
 9 cases where continuous periods include months
 10 in more than 1 taxable year.

11 “(5) HARDSHIPS.—Any applicable individual
 12 who for any month is determined by the Secretary
 13 of Health and Human Services under section
 14 1311(d)(4)(H) to have suffered a hardship with re-
 15 spect to the capability to obtain coverage under a
 16 qualified health plan.

17 “(f) MINIMUM ESSENTIAL COVERAGE.—For pur-
 18 poses of this section—

19 “(1) IN GENERAL.—The term ‘minimum essen-
 20 tial coverage’ means any of the following:

21 “(A) GOVERNMENT SPONSORED PRO-
 22 GRAMS.—Coverage under—

23 “(i) the Medicare program under part
 24 A of title XVIII of the Social Security Act,

1 “(ii) the Medicaid program under title
2 XIX of the Social Security Act,

3 “(iii) the CHIP program under title
4 XXI of the Social Security Act,

5 “(iv) the TRICARE for Life program,

6 “(v) the veteran’s health care program
7 under chapter 17 of title 38, United States
8 Code, or

9 “(vi) a health plan under section
10 2504(e) of title 22, United States Code
11 (relating to Peace Corps volunteers).

12 “(B) EMPLOYER-SPONSORED PLAN.—Cov-
13 erage under an eligible employer-sponsored
14 plan.

15 “(C) PLANS IN THE INDIVIDUAL MAR-
16 KET.—Coverage under a health plan offered in
17 the individual market within a State.

18 “(D) GRANDFATHERED HEALTH PLAN.—
19 Coverage under a grandfathered health plan.

20 “(E) OTHER COVERAGE.—Such other
21 health benefits coverage, such as a State health
22 benefits risk pool, as the Secretary of Health
23 and Human Services, in coordination with the
24 Secretary, recognizes for purposes of this sub-
25 section.

1 “(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—

2 The term ‘eligible employer-sponsored plan’ means,
3 with respect to any employee, a group health plan or
4 group health insurance coverage offered by an em-
5 ployer to the employee which is—

6 “(A) a governmental plan (within the
7 meaning of section 2791(d)(8) of the Public
8 Health Service Act), or

9 “(B) any other plan or coverage offered in
10 the small or large group market within a State.

11 Such term shall include a grandfathered health plan
12 described in paragraph (1)(D) offered in a group
13 market.

14 “(3) EXCEPTED BENEFITS NOT TREATED AS
15 MINIMUM ESSENTIAL COVERAGE.—The term ‘min-
16 imum essential coverage’ shall not include health in-
17 surance coverage which consists of coverage of ex-
18 cepted benefits—

19 “(A) described in paragraph (1) of sub-
20 section (c) of section 2791 of the Public Health
21 Service Act; or

22 “(B) described in paragraph (2), (3), or
23 (4) of such subsection if the benefits are pro-
24 vided under a separate policy, certificate, or
25 contract of insurance.

1 “(4) INDIVIDUALS RESIDING OUTSIDE UNITED
2 STATES OR RESIDENTS OF TERRITORIES.—Any ap-
3 plicable individual shall be treated as having min-
4 imum essential coverage for any month—

5 “(A) if such month occurs during any pe-
6 riod described in subparagraph (A) or (B) of
7 section 911(d)(1) which is applicable to the in-
8 dividual, or

9 “(B) if such individual is a bona fide resi-
10 dent of any possession of the United States (as
11 determined under section 937(a)) for such
12 month.

13 “(5) INSURANCE-RELATED TERMS.—Any term
14 used in this section which is also used in title I of
15 the Patient Protection and Affordable Care Act shall
16 have the same meaning as when used in such title.

17 “(g) ADMINISTRATION AND PROCEDURE.—

18 “(1) IN GENERAL.—The penalty provided by
19 this section shall be paid upon notice and demand by
20 the Secretary, and except as provided in paragraph
21 (2), shall be assessed and collected in the same man-
22 ner as an assessable penalty under subchapter B of
23 chapter 68.

24 “(2) SPECIAL RULES.—Notwithstanding any
25 other provision of law—

1 “(A) WAIVER OF CRIMINAL PENALTIES.—
2 In the case of any failure by a taxpayer to time-
3 ly pay any penalty imposed by this section, such
4 taxpayer shall not be subject to any criminal
5 prosecution or penalty with respect to such fail-
6 ure.

7 “(B) LIMITATIONS ON LIENS AND LEV-
8 IES.—The Secretary shall not—

9 “(i) file notice of lien with respect to
10 any property of a taxpayer by reason of
11 any failure to pay the penalty imposed by
12 this section, or

13 “(ii) levy on any such property with
14 respect to such failure.”.

15 (c) CLERICAL AMENDMENT.—The table of chapters
16 for subtitle D of the Internal Revenue Code of 1986 is
17 amended by inserting after the item relating to chapter
18 47 the following new item:

 “CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE.”.

19 (d) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to taxable years ending after De-
21 cember 31, 2013.

22 **SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.**

23 (a) IN GENERAL.—Part III of subchapter A of chap-
24 ter 61 of the Internal Revenue Code of 1986 is amended
25 by inserting after subpart C the following new subpart:

1 **“Subpart D—Information Regarding Health**
2 **Insurance Coverage**

“Sec. 6055. Reporting of health insurance coverage.

3 **“SEC. 6055. REPORTING OF HEALTH INSURANCE COV-**
4 **ERAGE.**

5 “(a) IN GENERAL.—Every person who provides min-
6 imum essential coverage to an individual during a calendar
7 year shall, at such time as the Secretary may prescribe,
8 make a return described in subsection (b).

9 “(b) FORM AND MANNER OF RETURN.—

10 “(1) IN GENERAL.—A return is described in
11 this subsection if such return—

12 “(A) is in such form as the Secretary may
13 prescribe, and

14 “(B) contains—

15 “(i) the name, address and TIN of
16 the primary insured and the name and
17 TIN of each other individual obtaining cov-
18 erage under the policy,

19 “(ii) the dates during which such indi-
20 vidual was covered under minimum essen-
21 tial coverage during the calendar year,

22 “(iii) in the case of minimum essential
23 coverage which consists of health insurance
24 coverage, information concerning—

1 “(I) whether or not the coverage
2 is a qualified health plan offered
3 through an Exchange established
4 under section 1311 of the Patient
5 Protection and Affordable Care Act,
6 and

7 “(II) in the case of a qualified
8 health plan, the amount (if any) of
9 any advance payment under section
10 1412 of the Patient Protection and
11 Affordable Care Act of any cost-shar-
12 ing reduction under section 1402 of
13 such Act or of any premium tax credit
14 under section 36B with respect to
15 such coverage, and

16 “(iv) such other information as the
17 Secretary may require.

18 “(2) INFORMATION RELATING TO EMPLOYER-
19 PROVIDED COVERAGE.—If minimum essential cov-
20 erage provided to an individual under subsection (a)
21 consists of health insurance coverage of a health in-
22 surance issuer provided through a group health plan
23 of an employer, a return described in this subsection
24 shall include—

1 “(A) the name, address, and employer
2 identification number of the employer maintain-
3 ing the plan,

4 “(B) the portion of the premium (if any)
5 required to be paid by the employer, and

6 “(C) if the health insurance coverage is a
7 qualified health plan in the small group market
8 offered through an Exchange, such other infor-
9 mation as the Secretary may require for admin-
10 istration of the credit under section 45R (relat-
11 ing to credit for employee health insurance ex-
12 penses of small employers).

13 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
14 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
15 PORTED.—

16 “(1) IN GENERAL.—Every person required to
17 make a return under subsection (a) shall furnish to
18 each individual whose name is required to be set
19 forth in such return a written statement showing—

20 “(A) the name and address of the person
21 required to make such return and the phone
22 number of the information contact for such per-
23 son, and

24 “(B) the information required to be shown
25 on the return with respect to such individual.

1 “(2) TIME FOR FURNISHING STATEMENTS.—

2 The written statement required under paragraph (1)
3 shall be furnished on or before January 31 of the
4 year following the calendar year for which the return
5 under subsection (a) was required to be made.

6 “(d) COVERAGE PROVIDED BY GOVERNMENTAL
7 UNITS.—In the case of coverage provided by any govern-
8 mental unit or any agency or instrumentality thereof, the
9 officer or employee who enters into the agreement to pro-
10 vide such coverage (or the person appropriately designated
11 for purposes of this section) shall make the returns and
12 statements required by this section.

13 “(e) MINIMUM ESSENTIAL COVERAGE.—For pur-
14 poses of this section, the term ‘minimum essential cov-
15 erage’ has the meaning given such term by section
16 5000A(f).”.

17 (b) ASSESSABLE PENALTIES.—

18 (1) Subparagraph (B) of section 6724(d)(1) of
19 the Internal Revenue Code of 1986 (relating to defi-
20 nitions) is amended by striking “or” at the end of
21 clause (xxii), by striking “and” at the end of clause
22 (xxiii) and inserting “or”, and by inserting after
23 clause (xxiii) the following new clause:

1 “(xxiv) section 6055 (relating to re-
2 turns relating to information regarding
3 health insurance coverage), and”.

4 (2) Paragraph (2) of section 6724(d) of such
5 Code is amended by striking “or” at the end of sub-
6 paragraph (EE), by striking the period at the end
7 of subparagraph (FF) and inserting “, or” and by
8 inserting after subparagraph (FF) the following new
9 subparagraph:

10 “(GG) section 6055(c) (relating to state-
11 ments relating to information regarding health
12 insurance coverage).”.

13 (c) NOTIFICATION OF NONENROLLMENT.—Not later
14 than June 30 of each year, the Secretary of the Treasury,
15 acting through the Internal Revenue Service and in con-
16 sultation with the Secretary of Health and Human Serv-
17 ices, shall send a notification to each individual who files
18 an individual income tax return and who is not enrolled
19 in minimum essential coverage (as defined in section
20 5000A of the Internal Revenue Code of 1986). Such noti-
21 fication shall contain information on the services available
22 through the Exchange operating in the State in which
23 such individual resides.

24 (d) CONFORMING AMENDMENT.—The table of sub-
25 parts for part III of subchapter A of chapter 61 of such

1 Code is amended by inserting after the item relating to
2 subpart C the following new item:

“SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE”.

3 (e) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to calendar years beginning after
5 2013.

6 **PART II—EMPLOYER RESPONSIBILITIES**

7 **SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF**
8 **LARGE EMPLOYERS.**

9 The Fair Labor Standards Act of 1938 is amended
10 by inserting after section 18 (29 U.S.C. 218) the fol-
11 lowing:

12 **“SEC. 18A. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF**
13 **LARGE EMPLOYERS.**

14 “In accordance with regulations promulgated by the
15 Secretary, an employer to which this Act applies that has
16 more than 200 full-time employees and that offers employ-
17 ees enrollment in 1 or more health benefits plans shall
18 automatically enroll new full-time employees in one of the
19 plans offered (subject to any waiting period authorized by
20 law) and to continue the enrollment of current employees
21 in a health benefits plan offered through the employer.
22 Any automatic enrollment program shall include adequate
23 notice and the opportunity for an employee to opt out of
24 any coverage the individual or employee were automati-
25 cally enrolled in. Nothing in this section shall be construed

1 to supersede any State law which establishes, implements,
2 or continues in effect any standard or requirement relating
3 to employers in connection with payroll except to the ex-
4 tent that such standard or requirement prevents an em-
5 ployer from instituting the automatic enrollment program
6 under this section.”.

7 **SEC. 1512. EMPLOYER REQUIREMENT TO INFORM EMPLOY-**
8 **EES OF COVERAGE OPTIONS.**

9 The Fair Labor Standards Act of 1938 is amended
10 by inserting after section 18A (as added by section 1513)
11 the following:

12 **“SEC. 18B. NOTICE TO EMPLOYEES.**

13 “(a) IN GENERAL.—In accordance with regulations
14 promulgated by the Secretary, an employer to which this
15 Act applies, shall provide to each employee at the time
16 of hiring (or with respect to current employees, not later
17 than March 1, 2013), written notice—

18 “(1) informing the employee of the existence of
19 an Exchange, including a description of the services
20 provided by such Exchange, and the manner in
21 which the employee may contact the Exchange to re-
22 quest assistance;

23 “(2) if the employer plan’s share of the total al-
24 lowed costs of benefits provided under the plan is
25 less than 60 percent of such costs, that the employee

1 may be eligible for a premium tax credit under sec-
2 tion 36B of the Internal Revenue Code of 1986 and
3 a cost sharing reduction under section 1402 of the
4 Patient Protection and Affordable Care Act if the
5 employee purchases a qualified health plan through
6 the Exchange; and

7 “(3) if the employee purchases a qualified
8 health plan through the Exchange, the employee will
9 lose the employer contribution (if any) to any health
10 benefits plan offered by the employer and that all or
11 a portion of such contribution may be excludable
12 from income for Federal income tax purposes.

13 “(b) EFFECTIVE DATE.—Subsection (a) shall take
14 effect with respect to employers in a State beginning on
15 March 1, 2013.”.

16 **SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.**

17 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
18 enue Code of 1986 is amended by adding at the end the
19 following:

20 **“SEC. 4980H. SHARED RESPONSIBILITY FOR EMPLOYERS**
21 **REGARDING HEALTH COVERAGE.**

22 “(a) LARGE EMPLOYERS NOT OFFERING HEALTH
23 COVERAGE.—If—

24 “(1) any applicable large employer fails to offer
25 to its full-time employees (and their dependents) the

1 opportunity to enroll in minimum essential coverage
2 under an eligible employer-sponsored plan (as de-
3 fined in section 5000A(f)(2)) for any month, and

4 “(2) at least one full-time employee of the ap-
5 plicable large employer has been certified to the em-
6 ployer under section 1411 of the Patient Protection
7 and Affordable Care Act as having enrolled for such
8 month in a qualified health plan with respect to
9 which an applicable premium tax credit or cost-shar-
10 ing reduction is allowed or paid with respect to the
11 employee,

12 then there is hereby imposed on the employer an assess-
13 able payment equal to the product of the applicable pay-
14 ment amount and the number of individuals employed by
15 the employer as full-time employees during such month.

16 “(b) LARGE EMPLOYERS WITH WAITING PERIODS
17 EXCEEDING 30 DAYS.—

18 “(1) IN GENERAL.—In the case of any applica-
19 ble large employer which requires an extended wait-
20 ing period to enroll in any minimum essential cov-
21 erage under an employer-sponsored plan (as defined
22 in section 5000A(f)(2)), there is hereby imposed on
23 the employer an assessable payment, in the amount
24 specified in paragraph (2), for each full-time em-

1 ployee of the employer to whom the extended waiting
2 period applies.

3 “(2) AMOUNT.—For purposes of paragraph (1),
4 the amount specified in this paragraph for a full-
5 time employee is—

6 “(A) in the case of an extended waiting pe-
7 riod which exceeds 30 days but does not exceed
8 60 days, \$400, and

9 “(B) in the case of an extended waiting pe-
10 riod which exceeds 60 days, \$600.

11 “(3) EXTENDED WAITING PERIOD.—The term
12 ‘extended waiting period’ means any waiting period
13 (as defined in section 2701(b)(4) of the Public
14 Health Service Act) which exceeds 30 days.

15 “(c) LARGE EMPLOYERS OFFERING COVERAGE
16 WITH EMPLOYEES WHO QUALIFY FOR PREMIUM TAX
17 CREDITS OR COST-SHARING REDUCTIONS.—

18 “(1) IN GENERAL.—If—

19 “(A) an applicable large employer offers to
20 its full-time employees (and their dependents)
21 the opportunity to enroll in minimum essential
22 coverage under an eligible employer-sponsored
23 plan (as defined in section 5000A(f)(2)) for any
24 month, and

1 “(B) 1 or more full-time employees of the
2 applicable large employer has been certified to
3 the employer under section 1411 of the Patient
4 Protection and Affordable Care Act as having
5 enrolled for such month in a qualified health
6 plan with respect to which an applicable pre-
7 mium tax credit or cost-sharing reduction is al-
8 lowed or paid with respect to the employee,
9 then there is hereby imposed on the employer an as-
10 sessable payment equal to the product of the number
11 of full-time employees of the applicable large em-
12 ployer described in subparagraph (B) for such
13 month and 400 percent of the applicable payment
14 amount.

15 “(2) OVERALL LIMITATION.—The aggregate
16 amount of tax determined under paragraph (1) with
17 respect to all employees of an applicable large em-
18 ployer for any month shall not exceed the product of
19 the applicable payment amount and the number of
20 individuals employed by the employer as full-time
21 employees during such month.

22 “(d) DEFINITIONS AND SPECIAL RULES.—For pur-
23 poses of this section—

1 “(1) APPLICABLE PAYMENT AMOUNT.—The
2 term ‘applicable payment amount’ means, with re-
3 spect to any month, $\frac{1}{12}$ of \$750.

4 “(2) APPLICABLE LARGE EMPLOYER.—

5 “(A) IN GENERAL.—The term ‘applicable
6 large employer’ means, with respect to a cal-
7 endar year, an employer who employed an aver-
8 age of at least 50 full-time employees on busi-
9 ness days during the preceding calendar year.

10 “(B) EXEMPTION FOR CERTAIN EMPLOY-
11 ERS.—

12 “(i) IN GENERAL.—An employer shall
13 not be considered to employ more than 50
14 full-time employees if—

15 “(I) the employer’s workforce ex-
16 ceeds 50 full-time employees for 120
17 days or fewer during the calendar
18 year, and

19 “(II) the employees in excess of
20 50 employed during such 120-day pe-
21 riod were seasonal workers.

22 “(ii) DEFINITION OF SEASONAL
23 WORKERS.—The term ‘seasonal worker’
24 means a worker who performs labor or
25 services on a seasonal basis as defined by

1 the Secretary of Labor, including workers
2 covered by section 500.20(s)(1) of title 29,
3 Code of Federal Regulations and retail
4 workers employed exclusively during holi-
5 day seasons.

6 “(C) RULES FOR DETERMINING EMPLOYER
7 SIZE.—For purposes of this paragraph—

8 “(i) APPLICATION OF AGGREGATION
9 RULE FOR EMPLOYERS.—All persons treat-
10 ed as a single employer under subsection
11 (b), (c), (m), or (o) of section 414 of the
12 Internal Revenue Code of 1986 shall be
13 treated as 1 employer.

14 “(ii) EMPLOYERS NOT IN EXISTENCE
15 IN PRECEDING YEAR.—In the case of an
16 employer which was not in existence
17 throughout the preceding calendar year,
18 the determination of whether such em-
19 ployer is an applicable large employer shall
20 be based on the average number of employ-
21 ees that it is reasonably expected such em-
22 ployer will employ on business days in the
23 current calendar year.

24 “(iii) PREDECESSORS.—Any reference
25 in this subsection to an employer shall in-

1 clude a reference to any predecessor of
2 such employer.

3 “(3) APPLICABLE PREMIUM TAX CREDIT AND
4 COST-SHARING REDUCTION.—The term ‘applicable
5 premium tax credit and cost-sharing reduction’
6 means—

7 “(A) any premium tax credit allowed under
8 section 36B,

9 “(B) any cost-sharing reduction under sec-
10 tion 1402 of the Patient Protection and Afford-
11 able Care Act, and

12 “(C) any advance payment of such credit
13 or reduction under section 1412 of such Act.

14 “(4) FULL-TIME EMPLOYEE.—

15 “(A) IN GENERAL.—The term ‘full-time
16 employee’ means an employee who is employed
17 on average at least 30 hours of service per
18 week.

19 “(B) HOURS OF SERVICE.—The Secretary,
20 in consultation with the Secretary of Labor,
21 shall prescribe such regulations, rules, and
22 guidance as may be necessary to determine the
23 hours of service of an employee, including rules
24 for the application of this paragraph to employ-

1 ees who are not compensated on an hourly
2 basis.

3 “(5) INFLATION ADJUSTMENT.—

4 “(A) IN GENERAL.—In the case of any cal-
5 endar year after 2014, each of the dollar
6 amounts in subsection (b)(2) and (d)(1) shall
7 be increased by an amount equal to the product
8 of—

9 “(i) such dollar amount, and

10 “(ii) the premium adjustment percent-
11 age (as defined in section 1302(c)(4) of
12 the Patient Protection and Affordable Care
13 Act) for the calendar year.

14 “(B) ROUNDING.—If the amount of any
15 increase under subparagraph (A) is not a mul-
16 tiple of \$10, such increase shall be rounded to
17 the next lowest multiple of \$10.

18 “(6) OTHER DEFINITIONS.—Any term used in
19 this section which is also used in the Patient Protec-
20 tion and Affordable Care Act shall have the same
21 meaning as when used in such Act.

22 “(7) TAX NONDEDUCTIBLE.—For denial of de-
23 duction for the tax imposed by this section, see sec-
24 tion 275(a)(6).

25 “(e) ADMINISTRATION AND PROCEDURE.—

1 “(1) IN GENERAL.—Any assessable payment
2 provided by this section shall be paid upon notice
3 and demand by the Secretary, and shall be assessed
4 and collected in the same manner as an assessable
5 penalty under subchapter B of chapter 68.

6 “(2) TIME FOR PAYMENT.—The Secretary may
7 provide for the payment of any assessable payment
8 provided by this section on an annual, monthly, or
9 other periodic basis as the Secretary may prescribe.

10 “(3) COORDINATION WITH CREDITS, ETC.—
11 The Secretary shall prescribe rules, regulations, or
12 guidance for the repayment of any assessable pay-
13 ment (including interest) if such payment is based
14 on the allowance or payment of an applicable pre-
15 mium tax credit or cost-sharing reduction with re-
16 spect to an employee, such allowance or payment is
17 subsequently disallowed, and the assessable payment
18 would not have been required to be made but for
19 such allowance or payment.”.

20 (b) CLERICAL AMENDMENT.—The table of sections
21 for chapter 43 of such Code is amended by adding at the
22 end the following new item:

 “Sec. 4980H. Shared responsibility for employers regarding health coverage.”.

23 (c) STUDY AND REPORT OF EFFECT OF TAX ON
24 WORKERS’ WAGES.—

1 (1) IN GENERAL.—The Secretary of Labor shall
2 conduct a study to determine whether employees’
3 wages are reduced by reason of the application of
4 the assessable payments under section 4980H of the
5 Internal Revenue Code of 1986 (as added by the
6 amendments made by this section). The Secretary
7 shall make such determination on the basis of the
8 National Compensation Survey published by the Bu-
9 reau of Labor Statistics.

10 (2) REPORT.—The Secretary shall report the
11 results of the study under paragraph (1) to the
12 Committee on Ways and Means of the House of
13 Representatives and to the Committee on Finance of
14 the Senate.

15 (d) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to months beginning after Decem-
17 ber 31, 2013.

18 **SEC. 1514. REPORTING OF EMPLOYER HEALTH INSURANCE**

19 **COVERAGE.**

20 (a) IN GENERAL.—Subpart D of part III of sub-
21 chapter A of chapter 61 of the Internal Revenue Code of
22 1986, as added by section 1502, is amended by inserting
23 after section 6055 the following new section:

1 **“SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON**
2 **HEALTH INSURANCE COVERAGE.**

3 “(a) IN GENERAL.—Every applicable large employer
4 required to meet the requirements of section 4980H with
5 respect to its full-time employees during a calendar year
6 shall, at such time as the Secretary may prescribe, make
7 a return described in subsection (b).

8 “(b) FORM AND MANNER OF RETURN.—A return is
9 described in this subsection if such return—

10 “(1) is in such form as the Secretary may pre-
11 scribe, and

12 “(2) contains—

13 “(A) the name, date, and employer identi-
14 fication number of the employer,

15 “(B) a certification as to whether the em-
16 ployer offers to its full-time employees (and
17 their dependents) the opportunity to enroll in
18 minimum essential coverage under an eligible
19 employer-sponsored plan (as defined in section
20 5000A(f)(2)),

21 “(C) if the employer certifies that the em-
22 ployer did offer to its full-time employees (and
23 their dependents) the opportunity to so enroll—

24 “(i) the length of any waiting period
25 (as defined in section 2701(b)(4) of the

1 Public Health Service Act) with respect to
2 such coverage,

3 “(ii) the months during the calendar
4 year for which coverage under the plan was
5 available,

6 “(iii) the monthly premium for the
7 lowest cost option in each of the enroll-
8 ment categories under the plan, and

9 “(iv) the applicable large employer’s
10 share of the total allowed costs of benefits
11 provided under the plan,

12 “(D) the number of full-time employees for
13 each month during the calendar year,

14 “(E) the name, address, and TIN of each
15 full-time employee during the calendar year and
16 the months (if any) during which such employee
17 (and any dependents) were covered under any
18 such health benefits plans, and

19 “(F) such other information as the Sec-
20 retary may require.

21 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
22 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
23 PORTED.—

24 “(1) IN GENERAL.—Every person required to
25 make a return under subsection (a) shall furnish to

1 each full-time employee whose name is required to
2 be set forth in such return under subsection
3 (b)(2)(E) a written statement showing—

4 “(A) the name and address of the person
5 required to make such return and the phone
6 number of the information contact for such per-
7 son, and

8 “(B) the information required to be shown
9 on the return with respect to such individual.

10 “(2) TIME FOR FURNISHING STATEMENTS.—

11 The written statement required under paragraph (1)
12 shall be furnished on or before January 31 of the
13 year following the calendar year for which the return
14 under subsection (a) was required to be made.

15 “(d) COORDINATION WITH OTHER REQUIRE-
16 MENTS.—To the maximum extent feasible, the Secretary
17 may provide that—

18 “(1) any return or statement required to be
19 provided under this section may be provided as part
20 of any return or statement required under section
21 6051 or 6055, and

22 “(2) in the case of an applicable large employer
23 offering health insurance coverage of a health insur-
24 ance issuer, the employer may enter into an agree-
25 ment with the issuer to include information required

1 under this section with the return and statement re-
2 quired to be provided by the issuer under section
3 6055.

4 “(e) COVERAGE PROVIDED BY GOVERNMENTAL
5 UNITS.—In the case of any applicable large employer
6 which is a governmental unit or any agency or instrumen-
7 tality thereof, the person appropriately designated for pur-
8 poses of this section shall make the returns and state-
9 ments required by this section.

10 “(f) DEFINITIONS.—For purposes of this section, any
11 term used in this section which is also used in section
12 4980H shall have the meaning given such term by section
13 4980H.”

14 (b) ASSESSABLE PENALTIES.—

15 (1) Subparagraph (B) of section 6724(d)(1) of
16 the Internal Revenue Code of 1986 (relating to defi-
17 nitions), as amended by section 1502, is amended by
18 striking “or” at the end of clause (xxiii), by striking
19 “and” at the end of clause (xxiv) and inserting “or”,
20 and by inserting after clause (xxiv) the following
21 new clause:

22 “(xxv) section 6056 (relating to re-
23 turns relating to large employers required
24 to report on health insurance coverage),
25 and”.

1 (2) Paragraph (2) of section 6724(d) of such
 2 Code, as so amended, is amended by striking “or”
 3 at the end of subparagraph (FF), by striking the pe-
 4 riod at the end of subparagraph (GG) and inserting
 5 “, or” and by inserting after subparagraph (GG) the
 6 following new subparagraph:

7 “(HH) section 6056(c) (relating to state-
 8 ments relating to large employers required to
 9 report on health insurance coverage).”.

10 (c) CONFORMING AMENDMENT.—The table of sec-
 11 tions for subpart D of part III of subchapter A of chapter
 12 61 of such Code, as added by section 1502, is amended
 13 by adding at the end the following new item:

 “Sec. 6056. Large employers required to report on health insurance coverage.”.

14 (d) EFFECTIVE DATE.—The amendments made by
 15 this section shall apply to periods beginning after Decem-
 16 ber 31, 2013.

17 **SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING**
 18 **QUALIFIED HEALTH PLANS THROUGH CAFE-**
 19 **TERIA PLANS.**

20 (a) IN GENERAL.—Subsection (f) of section 125 of
 21 the Internal Revenue Code of 1986 is amended by adding
 22 at the end the following new paragraph:

23 “(3) CERTAIN EXCHANGE-PARTICIPATING
 24 QUALIFIED HEALTH PLANS NOT QUALIFIED.—

1 “(A) IN GENERAL.—The term ‘qualified
2 benefit’ shall not include any qualified health
3 plan (as defined in section 1301(a) of the Pa-
4 tient Protection and Affordable Care Act) of-
5 fered through an Exchange established under
6 section 1311 of such Act.

7 “(B) EXCEPTION FOR EXCHANGE-ELIGI-
8 BLE EMPLOYERS.—Subparagraph (A) shall not
9 apply with respect to any employee if such em-
10 ployee’s employer is a qualified employer (as de-
11 fined in section 1312(f)(2) of the Patient Pro-
12 tection and Affordable Care Act) offering the
13 employee the opportunity to enroll through such
14 an Exchange in a qualified health plan in a
15 group market.”.

16 (b) CONFORMING AMENDMENTS.—Subsection (f) of
17 section 125 of such Code is amended—

18 (1) by striking “For purposes of this section,
19 the term” and inserting “For purposes of this sec-
20 tion—

21 “(1) IN GENERAL.—The term”, and

22 (2) by striking “Such term shall not include”
23 and inserting the following:

1 “(2) LONG-TERM CARE INSURANCE NOT QUALI-
2 FIED.—The term ‘qualified benefit’ shall not in-
3 clude”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to taxable years beginning after
6 December 31, 2013.

7 **Subtitle G—Miscellaneous** 8 **Provisions**

9 **SEC. 1551. DEFINITIONS.**

10 Unless specifically provided for otherwise, the defini-
11 tions contained in section 2791 of the Public Health Serv-
12 ice Act (42 U.S.C. 300gg-91) shall apply with respect to
13 this title.

14 **SEC. 1552. TRANSPARENCY IN GOVERNMENT.**

15 Not later than 30 days after the date of enactment
16 of this Act, the Secretary of Health and Human Services
17 shall publish on the Internet website of the Department
18 of Health and Human Services, a list of all of the authori-
19 ties provided to the Secretary under this Act (and the
20 amendments made by this Act).

21 **SEC. 1553. PROHIBITION AGAINST DISCRIMINATION ON AS-** 22 **SISTED SUICIDE.**

23 (a) IN GENERAL.—The Federal Government, and
24 any State or local government or health care provider that
25 receives Federal financial assistance under this Act (or

1 under an amendment made by this Act) or any health plan
2 created under this Act (or under an amendment made by
3 this Act), may not subject an individual or institutional
4 health care entity to discrimination on the basis that the
5 entity does not provide any health care item or service fur-
6 nished for the purpose of causing, or for the purpose of
7 assisting in causing, the death of any individual, such as
8 by assisted suicide, euthanasia, or mercy killing.

9 (b) DEFINITION.—In this section, the term “health
10 care entity” includes an individual physician or other
11 health care professional, a hospital, a provider-sponsored
12 organization, a health maintenance organization, a health
13 insurance plan, or any other kind of health care facility,
14 organization, or plan.

15 (c) CONSTRUCTION AND TREATMENT OF CERTAIN
16 SERVICES.—Nothing in subsection (a) shall be construed
17 to apply to, or to affect, any limitation relating to—

18 (1) the withholding or withdrawing of medical
19 treatment or medical care;

20 (2) the withholding or withdrawing of nutrition
21 or hydration;

22 (3) abortion; or

23 (4) the use of an item, good, benefit, or service
24 furnished for the purpose of alleviating pain or dis-
25 comfort, even if such use may increase the risk of

1 death, so long as such item, good, benefit, or service
2 is not also furnished for the purpose of causing, or
3 the purpose of assisting in causing, death, for any
4 reason.

5 (d) ADMINISTRATION.—The Office for Civil Rights of
6 the Department of Health and Human Services is des-
7 ignated to receive complaints of discrimination based on
8 this section.

9 **SEC. 1554. ACCESS TO THERAPIES.**

10 Notwithstanding any other provision of this Act, the
11 Secretary of Health and Human Services shall not pro-
12 mulgate any regulation that—

13 (1) creates any unreasonable barriers to the
14 ability of individuals to obtain appropriate medical
15 care;

16 (2) impedes timely access to health care serv-
17 ices;

18 (3) interferes with communications regarding a
19 full range of treatment options between the patient
20 and the provider;

21 (4) restricts the ability of health care providers
22 to provide full disclosure of all relevant information
23 to patients making health care decisions;

1 (5) violates the principles of informed consent
2 and the ethical standards of health care profes-
3 sionals; or

4 (6) limits the availability of health care treat-
5 ment for the full duration of a patient’s medical
6 needs.

7 **SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL**
8 **HEALTH INSURANCE PROGRAMS.**

9 No individual, company, business, nonprofit entity, or
10 health insurance issuer offering group or individual health
11 insurance coverage shall be required to participate in any
12 Federal health insurance program created under this Act
13 (or any amendments made by this Act), or in any Federal
14 health insurance program expanded by this Act (or any
15 such amendments), and there shall be no penalty or fine
16 imposed upon any such issuer for choosing not to partici-
17 pate in such programs.

18 **SEC. 1556. EQUITY FOR CERTAIN ELIGIBLE SURVIVORS.**

19 (a) **REBUTTABLE PRESUMPTION.**—Section 411(c)(4)
20 of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is
21 amended by striking the last sentence.

22 (b) **CONTINUATION OF BENEFITS.**—Section 422(l) of
23 the Black Lung Benefits Act (30 U.S.C. 932(l)) is amend-
24 ed by striking “, except with respect to a claim filed under

1 this part on or after the effective date of the Black Lung
2 Benefits Amendments of 1981”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply with respect to claims filed under
5 part B or part C of the Black Lung Benefits Act (30
6 U.S.C. 921 et seq., 931 et seq.) after January 1, 2005,
7 that are pending on or after the date of enactment of this
8 Act.

9 **SEC. 1557. NONDISCRIMINATION.**

10 (a) IN GENERAL.—Except as otherwise provided for
11 in this title (or an amendment made by this title), an indi-
12 vidual shall not, on the ground prohibited under title VI
13 of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.),
14 title IX of the Education Amendments of 1972 (20 U.S.C.
15 1681 et seq.), the Age Discrimination Act of 1975 (42
16 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation
17 Act of 1973 (29 U.S.C. 794), be excluded from participa-
18 tion in, be denied the benefits of, or be subjected to dis-
19 crimination under, any health program or activity, any
20 part of which is receiving Federal financial assistance, in-
21 cluding credits, subsidies, or contracts of insurance, or
22 under any program or activity that is administered by an
23 Executive Agency or any entity established under this title
24 (or amendments). The enforcement mechanisms provided
25 for and available under such title VI, title IX, section 504,

1 or such Age Discrimination Act shall apply for purposes
2 of violations of this subsection.

3 (b) CONTINUED APPLICATION OF LAWS.—Nothing in
4 this title (or an amendment made by this title) shall be
5 construed to invalidate or limit the rights, remedies, proce-
6 dures, or legal standards available to individuals aggrieved
7 under title VI of the Civil Rights Act of 1964 (42 U.S.C.
8 2000d et seq.), title VII of the Civil Rights Act of 1964
9 (42 U.S.C. 2000e et seq.), title IX of the Education
10 Amendments of 1972 (20 U.S.C. 1681 et seq.), section
11 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794),
12 or the Age Discrimination Act of 1975 (42 U.S.C. 611
13 et seq.), or to supersede State laws that provide additional
14 protections against discrimination on any basis described
15 in subsection (a).

16 (c) REGULATIONS.—The Secretary may promulgate
17 regulations to implement this section.

18 **SEC. 1558. PROTECTIONS FOR EMPLOYEES.**

19 The Fair Labor Standards Act of 1938 is amended
20 by inserting after section 18B (as added by section 1512)
21 the following:

22 **“SEC. 18C. PROTECTIONS FOR EMPLOYEES.**

23 “(a) PROHIBITION.—No employer shall discharge or
24 in any manner discriminate against any employee with re-
25 spect to his or her compensation, terms, conditions, or

1 other privileges of employment because the employee (or
2 an individual acting at the request of the employee) has—

3 “(1) received a credit under section 36B of the
4 Internal Revenue Code of 1986 or a subsidy under
5 section 1402 of this Act;

6 “(2) provided, caused to be provided, or is
7 about to provide or cause to be provided to the em-
8 ployer, the Federal Government, or the attorney
9 general of a State information relating to any viola-
10 tion of, or any act or omission the employee reason-
11 ably believes to be a violation of, any provision of
12 this title (or an amendment made by this title);

13 “(3) testified or is about to testify in a pro-
14 ceeding concerning such violation;

15 “(4) assisted or participated, or is about to as-
16 sist or participate, in such a proceeding; or

17 “(5) objected to, or refused to participate in,
18 any activity, policy, practice, or assigned task that
19 the employee (or other such person) reasonably be-
20 lieved to be in violation of any provision of this title
21 (or amendment), or any order, rule, regulation,
22 standard, or ban under this title (or amendment).

23 “(b) COMPLAINT PROCEDURE.—

24 “(1) IN GENERAL.—An employee who believes
25 that he or she has been discharged or otherwise dis-

1 criminated against by any employer in violation of
2 this section may seek relief in accordance with the
3 procedures, notifications, burdens of proof, remedies,
4 and statutes of limitation set forth in section
5 2087(b) of title 15, United States Code.

6 “(2) NO LIMITATION ON RIGHTS.—Nothing in
7 this section shall be deemed to diminish the rights,
8 privileges, or remedies of any employee under any
9 Federal or State law or under any collective bar-
10 gaining agreement. The rights and remedies in this
11 section may not be waived by any agreement, policy,
12 form, or condition of employment.”.

13 **SEC. 1559. OVERSIGHT.**

14 The Inspector General of the Department of Health
15 and Human Services shall have oversight authority with
16 respect to the administration and implementation of this
17 title as it relates to such Department.

18 **SEC. 1560. RULES OF CONSTRUCTION.**

19 (a) NO EFFECT ON ANTITRUST LAWS.—Nothing in
20 this title (or an amendment made by this title) shall be
21 construed to modify, impair, or supersede the operation
22 of any of the antitrust laws. For the purposes of this sec-
23 tion, the term “antitrust laws” has the meaning given
24 such term in subsection (a) of the first section of the Clay-
25 ton Act, except that such term includes section 5 of the

1 Federal Trade Commission Act to the extent that such
2 section 5 applies to unfair methods of competition.

3 (b) RULE OF CONSTRUCTION REGARDING HAWAII'S
4 PREPAID HEALTH CARE ACT.—Nothing in this title (or
5 an amendment made by this title) shall be construed to
6 modify or limit the application of the exemption for Ha-
7 waii's Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-
8 1 et seq.) as provided for under section 514(b)(5) of the
9 Employee Retirement Income Security Act of 1974 (29
10 U.S.C. 1144(b)(5)).

11 (c) STUDENT HEALTH INSURANCE PLANS.—Nothing
12 in this title (or an amendment made by this title) shall
13 be construed to prohibit an institution of higher education
14 (as such term is defined for purposes of the Higher Edu-
15 cation Act of 1965) from offering a student health insur-
16 ance plan, to the extent that such requirement is otherwise
17 permitted under applicable Federal, State or local law.

18 (d) NO EFFECT ON EXISTING REQUIREMENTS.—
19 Nothing in this title (or an amendment made by this title,
20 unless specified by direct statutory reference) shall be con-
21 strued to modify any existing Federal requirement con-
22 cerning the State agency responsible for determining eligi-
23 bility for programs identified in section 1413.

1 **SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLL-**
2 **MENT STANDARDS AND PROTOCOLS.**

3 Title XXX of the Public Health Service Act (42
4 U.S.C. 300jj et seq.) is amended by adding at the end
5 the following:

6 **“Subtitle C—Other Provisions**

7 **“SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLL-**
8 **MENT STANDARDS AND PROTOCOLS.**

9 “(a) IN GENERAL.—

10 “(1) STANDARDS AND PROTOCOLS.—Not later
11 than 180 days after the date of enactment of this
12 title, the Secretary, in consultation with the HIT
13 Policy Committee and the HIT Standards Com-
14 mittee, shall develop interoperable and secure stand-
15 ards and protocols that facilitate enrollment of indi-
16 viduals in Federal and State health and human serv-
17 ices programs, as determined by the Secretary.

18 “(2) METHODS.—The Secretary shall facilitate
19 enrollment in such programs through methods deter-
20 mined appropriate by the Secretary, which shall in-
21 clude providing individuals and third parties author-
22 ized by such individuals and their designees notifica-
23 tion of eligibility and verification of eligibility re-
24 quired under such programs.

1 “(b) CONTENT.—The standards and protocols for
2 electronic enrollment in the Federal and State programs
3 described in subsection (a) shall allow for the following:

4 “(1) Electronic matching against existing Fed-
5 eral and State data, including vital records, employ-
6 ment history, enrollment systems, tax records, and
7 other data determined appropriate by the Secretary
8 to serve as evidence of eligibility and in lieu of
9 paper-based documentation.

10 “(2) Simplification and submission of electronic
11 documentation, digitization of documents, and sys-
12 tems verification of eligibility.

13 “(3) Reuse of stored eligibility information (in-
14 cluding documentation) to assist with retention of el-
15 igible individuals.

16 “(4) Capability for individuals to apply, recer-
17 tify and manage their eligibility information online,
18 including at home, at points of service, and other
19 community-based locations.

20 “(5) Ability to expand the enrollment system to
21 integrate new programs, rules, and functionalities, to
22 operate at increased volume, and to apply stream-
23 lined verification and eligibility processes to other
24 Federal and State programs, as appropriate.

1 “(6) Notification of eligibility, recertification,
2 and other needed communication regarding eligi-
3 bility, which may include communication via email
4 and cellular phones.

5 “(7) Other functionalities necessary to provide
6 eligibles with streamlined enrollment process.

7 “(c) APPROVAL AND NOTIFICATION.—With respect
8 to any standard or protocol developed under subsection (a)
9 that has been approved by the HIT Policy Committee and
10 the HIT Standards Committee, the Secretary—

11 “(1) shall notify States of such standards or
12 protocols; and

13 “(2) may require, as a condition of receiving
14 Federal funds for the health information technology
15 investments, that States or other entities incorporate
16 such standards and protocols into such investments.

17 “(d) GRANTS FOR IMPLEMENTATION OF APPRO-
18 PRIATE ENROLLMENT HIT.—

19 “(1) IN GENERAL.—The Secretary shall award
20 grant to eligible entities to develop new, and adapt
21 existing, technology systems to implement the HIT
22 enrollment standards and protocols developed under
23 subsection (a) (referred to in this subsection as ‘ap-
24 propriate HIT technology’).

1 “(2) ELIGIBLE ENTITIES.—To be eligible for a
2 grant under this subsection, an entity shall—

3 “(A) be a State, political subdivision of a
4 State, or a local governmental entity; and

5 “(B) submit to the Secretary an applica-
6 tion at such time, in such manner, and con-
7 taining—

8 “(i) a plan to adopt and implement
9 appropriate enrollment technology that in-
10 cludes—

11 “(I) proposed reduction in main-
12 tenance costs of technology systems;

13 “(II) elimination or updating of
14 legacy systems; and

15 “(III) demonstrated collaboration
16 with other entities that may receive a
17 grant under this section that are lo-
18 cated in the same State, political sub-
19 division, or locality;

20 “(ii) an assurance that the entity will
21 share such appropriate enrollment tech-
22 nology in accordance with paragraph (4);
23 and

24 “(iii) such other information as the
25 Secretary may require.

1 “(3) SHARING.—

2 “(A) IN GENERAL.—The Secretary shall
3 ensure that appropriate enrollment HIT adopt-
4 ed under grants under this subsection is made
5 available to other qualified State, qualified po-
6 litical subdivisions of a State, or other appro-
7 priate qualified entities (as described in sub-
8 paragraph (B)) at no cost.

9 “(B) QUALIFIED ENTITIES.—The Sec-
10 retary shall determine what entities are quali-
11 fied to receive enrollment HIT under subpara-
12 graph (A), taking into consideration the rec-
13 ommendations of the HIT Policy Committee
14 and the HIT Standards Committee.”.

15 **SEC. 1562. CONFORMING AMENDMENTS.**

16 (a) APPLICABILITY.—Section 2735 of the Public
17 Health Service Act (42 U.S.C. 300gg-21), as so redesign-
18 nated by section 1001(4), is amended—

19 (1) by striking subsection (a);

20 (2) in subsection (b)—

21 (A) in paragraph (1), by striking “1
22 through 3” and inserting “1 and 2”; and

23 (B) in paragraph (2)—

1 (i) in subparagraph (A), by striking
2 “subparagraph (D)” and inserting “sub-
3 paragraph (D) or (E)”;

4 (ii) by striking “1 through 3” and in-
5 sserting “1 and 2”; and

6 (iii) by adding at the end the fol-
7 lowing:

8 “(E) ELECTION NOT APPLICABLE.—The
9 election described in subparagraph (A) shall not
10 be available with respect to the provisions of
11 subpart 1.”;

12 (3) in subsection (c), by striking “1 through 3
13 shall not apply to any group” and inserting “1 and
14 2 shall not apply to any individual coverage or any
15 group”; and

16 (4) in subsection (d)—

17 (A) in paragraph (1), by striking “1
18 through 3 shall not apply to any group” and in-
19 sserting “1 and 2 shall not apply to any indi-
20 vidual coverage or any group”;

21 (B) in paragraph (2)—

22 (i) in the matter preceding subpara-
23 graph (A), by striking “1 through 3 shall
24 not apply to any group” and inserting “1

1 and 2 shall not apply to any individual cov-
2 erage or any group”; and

3 (ii) in subparagraph (C), by inserting
4 “or, with respect to individual coverage,
5 under any health insurance coverage main-
6 tained by the same health insurance
7 issuer”; and

8 (C) in paragraph (3), by striking “any
9 group” and inserting “any individual coverage
10 or any group”.

11 (b) DEFINITIONS.—Section 2791(d) of the Public
12 Health Service Act (42 U.S.C. 300gg-91(d)) is amended
13 by adding at the end the following:

14 “(20) QUALIFIED HEALTH PLAN.—The term
15 ‘qualified health plan’ has the meaning given such
16 term in section 1301(a) of the Patient Protection
17 and Affordable Care Act.

18 “(21) EXCHANGE.—The term ‘Exchange’
19 means an American Health Benefit Exchange estab-
20 lished under section 1311 of the Patient Protection
21 and Affordable Care Act.”.

22 (c) TECHNICAL AND CONFORMING AMENDMENTS.—
23 Title XXVII of the Public Health Service Act (42 U.S.C.
24 300gg et seq.) is amended—

1 (1) in section 2704 (42 U.S.C. 300gg), as so
2 redesignated by section 1201(2)—

3 (A) in subsection (c)—

4 (i) in paragraph (2), by striking
5 “group health plan” each place that such
6 term appears and inserting “group or indi-
7 vidual health plan”; and

8 (ii) in paragraph (3)—

9 (I) by striking “group health in-
10 surance” each place that such term
11 appears and inserting “group or indi-
12 vidual health insurance”; and

13 (II) in subparagraph (D), by
14 striking “small or large” and insert-
15 ing “individual or group”;

16 (B) in subsection (d), by striking “group
17 health insurance” each place that such term ap-
18 pears and inserting “group or individual health
19 insurance”; and

20 (C) in subsection (e)(1)(A), by striking
21 “group health insurance” and inserting “group
22 or individual health insurance”;

23 (2) by striking the second heading for subpart
24 2 of part A (relating to other requirements);

1 (3) in section 2725 (42 U.S.C. 300gg-4), as so
2 redesignated by section 1001(2)—

3 (A) in subsection (a), by striking “health
4 insurance issuer offering group health insur-
5 ance coverage” and inserting “health insurance
6 issuer offering group or individual health insur-
7 ance coverage”;

8 (B) in subsection (b)—

9 (i) by striking “health insurance
10 issuer offering group health insurance cov-
11 erage in connection with a group health
12 plan” in the matter preceding paragraph
13 (1) and inserting “health insurance issuer
14 offering group or individual health insur-
15 ance coverage”; and

16 (ii) in paragraph (1), by striking
17 “plan” and inserting “plan or coverage”;

18 (C) in subsection (c)—

19 (i) in paragraph (2), by striking
20 “group health insurance coverage offered
21 by a health insurance issuer” and inserting
22 “health insurance issuer offering group or
23 individual health insurance coverage”; and

1 (ii) in paragraph (3), by striking
2 “issuer” and inserting “health insurance
3 issuer”; and

4 (D) in subsection (e), by striking “health
5 insurance issuer offering group health insur-
6 ance coverage” and inserting “health insurance
7 issuer offering group or individual health insur-
8 ance coverage”;

9 (4) in section 2726 (42 U.S.C. 300gg-5), as so
10 redesignated by section 1001(2)—

11 (A) in subsection (a), by striking “(or
12 health insurance coverage offered in connection
13 with such a plan)” each place that such term
14 appears and inserting “or a health insurance
15 issuer offering group or individual health insur-
16 ance coverage”;

17 (B) in subsection (b), by striking “(or
18 health insurance coverage offered in connection
19 with such a plan)” each place that such term
20 appears and inserting “or a health insurance
21 issuer offering group or individual health insur-
22 ance coverage”; and

23 (C) in subsection (c)—

24 (i) in paragraph (1), by striking “(and
25 group health insurance coverage offered in

1 connection with a group health plan)” and
2 inserting “and a health insurance issuer
3 offering group or individual health insur-
4 ance coverage”;

5 (ii) in paragraph (2), by striking “(or
6 health insurance coverage offered in con-
7 nection with such a plan)” each place that
8 such term appears and inserting “or a
9 health insurance issuer offering group or
10 individual health insurance coverage”;

11 (5) in section 2727 (42 U.S.C. 300gg-6), as so
12 redesignated by section 1001(2), by striking “health
13 insurance issuers providing health insurance cov-
14 erage in connection with group health plans” and in-
15 serting “and health insurance issuers offering group
16 or individual health insurance coverage”;

17 (6) in section 2728 (42 U.S.C. 300gg-7), as so
18 redesignated by section 1001(2)—

19 (A) in subsection (a), by striking “health
20 insurance coverage offered in connection with
21 such plan” and inserting “individual health in-
22 surance coverage”;

23 (B) in subsection (b)—

24 (i) in paragraph (1), by striking “or a
25 health insurance issuer that provides

1 health insurance coverage in connection
2 with a group health plan” and inserting
3 “or a health insurance issuer that offers
4 group or individual health insurance cov-
5 erage”;

6 (ii) in paragraph (2), by striking
7 “health insurance coverage offered in con-
8 nection with the plan” and inserting “indi-
9 vidual health insurance coverage”; and

10 (iii) in paragraph (3), by striking
11 “health insurance coverage offered by an
12 issuer in connection with such plan” and
13 inserting “individual health insurance cov-
14 erage”;

15 (C) in subsection (c), by striking “health
16 insurance issuer providing health insurance cov-
17 erage in connection with a group health plan”
18 and inserting “health insurance issuer that of-
19 fers group or individual health insurance cov-
20 erage”; and

21 (D) in subsection (e)(1), by striking
22 “health insurance coverage offered in connec-
23 tion with such a plan” and inserting “individual
24 health insurance coverage”;

25 (7) by striking the heading for subpart 3;

1 (8) in section 2731 (42 U.S.C. 300gg-11), as so
2 redesignated by section 1001(3)—

3 (A) by striking the section heading and all
4 that follows through subsection (b);

5 (B) in subsection (c)—

6 (i) in paragraph (1)—

7 (I) in the matter preceding sub-
8 paragraph (A), by striking “small
9 group” and inserting “group and indi-
10 vidual”; and

11 (II) in subparagraph (B)—

12 (aa) in the matter preceding
13 clause (i), by inserting “and indi-
14 viduals” after “employers”;

15 (bb) in clause (i), by insert-
16 ing “or any additional individ-
17 uals” after “additional groups”;
18 and

19 (cc) in clause (ii), by strik-
20 ing “without regard to the claims
21 experience of those employers
22 and their employees (and their
23 dependents) or any health status-
24 related factor relating to such”
25 and inserting “and individuals

1 without regard to the claims ex-
2 perience of those individuals, em-
3 ployers and their employees (and
4 their dependents) or any health
5 status-related factor relating to
6 such individuals”; and

7 (ii) in paragraph (2), by striking
8 “small group” and inserting “group or in-
9 dividual”;

10 (C) in subsection (d)—

11 (i) by striking “small group” each
12 place that such appears and inserting
13 “group or individual”; and

14 (ii) in paragraph (1)(B)—

15 (I) by striking “all employers”
16 and inserting “all employers and indi-
17 viduals”;

18 (II) by striking “those employ-
19 ers” and inserting “those individuals,
20 employers”; and

21 (III) by striking “such employ-
22 ees” and inserting “such individuals,
23 employees”;

24 (D) by striking subsection (e);

25 (E) by striking subsection (f); and

1 (F) by transferring such section (as
2 amended by this paragraph) to appear at the
3 end of section 2702 (as added by section
4 1001(4));

5 (9) in section 2732 (42 U.S.C. 300gg-12), as so
6 redesignated by section 1001(3)—

7 (A) by striking the section heading and all
8 that follows through subsection (a);

9 (B) in subsection (b)—

10 (i) in the matter preceding paragraph
11 (1), by striking “group health plan in the
12 small or large group market” and inserting
13 “health insurance coverage offered in the
14 group or individual market”;

15 (ii) in paragraph (1), by inserting “,
16 or individual, as applicable,” after “plan
17 sponsor”;

18 (iii) in paragraph (2), by inserting “,
19 or individual, as applicable,” after “plan
20 sponsor”; and

21 (iv) by striking paragraph (3) and in-
22 serting the following:

23 “(3) VIOLATION OF PARTICIPATION OR CON-
24 TRIBUTION RATES.—In the case of a group health
25 plan, the plan sponsor has failed to comply with a

1 material plan provision relating to employer con-
2 tribution or group participation rules, pursuant to
3 applicable State law.”;

4 (C) in subsection (c)—

5 (i) in paragraph (1)—

6 (I) in the matter preceding sub-
7 paragraph (A), by striking “group
8 health insurance coverage offered in
9 the small or large group market” and
10 inserting “group or individual health
11 insurance coverage”;

12 (II) in subparagraph (A), by in-
13 serting “or individual, as applicable,”
14 after “plan sponsor”;

15 (III) in subparagraph (B)—

16 (aa) by inserting “or indi-
17 vidual, as applicable,” after “plan
18 sponsor”; and

19 (bb) by inserting “or indi-
20 vidual health insurance cov-
21 erage”; and

22 (IV) in subparagraph (C), by in-
23 serting “or individuals, as applicable,”
24 after “those sponsors”; and

25 (ii) in paragraph (2)(A)—

1 (I) in the matter preceding clause
2 (i), by striking “small group market
3 or the large group market, or both
4 markets,” and inserting “individual or
5 group market, or all markets,”; and

6 (II) in clause (i), by inserting “or
7 individual, as applicable,” after “plan
8 sponsor”; and

9 (D) by transferring such section (as
10 amended by this paragraph) to appear at the
11 end of section 2703 (as added by section
12 1001(4));

13 (10) in section 2733 (42 U.S.C. 300gg-13), as
14 so redesignated by section 1001(4)—

15 (A) in subsection (a)—

16 (i) in the matter preceding paragraph
17 (1), by striking “small employer” and in-
18 serting “small employer or an individual”;

19 (ii) in paragraph (1), by inserting “,
20 or individual, as applicable,” after “em-
21 ployer” each place that such appears; and

22 (iii) in paragraph (2), by striking
23 “small employer” and inserting “employer,
24 or individual, as applicable,”;

25 (B) in subsection (b)—

1 (i) in paragraph (1)—

2 (I) in the matter preceding sub-
3 paragraph (A), by striking “small em-
4 ployer” and inserting “employer, or
5 individual, as applicable,”;

6 (II) in subparagraph (A), by add-
7 ing “and” at the end;

8 (III) by striking subparagraphs
9 (B) and (C); and

10 (IV) in subparagraph (D)—

11 (aa) by inserting “, or indi-
12 vidual, as applicable,” after “em-
13 ployer”; and

14 (bb) by redesignating such
15 subparagraph as subparagraph
16 (B);

17 (ii) in paragraph (2)—

18 (I) by striking “small employers”
19 each place that such term appears
20 and inserting “employers, or individ-
21 uals, as applicable,”; and

22 (II) by striking “small employer”
23 and inserting “employer, or indi-
24 vidual, as applicable,”; and

1 (C) by redesignating such section (as
2 amended by this paragraph) as section 2709
3 and transferring such section to appear after
4 section 2708 (as added by section 1001(5));

5 (11) by redesignating subpart 4 as subpart 2;

6 (12) in section 2735 (42 U.S.C. 300gg-21), as
7 so redesignated by section 1001(4)—

8 (A) by striking subsection (a);

9 (B) by striking “subparts 1 through 3”
10 each place that such appears and inserting
11 “subpart 1”;

12 (C) by redesignating subsections (b)
13 through (e) as subsections (a) through (d), re-
14 spectively; and

15 (D) by redesignating such section (as
16 amended by this paragraph) as section 2722;

17 (13) in section 2736 (42 U.S.C. 300gg-22), as
18 so redesignated by section 1001(4)—

19 (A) in subsection (a)—

20 (i) in paragraph (1), by striking
21 “small or large group markets” and insert-
22 ing “individual or group market”; and

23 (ii) in paragraph (2), by inserting “or
24 individual health insurance coverage” after
25 “group health plans”;

1 (B) in subsection (b)(1)(B), by inserting
2 “individual health insurance coverage or” after
3 “respect to”; and

4 (C) by redesignating such section (as
5 amended by this paragraph) as section 2723;

6 (14) in section 2737(a)(1) (42 U.S.C. 300gg-
7 23), as so redesignated by section 1001(4)—

8 (A) by inserting “individual or” before
9 “group health insurance”; and

10 (B) by redesignating such section (as
11 amended by this paragraph) as section 2724;

12 (15) in section 2762 (42 U.S.C. 300gg-62)—

13 (A) in the section heading by inserting
14 “**AND APPLICATION**” before the period; and

15 (B) by adding at the end the following:

16 “(c) APPLICATION OF PART A PROVISIONS.—

17 “(1) IN GENERAL.—The provisions of part A
18 shall apply to health insurance issuers providing
19 health insurance coverage in the individual market
20 in a State as provided for in such part.

21 “(2) CLARIFICATION.—To the extent that any
22 provision of this part conflicts with a provision of
23 part A with respect to health insurance issuers pro-
24 viding health insurance coverage in the individual

1 market in a State, the provisions of such part A
2 shall apply.”; and

3 (16) in section 2791(e) (42 U.S.C. 300gg-
4 91(e))—

5 (A) in paragraph (2), by striking “51” and
6 inserting “101”; and

7 (B) in paragraph (4)—

8 (i) by striking “at least 2” each place
9 that such appears and inserting “at least
10 1”; and

11 (ii) by striking “50” and inserting
12 “100”.

13 (d) APPLICATION.—Notwithstanding any other provi-
14 sion of the Patient Protection and Affordable Care Act,
15 nothing in such Act (or an amendment made by such Act)
16 shall be construed to—

17 (1) prohibit (or authorize the Secretary of
18 Health and Human Services to promulgate regula-
19 tions that prohibit) a group health plan or health in-
20 surance issuer from carrying out utilization manage-
21 ment techniques that are commonly used as of the
22 date of enactment of this Act; or

23 (2) restrict the application of the amendments
24 made by this subtitle.

1 (e) TECHNICAL AMENDMENT TO THE EMPLOYEE
2 RETIREMENT INCOME SECURITY ACT OF 1974.—Subpart
3 B of part 7 of subtitle A of title I of the Employee Retire-
4 ment Income Security Act of 1974 (29 U.S.C. 1181 et.
5 seq.) is amended, by adding at the end the following:

6 **“SEC. 715. ADDITIONAL MARKET REFORMS.**

7 “(a) GENERAL RULE.—Except as provided in sub-
8 section (b)—

9 “(1) the provisions of part A of title XXVII of
10 the Public Health Service Act (as amended by the
11 Patient Protection and Affordable Care Act) shall
12 apply to group health plans, and health insurance
13 issuers providing health insurance coverage in con-
14 nection with group health plans, as if included in
15 this subpart; and

16 “(2) to the extent that any provision of this
17 part conflicts with a provision of such part A with
18 respect to group health plans, or health insurance
19 issuers providing health insurance coverage in con-
20 nection with group health plans, the provisions of
21 such part A shall apply.

22 “(b) EXCEPTION.—Notwithstanding subsection (a),
23 the provisions of sections 2716 and 2718 of title XXVII
24 of the Public Health Service Act (as amended by the Pa-
25 tient Protection and Affordable Care Act) shall not apply

1 with respect to self-insured group health plans, and the
2 provisions of this part shall continue to apply to such
3 plans as if such sections of the Public Health Service Act
4 (as so amended) had not been enacted.”.

5 (f) TECHNICAL AMENDMENT TO THE INTERNAL
6 REVENUE CODE OF 1986.—Subchapter B of chapter 100
7 of the Internal Revenue Code of 1986 is amended by add-
8 ing at the end the following:

9 **“SEC. 9815. ADDITIONAL MARKET REFORMS.**

10 “(a) GENERAL RULE.—Except as provided in sub-
11 section (b)—

12 “(1) the provisions of part A of title XXVII of
13 the Public Health Service Act (as amended by the
14 Patient Protection and Affordable Care Act) shall
15 apply to group health plans, and health insurance
16 issuers providing health insurance coverage in con-
17 nection with group health plans, as if included in
18 this subchapter; and

19 “(2) to the extent that any provision of this
20 subchapter conflicts with a provision of such part A
21 with respect to group health plans, or health insur-
22 ance issuers providing health insurance coverage in
23 connection with group health plans, the provisions of
24 such part A shall apply.

1 “(b) EXCEPTION.—Notwithstanding subsection (a),
 2 the provisions of sections 2716 and 2718 of title XXVII
 3 of the Public Health Service Act (as amended by the Pa-
 4 tient Protection and Affordable Care Act) shall not apply
 5 with respect to self-insured group health plans, and the
 6 provisions of this subchapter shall continue to apply to
 7 such plans as if such sections of the Public Health Service
 8 Act (as so amended) had not been enacted.”.

9 **TITLE II—ROLE OF PUBLIC**
 10 **PROGRAMS**
 11 **Subtitle A—Improved Access to**
 12 **Medicaid**

13 **SEC. 2001. MEDICAID COVERAGE FOR THE LOWEST INCOME**
 14 **POPULATIONS.**

15 (a) COVERAGE FOR INDIVIDUALS WITH INCOME AT
 16 OR BELOW 133 PERCENT OF THE POVERTY LINE.—

17 (1) BEGINNING 2014.—Section
 18 1902(a)(10)(A)(i) of the Social Security Act (42
 19 U.S.C. 1396a) is amended—

20 (A) by striking “or” at the end of sub-
 21 clause (VI);

22 (B) by adding “or” at the end of subclause
 23 (VII); and

24 (C) by inserting after subclause (VII) the
 25 following:

1 “(VIII) beginning January 1,
2 2014, who are under 65 years of age,
3 not pregnant, not entitled to, or en-
4 rolled for, benefits under part A of
5 title XVIII, or enrolled for benefits
6 under part B of title XVIII, and are
7 not described in a previous subclause
8 of this clause, and whose income (as
9 determined under subsection (e)(14))
10 does not exceed 133 percent of the
11 poverty line (as defined in section
12 2110(e)(5)) applicable to a family of
13 the size involved, subject to subsection
14 (k);”.

15 (2) PROVISION OF AT LEAST MINIMUM ESSEN-
16 TIAL COVERAGE.—

17 (A) IN GENERAL.—Section 1902 of such
18 Act (42 U.S.C. 1396a) is amended by inserting
19 after subsection (j) the following:

20 “(k)(1) The medical assistance provided to an indi-
21 vidual described in subclause (VIII) of subsection
22 (a)(10)(A)(i) shall consist of benchmark coverage de-
23 scribed in section 1937(b)(1) or benchmark equivalent
24 coverage described in section 1937(b)(2). Such medical as-
25 sistance shall be provided subject to the requirements of

1 section 1937, without regard to whether a State otherwise
 2 has elected the option to provide medical assistance
 3 through coverage under that section, unless an individual
 4 described in subclause (VIII) of subsection (a)(10)(A)(i)
 5 is also an individual for whom, under subparagraph (B)
 6 of section 1937(a)(2), the State may not require enroll-
 7 ment in benchmark coverage described in subsection
 8 (b)(1) of section 1937 or benchmark equivalent coverage
 9 described in subsection (b)(2) of that section.”.

10 (B) CONFORMING AMENDMENT.—Section
 11 1903(i) of the Social Security Act, as amended
 12 by section 6402(c), is amended—

13 (i) in paragraph (24), by striking “or”
 14 at the end;

15 (ii) in paragraph (25), by striking the
 16 period and inserting “; or”; and

17 (iii) by adding at the end the fol-
 18 lowing:

19 “(26) with respect to any amounts expended for
 20 medical assistance for individuals described in sub-
 21 clause (VIII) of subsection (a)(10)(A)(i) other than
 22 medical assistance provided through benchmark cov-
 23 erage described in section 1937(b)(1) or benchmark
 24 equivalent coverage described in section
 25 1937(b)(2).”.

1 (3) FEDERAL FUNDING FOR COST OF COVERING
2 NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of
3 the Social Security Act (42 U.S.C. 1396d), is
4 amended—

5 (A) in subsection (b), in the first sentence,
6 by inserting “subsection (y) and” before “sec-
7 tion 1933(d)”; and

8 (B) by adding at the end the following new
9 subsection:

10 “(y) INCREASED FMAP FOR MEDICAL ASSISTANCE
11 FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

12 “(1) AMOUNT OF INCREASE.—

13 “(A) 100 PERCENT FMAP.—During the pe-
14 riod that begins on January 1, 2014, and ends
15 on December 31, 2016, notwithstanding sub-
16 section (b), the Federal medical assistance per-
17 centage determined for a State that is one of
18 the 50 States or the District of Columbia for
19 each fiscal year occurring during that period
20 with respect to amounts expended for medical
21 assistance for newly eligible individuals de-
22 scribed in subclause (VIII) of section
23 1902(a)(10)(A)(i) shall be equal to 100 percent.

24 “(B) 2017 AND 2018.—

1 “(i) IN GENERAL.—During the period
 2 that begins on January 1, 2017, and ends
 3 on December 31, 2018, notwithstanding
 4 subsection (b) and subject to subparagraph
 5 (D), the Federal medical assistance per-
 6 centage determined for a State that is one
 7 of the 50 States or the District of Colum-
 8 bia for each fiscal year occurring during
 9 that period with respect to amounts ex-
 10 pended for medical assistance for newly eli-
 11 gible individuals described in subclause
 12 (VIII) of section 1902(a)(10)(A)(i), shall
 13 be increased by the applicable percentage
 14 point increase specified in clause (ii) for
 15 the quarter and the State.

16 “(ii) APPLICABLE PERCENTAGE POINT
 17 INCREASE.—

18 “(I) IN GENERAL.—For purposes
 19 of clause (i), the applicable percentage
 20 point increase for a quarter is the fol-
 21 lowing:

“For any fiscal year quarter occurring in the calendar year:	If the State is an ex- pansion State, the applicable percent- age point increase is:	If the State is not an expansion State, the applicable percent- age point increase is:
2017	30.3	34.3
2018	31.3	33.3

1 “(II) EXPANSION STATE DE-
2 FINED.—For purposes of the table in
3 subclause (I), a State is an expansion
4 State if, on the date of the enactment
5 of the Patient Protection and Afford-
6 able Care Act, the State offers health
7 benefits coverage statewide to parents
8 and nonpregnant, childless adults
9 whose income is at least 100 percent
10 of the poverty line, that is not depend-
11 ent on access to employer coverage,
12 employer contribution, or employment
13 and is not limited to premium assist-
14 ance, hospital-only benefits, a high de-
15 ductible health plan, or alternative
16 benefits under a demonstration pro-
17 gram authorized under section 1938.
18 A State that offers health benefits
19 coverage to only parents or only non-
20 pregnant childless adults described in
21 the preceding sentence shall not be
22 considered to be an expansion State.

23 “(C) 2019 AND SUCCEEDING YEARS.—Be-
24 ginning January 1, 2019, notwithstanding sub-
25 section (b) but subject to subparagraph (D),

1 the Federal medical assistance percentage de-
2 termined for a State that is one of the 50
3 States or the District of Columbia for each fis-
4 cal year quarter occurring during that period
5 with respect to amounts expended for medical
6 assistance for newly eligible individuals de-
7 scribed in subclause (VIII) of section
8 1902(a)(10)(A)(i), shall be increased by 32.3
9 percentage points.

10 “(D) LIMITATION.—The Federal medical
11 assistance percentage determined for a State
12 under subparagraph (B) or (C) shall in no case
13 be more than 95 percent.

14 “(2) DEFINITIONS.—In this subsection:

15 “(A) NEWLY ELIGIBLE.—The term ‘newly
16 eligible’ means, with respect to an individual de-
17 scribed in subclause (VIII) of section
18 1902(a)(10)(A)(i), an individual who is not
19 under 19 years of age (or such higher age as
20 the State may have elected) and who, on the
21 date of enactment of the Patient Protection and
22 Affordable Care Act, is not eligible under the
23 State plan or under a waiver of the plan for full
24 benefits or for benchmark coverage described in
25 subparagraph (A), (B), or (C) of section

1 1937(b)(1) or benchmark equivalent coverage
2 described in section 1937(b)(2) that has an ag-
3 gregate actuarial value that is at least actuari-
4 ally equivalent to benchmark coverage described
5 in subparagraph (A), (B), or (C) of section
6 1937(b)(1), or is eligible but not enrolled (or is
7 on a waiting list) for such benefits or coverage
8 through a waiver under the plan that has a
9 capped or limited enrollment that is full.

10 “(B) FULL BENEFITS.—The term ‘full
11 benefits’ means, with respect to an individual,
12 medical assistance for all services covered under
13 the State plan under this title that is not less
14 in amount, duration, or scope, or is determined
15 by the Secretary to be substantially equivalent,
16 to the medical assistance available for an indi-
17 vidual described in section 1902(a)(10)(A)(i).”.

18 (4) STATE OPTIONS TO OFFER COVERAGE EAR-
19 LIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN
20 REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE
21 ELIGIBLE.—

22 (A) IN GENERAL.—Subsection (k) of sec-
23 tion 1902 of the Social Security Act (as added
24 by paragraph (2)), is amended by inserting
25 after paragraph (1) the following:

1 “(2) Beginning with the first day of any fiscal year
2 quarter that begins on or after January 1, 2011, and be-
3 fore January 1, 2014, a State may elect through a State
4 plan amendment to provide medical assistance to individ-
5 uals who would be described in subclause (VIII) of sub-
6 section (a)(10)(A)(i) if that subclause were effective before
7 January 1, 2014. A State may elect to phase-in the exten-
8 sion of eligibility for medical assistance to such individuals
9 based on income, so long as the State does not extend
10 such eligibility to individuals described in such subclause
11 with higher income before making individuals described in
12 such subclause with lower income eligible for medical as-
13 sistance.

14 “(3) If an individual described in subclause (VIII) of
15 subsection (a)(10)(A)(i) is the parent of a child who is
16 under 19 years of age (or such higher age as the State
17 may have elected) who is eligible for medical assistance
18 under the State plan or under a waiver of such plan
19 (under that subclause or under a State plan amendment
20 under paragraph (2), the individual may not be enrolled
21 under the State plan unless the individual’s child is en-
22 rolled under the State plan or under a waiver of the plan
23 or is enrolled in other health insurance coverage. For pur-
24 poses of the preceding sentence, the term ‘parent’ includes

1 an individual treated as a caretaker relative for purposes
2 of carrying out section 1931.”.

3 (B) PRESUMPTIVE ELIGIBILITY.—Section
4 1920 of the Social Security Act (42 U.S.C.
5 1396r–1) is amended by adding at the end the
6 following:

7 “(e) If the State has elected the option to provide
8 a presumptive eligibility period under this section or sec-
9 tion 1920A, the State may elect to provide a presumptive
10 eligibility period (as defined in subsection (b)(1)) for indi-
11 viduals who are eligible for medical assistance under
12 clause (i)(VIII) of subsection (a)(10)(A) or section 1931
13 in the same manner as the State provides for such a pe-
14 riod under this section or section 1920A, subject to such
15 guidance as the Secretary shall establish.”.

16 (5) CONFORMING AMENDMENTS.—

17 (A) Section 1902(a)(10) of such Act (42
18 U.S.C. 1396a(a)(10)) is amended in the matter
19 following subparagraph (G), by striking “and
20 (XIV)” and inserting “(XIV)” and by inserting
21 “and (XV) the medical assistance made avail-
22 able to an individual described in subparagraph
23 (A)(i)(VIII) shall be limited to medical assist-
24 ance described in subsection (k)(1)” before the
25 semicolon.

1 (B) Section 1902(l)(2)(C) of such Act (42
2 U.S.C. 1396a(l)(2)(C)) is amended by striking
3 “100” and inserting “133”.

4 (C) Section 1905(a) of such Act (42
5 U.S.C. 1396d(a)) is amended in the matter pre-
6 ceding paragraph (1)—

7 (i) by striking “or” at the end of
8 clause (xii);

9 (ii) by inserting “or” at the end of
10 clause (xiii); and

11 (iii) by inserting after clause (xiii) the
12 following:

13 “(xiv) individuals described in section
14 1902(a)(10)(A)(i)(VIII),”.

15 (D) Section 1903(f)(4) of such Act (42
16 U.S.C. 1396b(f)(4)) is amended by inserting
17 “1902(a)(10)(A)(i)(VIII),” after
18 “1902(a)(10)(A)(i)(VII),”.

19 (E) Section 1937(a)(1)(B) of such Act (42
20 U.S.C. 1396u-7(a)(1)(B)) is amended by in-
21 serting “subclause (VIII) of section
22 1902(a)(10)(A)(i) or under” after “eligible
23 under”.

1 (b) MAINTENANCE OF MEDICAID INCOME ELIGI-
2 BILITY.—Section 1902 of the Social Security Act (42
3 U.S.C. 1396a) is amended—

4 (1) in subsection (a)—

5 (A) by striking “and” at the end of para-
6 graph (72);

7 (B) by striking the period at the end of
8 paragraph (73) and inserting “; and”; and

9 (C) by inserting after paragraph (73) the
10 following new paragraph:

11 “(74) provide for maintenance of effort under
12 the State plan or under any waiver of the plan in
13 accordance with subsection (gg).”; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(gg) MAINTENANCE OF EFFORT.—

17 “(1) GENERAL REQUIREMENT TO MAINTAIN
18 ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS
19 FULLY OPERATIONAL.—Subject to the succeeding
20 paragraphs of this subsection, during the period that
21 begins on the date of enactment of the Patient Pro-
22 tection and Affordable Care Act and ends on the
23 date on which the Secretary determines that an Ex-
24 change established by the State under section 1311
25 of the Patient Protection and Affordable Care Act is

1 fully operational, as a condition for receiving any
2 Federal payments under section 1903(a) for cal-
3 endar quarters occurring during such period, a State
4 shall not have in effect eligibility standards, meth-
5 odologies, or procedures under the State plan under
6 this title or under any waiver of such plan that is
7 in effect during that period, that are more restrictive
8 than the eligibility standards, methodologies, or pro-
9 cedures, respectively, under the plan or waiver that
10 are in effect on the date of enactment of the Patient
11 Protection and Affordable Care Act.

12 “(2) CONTINUATION OF ELIGIBILITY STAND-
13 ARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The
14 requirement under paragraph (1) shall continue to
15 apply to a State through September 30, 2019, with
16 respect to the eligibility standards, methodologies,
17 and procedures under the State plan under this title
18 or under any waiver of such plan that are applicable
19 to determining the eligibility for medical assistance
20 of any child who is under 19 years of age (or such
21 higher age as the State may have elected).

22 “(3) NONAPPLICATION.—During the period
23 that begins on January 1, 2011, and ends on De-
24 cember 31, 2013, the requirement under paragraph
25 (1) shall not apply to a State with respect to non-

1 pregnant, nondisabled adults who are eligible for
2 medical assistance under the State plan or under a
3 waiver of the plan at the option of the State and
4 whose income exceeds 133 percent of the poverty
5 line (as defined in section 2110(c)(5)) applicable to
6 a family of the size involved if, on or after December
7 31, 2010, the State certifies to the Secretary that,
8 with respect to the State fiscal year during which
9 the certification is made, the State has a budget def-
10 icit, or with respect to the succeeding State fiscal
11 year, the State is projected to have a budget deficit.
12 Upon submission of such a certification to the Sec-
13 retary, the requirement under paragraph (1) shall
14 not apply to the State with respect to any remaining
15 portion of the period described in the preceding sen-
16 tence.

17 “(4) DETERMINATION OF COMPLIANCE.—

18 “(A) STATES SHALL APPLY MODIFIED
19 GROSS INCOME.—A State’s determination of in-
20 come in accordance with subsection (e)(14)
21 shall not be considered to be eligibility stand-
22 ards, methodologies, or procedures that are
23 more restrictive than the standards, methodolo-
24 gies, or procedures in effect under the State
25 plan or under a waiver of the plan on the date

1 of enactment of the Patient Protection and Af-
2 fordable Care Act for purposes of determining
3 compliance with the requirements of paragraph
4 (1), (2), or (3).

5 “(B) STATES MAY EXPAND ELIGIBILITY OR
6 MOVE WAIVERED POPULATIONS INTO COVERAGE
7 UNDER THE STATE PLAN.—With respect to any
8 period applicable under paragraph (1), (2), or
9 (3), a State that applies eligibility standards,
10 methodologies, or procedures under the State
11 plan under this title or under any waiver of the
12 plan that are less restrictive than the eligibility
13 standards, methodologies, or procedures, ap-
14 plied under the State plan or under a waiver of
15 the plan on the date of enactment of the Pa-
16 tient Protection and Affordable Care Act, or
17 that makes individuals who, on such date of en-
18 actment, are eligible for medical assistance
19 under a waiver of the State plan, after such
20 date of enactment eligible for medical assistance
21 through a State plan amendment with an in-
22 come eligibility level that is not less than the in-
23 come eligibility level that applied under the
24 waiver, or as a result of the application of sub-
25 clause (VIII) of section 1902(a)(10)(A)(i), shall

1 not be considered to have in effect eligibility
2 standards, methodologies, or procedures that
3 are more restrictive than the standards, meth-
4 odologies, or procedures in effect under the
5 State plan or under a waiver of the plan on the
6 date of enactment of the Patient Protection and
7 Affordable Care Act for purposes of deter-
8 mining compliance with the requirements of
9 paragraph (1), (2), or (3).”.

10 (c) MEDICAID BENCHMARK BENEFITS MUST CON-
11 SIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—
12 Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is
13 amended—

14 (1) in paragraph (1), in the matter preceding
15 subparagraph (A), by inserting “subject to para-
16 graphs (5) and (6),” before “each”;

17 (2) in paragraph (2)—

18 (A) in the matter preceding subparagraph
19 (A), by inserting “subject to paragraphs (5)
20 and (6)” after “subsection (a)(1),”;

21 (B) in subparagraph (A)—

22 (i) by redesignating clauses (iv) and
23 (v) as clauses (vi) and (vii), respectively;
24 and

1 (ii) by inserting after clause (iii), the
2 following:

3 “(iv) Coverage of prescription drugs.

4 “(v) Mental health services.”; and

5 (C) in subparagraph (C)—

6 (i) by striking clauses (i) and (ii); and

7 (ii) by redesignating clauses (iii) and

8 (iv) as clauses (i) and (ii), respectively; and

9 (3) by adding at the end the following new
10 paragraphs:

11 “(5) MINIMUM STANDARDS.—Effective January
12 1, 2014, any benchmark benefit package under para-
13 graph (1) or benchmark equivalent coverage under
14 paragraph (2) must provide at least essential health
15 benefits as described in section 1302(b) of the Pa-
16 tient Protection and Affordable Care Act.

17 “(6) MENTAL HEALTH SERVICES PARITY.—

18 “(A) IN GENERAL.—In the case of any
19 benchmark benefit package under paragraph
20 (1) or benchmark equivalent coverage under
21 paragraph (2) that is offered by an entity that
22 is not a medicaid managed care organization
23 and that provides both medical and surgical
24 benefits and mental health or substance use dis-
25 order benefits, the entity shall ensure that the

1 financial requirements and treatment limita-
2 tions applicable to such mental health or sub-
3 stance use disorder benefits comply with the re-
4 quirements of section 2705(a) of the Public
5 Health Service Act in the same manner as such
6 requirements apply to a group health plan.

7 “(B) DEEMED COMPLIANCE.—Coverage
8 provided with respect to an individual described
9 in section 1905(a)(4)(B) and covered under the
10 State plan under section 1902(a)(10)(A) of the
11 services described in section 1905(a)(4)(B) (re-
12 lating to early and periodic screening, diag-
13 nostic, and treatment services defined in section
14 1905(r)) and provided in accordance with sec-
15 tion 1902(a)(43), shall be deemed to satisfy the
16 requirements of subparagraph (A).”.

17 (d) ANNUAL REPORTS ON MEDICAID ENROLL-
18 MENT.—

19 (1) STATE REPORTS.—Section 1902(a) of the
20 Social Security Act (42 U.S.C. 1396a(a)), as amend-
21 ed by subsection (b), is amended—

22 (A) by striking “and” at the end of para-
23 graph (73);

24 (B) by striking the period at the end of
25 paragraph (74) and inserting “; and”; and

1 (C) by inserting after paragraph (74) the
2 following new paragraph:

3 “(75) provide that, beginning January 2015,
4 and annually thereafter, the State shall submit a re-
5 port to the Secretary that contains—

6 “(A) the total number of enrolled and
7 newly enrolled individuals in the State plan or
8 under a waiver of the plan for the fiscal year
9 ending on September 30 of the preceding cal-
10 endar year, disaggregated by population, includ-
11 ing children, parents, nonpregnant childless
12 adults, disabled individuals, elderly individuals,
13 and such other categories or sub-categories of
14 individuals eligible for medical assistance under
15 the State plan or under a waiver of the plan as
16 the Secretary may require;

17 “(B) a description, which may be specified
18 by population, of the outreach and enrollment
19 processes used by the State during such fiscal
20 year; and

21 “(C) any other data reporting determined
22 necessary by the Secretary to monitor enroll-
23 ment and retention of individuals eligible for
24 medical assistance under the State plan or
25 under a waiver of the plan.”.

1 (2) REPORTS TO CONGRESS.—Beginning April
2 2015, and annually thereafter, the Secretary of
3 Health and Human Services shall submit a report to
4 the appropriate committees of Congress on the total
5 enrollment and new enrollment in Medicaid for the
6 fiscal year ending on September 30 of the preceding
7 calendar year on a national and State-by-State
8 basis, and shall include in each such report such rec-
9 ommendations for administrative or legislative
10 changes to improve enrollment in the Medicaid pro-
11 gram as the Secretary determines appropriate.

12 (e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS
13 WITH INCOME THAT EXCEEDS 133 PERCENT OF THE
14 POVERTY LINE.—

15 (1) COVERAGE AS OPTIONAL CATEGORICALLY
16 NEEDY GROUP.—Section 1902 of the Social Security
17 Act (42 U.S.C. 1396a) is amended—

18 (A) in subsection (a)(10)(A)(ii)—

19 (i) in subclause (XVIII), by striking
20 “or” at the end;

21 (ii) in subclause (XIX), by adding
22 “or” at the end; and

23 (iii) by adding at the end the fol-
24 lowing new subclause:

1 “(XX) beginning January 1,
2 2014, who are under 65 years of age
3 and are not described in or enrolled
4 under a previous subclause of this
5 clause, and whose income (as deter-
6 mined under subsection (e)(14)) ex-
7 ceeds 133 percent of the poverty line
8 (as defined in section 2110(c)(5)) ap-
9 plicable to a family of the size in-
10 volved but does not exceed the highest
11 income eligibility level established
12 under the State plan or under a waiv-
13 er of the plan, subject to subsection
14 (hh);” and

15 (B) by adding at the end the following new
16 subsection:

17 “(hh)(1) A State may elect to phase-in the extension
18 of eligibility for medical assistance to individuals described
19 in subclause (XX) of subsection (a)(10)(A)(ii) based on
20 the categorical group (including nonpregnant childless
21 adults) or income, so long as the State does not extend
22 such eligibility to individuals described in such subclause
23 with higher income before making individuals described in
24 such subclause with lower income eligible for medical as-
25 sistance.

1 “(2) If an individual described in subclause (XX) of
2 subsection (a)(10)(A)(ii) is the parent of a child who is
3 under 19 years of age (or such higher age as the State
4 may have elected) who is eligible for medical assistance
5 under the State plan or under a waiver of such plan, the
6 individual may not be enrolled under the State plan unless
7 the individual’s child is enrolled under the State plan or
8 under a waiver of the plan or is enrolled in other health
9 insurance coverage. For purposes of the preceding sen-
10 tence, the term ‘parent’ includes an individual treated as
11 a caretaker relative for purposes of carrying out section
12 1931.”.

13 (2) CONFORMING AMENDMENTS.—

14 (A) Section 1905(a) of such Act (42
15 U.S.C. 1396d(a)), as amended by subsection
16 (a)(5)(C), is amended in the matter preceding
17 paragraph (1)—

18 (i) by striking “or” at the end of
19 clause (xiii);

20 (ii) by inserting “or” at the end of
21 clause (xiv); and

22 (iii) by inserting after clause (xiv) the
23 following:

24 “(xv) individuals described in section
25 1902(a)(10)(A)(ii)(XX).”.

1 (B) Section 1903(f)(4) of such Act (42
 2 U.S.C. 1396b(f)(4)) is amended by inserting
 3 “1902(a)(10)(A)(ii)(XX),” after
 4 “1902(a)(10)(A)(ii)(XIX),”.

5 (C) Section 1920(e) of such Act (42
 6 U.S.C. 1396r-1(e)), as added by subsection
 7 (a)(4)(B), is amended by inserting “or clause
 8 (ii)(XX)” after “clause (i)(VIII)”.

9 **SEC. 2002. INCOME ELIGIBILITY FOR NONELDERLY DETER-**
 10 **MINED USING MODIFIED GROSS INCOME.**

11 (a) IN GENERAL.—Section 1902(e) of the Social Se-
 12 curity Act (42 U.S.C. 1396a(e)) is amended by adding at
 13 the end the following:

14 “(14) INCOME DETERMINED USING MODIFIED
 15 GROSS INCOME.—

16 “(A) IN GENERAL.—Notwithstanding sub-
 17 section (r) or any other provision of this title,
 18 except as provided in subparagraph (D), for
 19 purposes of determining income eligibility for
 20 medical assistance under the State plan or
 21 under any waiver of such plan and for any
 22 other purpose applicable under the plan or
 23 waiver for which a determination of income is
 24 required, including with respect to the imposi-
 25 tion of premiums and cost-sharing, a State

1 shall use the modified gross income of an indi-
2 vidual and, in the case of an individual in a
3 family greater than 1, the household income of
4 such family. A State shall establish income eli-
5 gibility thresholds for populations to be eligible
6 for medical assistance under the State plan or
7 a waiver of the plan using modified gross in-
8 come and household income that are not less
9 than the effective income eligibility levels that
10 applied under the State plan or waiver on the
11 date of enactment of the Patient Protection and
12 Affordable Care Act. For purposes of complying
13 with the maintenance of effort requirements
14 under subsection (gg) during the transition to
15 modified gross income and household income, a
16 State shall, working with the Secretary, estab-
17 lish an equivalent income test that ensures indi-
18 viduals eligible for medical assistance under the
19 State plan or under a waiver of the plan on the
20 date of enactment of the Patient Protection and
21 Affordable Care Act, do not lose coverage under
22 the State plan or under a waiver of the plan.
23 The Secretary may waive such provisions of this
24 title and title XXI as are necessary to ensure

1 that States establish income and eligibility de-
2 termination systems that protect beneficiaries.

3 “(B) NO INCOME OR EXPENSE DIS-
4 REGARDS.—No type of expense, block, or other
5 income disregard shall be applied by a State to
6 determine income eligibility for medical assist-
7 ance under the State plan or under any waiver
8 of such plan or for any other purpose applicable
9 under the plan or waiver for which a determina-
10 tion of income is required.

11 “(C) NO ASSETS TEST.—A State shall not
12 apply any assets or resources test for purposes
13 of determining eligibility for medical assistance
14 under the State plan or under a waiver of the
15 plan.

16 “(D) EXCEPTIONS.—

17 “(i) INDIVIDUALS ELIGIBLE BECAUSE
18 OF OTHER AID OR ASSISTANCE, ELDERLY
19 INDIVIDUALS, MEDICALLY NEEDY INDIVID-
20 UALS, AND INDIVIDUALS ELIGIBLE FOR
21 MEDICARE COST-SHARING.—Subpara-
22 graphs (A), (B), and (C) shall not apply to
23 the determination of eligibility under the
24 State plan or under a waiver for medical
25 assistance for the following:

1 “(I) Individuals who are eligible
2 for medical assistance under the State
3 plan or under a waiver of the plan on
4 a basis that does not require a deter-
5 mination of income by the State agen-
6 cy administering the State plan or
7 waiver, including as a result of eligi-
8 bility for, or receipt of, other Federal
9 or State aid or assistance, individuals
10 who are eligible on the basis of receiv-
11 ing (or being treated as if receiving)
12 supplemental security income benefits
13 under title XVI, and individuals who
14 are eligible as a result of being or
15 being deemed to be a child in foster
16 care under the responsibility of the
17 State.

18 “(II) Individuals who have at-
19 tained age 65.

20 “(III) Individuals who qualify for
21 medical assistance under the State
22 plan or under any waiver of such plan
23 on the basis of being blind or disabled
24 (or being treated as being blind or
25 disabled) without regard to whether

1 the individual is eligible for supple-
2 mental security income benefits under
3 title XVI on the basis of being blind
4 or disabled and including an indi-
5 vidual who is eligible for medical as-
6 sistance on the basis of section
7 1902(e)(3).

8 “(IV) Individuals described in
9 subsection (a)(10)(C).

10 “(V) Individuals described in any
11 clause of subsection (a)(10)(E).

12 “(ii) EXPRESS LANE AGENCY FIND-
13 INGS.—In the case of a State that elects
14 the Express Lane option under paragraph
15 (13), notwithstanding subparagraphs (A),
16 (B), and (C), the State may rely on a find-
17 ing made by an Express Lane agency in
18 accordance with that paragraph relating to
19 the income of an individual for purposes of
20 determining the individual’s eligibility for
21 medical assistance under the State plan or
22 under a waiver of the plan.

23 “(iii) MEDICARE PRESCRIPTION DRUG
24 SUBSIDIES DETERMINATIONS.—Subpara-
25 graphs (A), (B), and (C) shall not apply to

1 any determinations of eligibility for pre-
2 mium and cost-sharing subsidies under
3 and in accordance with section 1860D–14
4 made by the State pursuant to section
5 1935(a)(2).

6 “(iv) LONG-TERM CARE.—Subpara-
7 graphs (A), (B), and (C) shall not apply to
8 any determinations of eligibility of individ-
9 uals for purposes of medical assistance for
10 nursing facility services, a level of care in
11 any institution equivalent to that of nurs-
12 ing facility services, home or community-
13 based services furnished under a waiver or
14 State plan amendment under section 1915
15 or a waiver under section 1115, and serv-
16 ices described in section 1917(c)(1)(C)(ii).

17 “(v) GRANDFATHER OF CURRENT EN-
18 ROLLEES UNTIL DATE OF NEXT REGULAR
19 REDETERMINATION.—An individual who,
20 on January 1, 2014, is enrolled in the
21 State plan or under a waiver of the plan
22 and who would be determined ineligible for
23 medical assistance solely because of the ap-
24 plication of the modified gross income or
25 household income standard described in

1 subparagraph (A), shall remain eligible for
2 medical assistance under the State plan or
3 waiver (and subject to the same premiums
4 and cost-sharing as applied to the indi-
5 vidual on that date) through March 31,
6 2014, or the date on which the individual's
7 next regularly scheduled redetermination of
8 eligibility is to occur, whichever is later.

9 “(E) TRANSITION PLANNING AND OVER-
10 SIGHT.—Each State shall submit to the Sec-
11 retary for the Secretary's approval the income
12 eligibility thresholds proposed to be established
13 using modified gross income and household in-
14 come, the methodologies and procedures to be
15 used to determine income eligibility using modi-
16 fied gross income and household income and, if
17 applicable, a State plan amendment establishing
18 an optional eligibility category under subsection
19 (a)(10)(A)(ii)(XX). To the extent practicable,
20 the State shall use the same methodologies and
21 procedures for purposes of making such deter-
22 minations as the State used on the date of en-
23 actment of the Patient Protection and Afford-
24 able Care Act. The Secretary shall ensure that
25 the income eligibility thresholds proposed to be

1 established using modified gross income and
2 household income, including under the eligibility
3 category established under subsection
4 (a)(10)(A)(ii)(XX), and the methodologies and
5 procedures proposed to be used to determine in-
6 come eligibility, will not result in children who
7 would have been eligible for medical assistance
8 under the State plan or under a waiver of the
9 plan on the date of enactment of the Patient
10 Protection and Affordable Care Act no longer
11 being eligible for such assistance.

12 “(F) LIMITATION ON SECRETARIAL AU-
13 THORITY.—The Secretary shall not waive com-
14 pliance with the requirements of this paragraph
15 except to the extent necessary to permit a State
16 to coordinate eligibility requirements for dual
17 eligible individuals (as defined in section
18 1915(h)(2)(B)) under the State plan or under
19 a waiver of the plan and under title XVIII and
20 individuals who require the level of care pro-
21 vided in a hospital, a nursing facility, or an in-
22 termediate care facility for the mentally re-
23 tarded.

24 “(G) DEFINITIONS OF MODIFIED GROSS
25 INCOME AND HOUSEHOLD INCOME.—In this

1 paragraph, the terms ‘modified gross income’
2 and ‘household income’ have the meanings
3 given such terms in section 36B(d)(2) of the
4 Internal Revenue Code of 1986.

5 “(H) CONTINUED APPLICATION OF MED-
6 ICAID RULES REGARDING POINT-IN-TIME IN-
7 COME AND SOURCES OF INCOME.—The require-
8 ment under this paragraph for States to use
9 modified gross income and household income to
10 determine income eligibility for medical assist-
11 ance under the State plan or under any waiver
12 of such plan and for any other purpose applica-
13 ble under the plan or waiver for which a deter-
14 mination of income is required shall not be con-
15 strued as affecting or limiting the application
16 of—

17 “(i) the requirement under this title
18 and under the State plan or a waiver of
19 the plan to determine an individual’s in-
20 come as of the point in time at which an
21 application for medical assistance under
22 the State plan or a waiver of the plan is
23 processed; or

24 “(ii) any rules established under this
25 title or under the State plan or a waiver of

1 the plan regarding sources of countable in-
2 come.”.

3 (b) CONFORMING AMENDMENT.—Section
4 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is
5 amended by inserting “(e)(14),” before “(l)(3)”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 subsections (a) and (b) take effect on January 1, 2014.

8 **SEC. 2003. REQUIREMENT TO OFFER PREMIUM ASSIST-**
9 **ANCE FOR EMPLOYER-SPONSORED INSUR-**
10 **ANCE.**

11 (a) IN GENERAL.—Section 1906A of such Act (42
12 U.S.C. 1396e–1) is amended—

13 (1) in subsection (a)—

14 (A) by striking “may elect to” and insert-
15 ing “shall”;

16 (B) by striking “under age 19”; and

17 (C) by inserting “, in the case of an indi-
18 vidual under age 19,” after “(and”;

19 (2) in subsection (c), in the first sentence, by
20 striking “under age 19”; and

21 (3) in subsection (d)—

22 (A) in paragraph (2)—

23 (i) in the first sentence, by striking
24 “under age 19”; and

1 (ii) by striking the third sentence and
2 inserting “A State may not require, as a
3 condition of an individual (or the individ-
4 ual’s parent) being or remaining eligible
5 for medical assistance under this title, that
6 the individual (or the individual’s parent)
7 apply for enrollment in qualified employer-
8 sponsored coverage under this section.”;
9 and

10 (B) in paragraph (3), by striking “the par-
11 ent of an individual under age 19” and insert-
12 ing “an individual (or the parent of an indi-
13 vidual)”;

14 (4) in subsection (e), by striking “under age
15 19” each place it appears.

16 (b) CONFORMING AMENDMENT.—The heading for
17 section 1906A of such Act (42 U.S.C. 1396e–1) is amend-
18 ed by striking “OPTION FOR CHILDREN”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section take effect on January 1, 2014.

21 **SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER**
22 **CARE CHILDREN.**

23 (a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the
24 Social Security Act (42 U.S.C. 1396a), as amended by
25 section 2001(a)(1), is amended—

1 (1) by striking “or” at the end of subclause
2 (VII);

3 (2) by adding “or” at the end of subclause
4 (VIII); and

5 (3) by inserting after subclause (VIII) the fol-
6 lowing:

7 “(IX) who were in foster care
8 under the responsibility of a State for
9 more than 6 months (whether or not
10 consecutive) but are no longer in such
11 care, who are not described in any of
12 subclauses (I) through (VII) of this
13 clause, and who are under 25 years of
14 age;”.

15 (b) OPTION TO PROVIDE PRESUMPTIVE ELIGI-
16 BILITY.—Section 1920(e) of such Act (42 U.S.C. 1396r-
17 1(e)), as added by section 2001(a)(4)(B) and amended by
18 section 2001(e)(2)(C), is amended by inserting “, clause
19 (i)(IX),” after “clause (i)(VIII)”.

20 (c) CONFORMING AMENDMENTS.—

21 (1) Section 1903(f)(4) of such Act (42 U.S.C.
22 1396b(f)(4)), as amended by section 2001(a)(5)(D),
23 is amended by inserting “1902(a)(10)(A)(i)(IX),”
24 after “1902(a)(10)(A)(i)(VIII),”.

1 (2) Section 1937(a)(2)(B)(viii) of such Act (42
2 U.S.C. 1396u-7(a)(2)(B)(viii)) is amended by in-
3 serting “, or the individual qualifies for medical as-
4 sistance on the basis of section
5 1902(a)(10)(A)(i)(IX)” before the period.

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section take effect on January 1, 2019.

8 **SEC. 2005. PAYMENTS TO TERRITORIES.**

9 (a) INCREASE IN LIMIT ON PAYMENTS.—Section
10 1108(g) of the Social Security Act (42 U.S.C. 1308(g))
11 is amended—

12 (1) in paragraph (2), in the matter preceding
13 subparagraph (A), by striking “paragraph (3)” and
14 inserting “paragraphs (3) and (5)”;

15 (2) in paragraph (4), by striking “and (3)” and
16 inserting “(3), and (4)”; and

17 (3) by adding at the end the following para-
18 graph:

19 “(5) FISCAL YEAR 2011 AND THEREAFTER.—
20 The amounts otherwise determined under this sub-
21 section for Puerto Rico, the Virgin Islands, Guam,
22 the Northern Mariana Islands, and American Samoa
23 for the second, third, and fourth quarters of fiscal
24 year 2011, and for each fiscal year after fiscal year
25 2011 (after the application of subsection (f) and the

1 preceding paragraphs of this subsection), shall be in-
2 creased by 30 percent.”.

3 (b) DISREGARD OF PAYMENTS FOR MANDATORY EX-
4 PANDED ENROLLMENT.—Section 1108(g)(4) of such Act
5 (42 U.S.C. 1308(g)(4)) is amended—

6 (1) by striking “to fiscal years beginning” and
7 inserting “to—

8 “(A) fiscal years beginning”;

9 (2) by striking the period at the end and insert-
10 ing “; and”; and

11 (3) by adding at the end the following:

12 “(B) fiscal years beginning with fiscal year
13 2014, payments made to Puerto Rico, the Vir-
14 gin Islands, Guam, the Northern Mariana Is-
15 lands, or American Samoa with respect to
16 amounts expended for medical assistance for
17 newly eligible (as defined in section 1905(y)(2))
18 nonpregnant childless adults who are eligible
19 under subclause (VIII) of section
20 1902(a)(10)(A)(i) and whose income (as deter-
21 mined under section 1902(e)(14)) does not ex-
22 ceed (in the case of each such commonwealth
23 and territory respectively) the income eligibility
24 level in effect for that population under title
25 XIX or under a waiver on the date of enact-

1 ment of the Patient Protection and Affordable
 2 Care Act, shall not be taken into account in ap-
 3 plying subsection (f) (as increased in accord-
 4 ance with paragraphs (1), (2), (3), and (5) of
 5 this subsection) to such commonwealth or terri-
 6 tory for such fiscal year.”.

7 (c) INCREASED FMAP.—

8 (1) IN GENERAL.—The first sentence of section
 9 1905(b) of the Social Security Act (42 U.S.C.
 10 1396d(b)) is amended by striking “shall be 50 per
 11 centum” and inserting “shall be 55 percent”.

12 (2) EFFECTIVE DATE.—The amendment made
 13 by paragraph (1) takes effect on January 1, 2011.

14 **SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINA-**
 15 **TION FOR CERTAIN STATES RECOVERING**
 16 **FROM A MAJOR DISASTER.**

17 Section 1905 of the Social Security Act (42 U.S.C.
 18 1396d), as amended by sections 2001(a)(3) and
 19 2001(b)(2), is amended—

20 (1) in subsection (b), in the first sentence, by
 21 striking “subsection (y)” and inserting “subsections
 22 (y) and (aa)”; and

23 (2) by adding at the end the following new sub-
 24 section:

1 “(aa)(1) Notwithstanding subsection (b), beginning
2 January 1, 2011, the Federal medical assistance percent-
3 age for a fiscal year for a disaster-recovery FMAP adjust-
4 ment State shall be equal to the following:

5 “(A) In the case of the first fiscal year (or part
6 of a fiscal year) for which this subsection applies to
7 the State, the Federal medical assistance percentage
8 determined for the fiscal year without regard to this
9 subsection and subsection (y), increased by 50 per-
10 cent of the number of percentage points by which
11 the Federal medical assistance percentage deter-
12 mined for the State for the fiscal year without re-
13 gard to this subsection and subsection (y), is less
14 than the Federal medical assistance percentage de-
15 termined for the State for the preceding fiscal year
16 after the application of only subsection (a) of section
17 5001 of Public Law 111–5 (if applicable to the pre-
18 ceding fiscal year) and without regard to this sub-
19 section, subsection (y), and subsections (b) and (c)
20 of section 5001 of Public Law 111–5.

21 “(B) In the case of the second or any suc-
22 ceeding fiscal year for which this subsection applies
23 to the State, the Federal medical assistance percent-
24 age determined for the preceding fiscal year under
25 this subsection for the State, increased by 25 per-

1 cent of the number of percentage points by which
2 the Federal medical assistance percentage deter-
3 mined for the State for the fiscal year without re-
4 gard to this subsection and subsection (y), is less
5 than the Federal medical assistance percentage de-
6 termined for the State for the preceding fiscal year
7 under this subsection.

8 “(2) In this subsection, the term ‘disaster-recovery
9 FMAP adjustment State’ means a State that is one of
10 the 50 States or the District of Columbia, for which, at
11 any time during the preceding 7 fiscal years, the President
12 has declared a major disaster under section 401 of the
13 Robert T. Stafford Disaster Relief and Emergency Assist-
14 ance Act and determined as a result of such disaster that
15 every county or parish in the State warrant individual and
16 public assistance or public assistance from the Federal
17 Government under such Act and for which—

18 “(A) in the case of the first fiscal year (or part
19 of a fiscal year) for which this subsection applies to
20 the State, the Federal medical assistance percentage
21 determined for the State for the fiscal year without
22 regard to this subsection and subsection (y), is less
23 than the Federal medical assistance percentage de-
24 termined for the State for the preceding fiscal year
25 after the application of only subsection (a) of section

1 5001 of Public Law 111–5 (if applicable to the pre-
2 ceding fiscal year) and without regard to this sub-
3 section, subsection (y), and subsections (b) and (c)
4 of section 5001 of Public Law 111–5, by at least 3
5 percentage points; and

6 “(B) in the case of the second or any suc-
7 ceeding fiscal year for which this subsection applies
8 to the State, the Federal medical assistance percent-
9 age determined for the State for the fiscal year with-
10 out regard to this subsection and subsection (y), is
11 less than the Federal medical assistance percentage
12 determined for the State for the preceding fiscal
13 year under this subsection by at least 3 percentage
14 points.

15 “(3) The Federal medical assistance percentage de-
16 termined for a disaster-recovery FMAP adjustment State
17 under paragraph (1) shall apply for purposes of this title
18 (other than with respect to disproportionate share hospital
19 payments described in section 1923 and payments under
20 this title that are based on the enhanced FMAP described
21 in 2105(b)) and shall not apply with respect to payments
22 under title IV (other than under part E of title IV) or
23 payments under title XXI.”.

1 **SEC. 2007. MEDICAID IMPROVEMENT FUND RESCISSION.**

2 (a) RESCISSION.—Any amounts available to the Med-
 3 icaid Improvement Fund established under section 1941
 4 of the Social Security Act (42 U.S.C. 1396w–1) for any
 5 of fiscal years 2014 through 2018 that are available for
 6 expenditure from the Fund and that are not so obligated
 7 as of the date of the enactment of this Act are rescinded.

8 (b) CONFORMING AMENDMENTS.—Section
 9 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–
 10 1(b)(1)) is amended—

11 (1) in subparagraph (A), by striking
 12 “\$100,000,000” and inserting “\$0”; and

13 (2) in subparagraph (B), by striking
 14 “\$150,000,000” and inserting “\$0”.

15 **Subtitle B—Enhanced Support for**
 16 **the Children’s Health Insurance**
 17 **Program**

18 **SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPA-**
 19 **TION FOR CHIP.**

20 (a) IN GENERAL.—Section 2105(b) of the Social Se-
 21 curity Act (42 U.S.C. 1397ee(b)) is amended by adding
 22 at the end the following: “Notwithstanding the preceding
 23 sentence, during the period that begins on October 1,
 24 2013, and ends on September 30, 2019, the enhanced
 25 FMAP determined for a State for a fiscal year (or for
 26 any portion of a fiscal year occurring during such period)

1 shall be increased by 23 percentage points, but in no case
2 shall exceed 100 percent. The increase in the enhanced
3 FMAP under the preceding sentence shall not apply with
4 respect to determining the payment to a State under sub-
5 section (a)(1) for expenditures described in subparagraph
6 (D)(iv), paragraphs (8), (9), (11) of subsection (c), or
7 clause (4) of the first sentence of section 1905(b).”.

8 (b) MAINTENANCE OF EFFORT.—

9 (1) IN GENERAL.—Section 2105(d) of the So-
10 cial Security Act (42 U.S.C. 1397ee(d)) is amended
11 by adding at the end the following:

12 “(3) CONTINUATION OF ELIGIBILITY STAND-
13 ARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—

14 “(A) IN GENERAL.—During the period
15 that begins on the date of enactment of the Pa-
16 tient Protection and Affordable Care Act and
17 ends on September 30, 2019, a State shall not
18 have in effect eligibility standards, methodolo-
19 gies, or procedures under its State child health
20 plan (including any waiver under such plan) for
21 children (including children provided medical
22 assistance for which payment is made under
23 section 2105(a)(1)(A)) that are more restrictive
24 than the eligibility standards, methodologies, or
25 procedures, respectively, under such plan (or

1 waiver) as in effect on the date of enactment of
2 that Act. The preceding sentence shall not be
3 construed as preventing a State during such pe-
4 riod from—

5 “(i) applying eligibility standards,
6 methodologies, or procedures for children
7 under the State child health plan or under
8 any waiver of the plan that are less restric-
9 tive than the eligibility standards, meth-
10 odologies, or procedures, respectively, for
11 children under the plan or waiver that are
12 in effect on the date of enactment of such
13 Act; or

14 “(ii) imposing a limitation described
15 in section 2112(b)(7) for a fiscal year in
16 order to limit expenditures under the State
17 child health plan to those for which Fed-
18 eral financial participation is available
19 under this section for the fiscal year.

20 “(B) ASSURANCE OF EXCHANGE COV-
21 ERAGE FOR TARGETED LOW-INCOME CHILDREN
22 UNABLE TO BE PROVIDED CHILD HEALTH AS-
23 SISTANCE AS A RESULT OF FUNDING SHORT-
24 FALLS.—In the event that allotments provided
25 under section 2104 are insufficient to provide

1 coverage to all children who are eligible to be
2 targeted low-income children under the State
3 child health plan under this title, a State shall
4 establish procedures to ensure that such chil-
5 dren are provided coverage through an Ex-
6 change established by the State under section
7 1311 of the Patient Protection and Affordable
8 Care Act.”.

9 (2) CONFORMING AMENDMENT TO TITLE XXI
10 MEDICAID MAINTENANCE OF EFFORT.—Section
11 2105(d)(1) of the Social Security Act (42 U.S.C.
12 1397ee(d)(1)) is amended by adding before the pe-
13 riod “, except as required under section
14 1902(e)(14)”.

15 (c) NO ENROLLMENT BONUS PAYMENTS FOR CHIL-
16 DREN ENROLLED AFTER FISCAL YEAR 2013.—Section
17 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C.
18 1397ee(a)(3)(F)(iii)) is amended by inserting “or any chil-
19 dren enrolled on or after October 1, 2013” before the pe-
20 riod.

21 (d) INCOME ELIGIBILITY DETERMINED USING MODI-
22 FIED GROSS INCOME.—

23 (1) STATE PLAN REQUIREMENT.—Section
24 2102(b)(1)(B) of the Social Security Act (42 U.S.C.
25 1397bb(b)(1)(B)) is amended—

1 (A) in clause (iii), by striking “and” after
2 the semicolon;

3 (B) in clause (iv), by striking the period
4 and inserting “; and”; and

5 (C) by adding at the end the following:

6 “(v) shall, beginning January 1, 2014,
7 use modified gross income and household
8 income (as defined in section 36B(d)(2) of
9 the Internal Revenue Code of 1986) to de-
10 termine eligibility for child health assist-
11 ance under the State child health plan or
12 under any waiver of such plan and for any
13 other purpose applicable under the plan or
14 waiver for which a determination of income
15 is required, including with respect to the
16 imposition of premiums and cost-sharing,
17 consistent with section 1902(e)(14).”.

18 (2) CONFORMING AMENDMENT.—Section
19 2107(e)(1) of the Social Security Act (42 U.S.C.
20 1397gg(e)(1)) is amended—

21 (A) by redesignating subparagraphs (E)
22 through (L) as subparagraphs (F) through (M),
23 respectively; and

24 (B) by inserting after subparagraph (D),
25 the following:

1 “(E) Section 1902(e)(14) (relating to in-
2 come determined using modified gross income
3 and household income).”.

4 (e) APPLICATION OF STREAMLINED ENROLLMENT
5 SYSTEM.—Section 2107(e)(1) of the Social Security Act
6 (42 U.S.C. 1397gg(e)(1)), as amended by subsection
7 (d)(2), is amended by adding at the end the following:

8 “(N) Section 1943(b) (relating to coordi-
9 nation with State Exchanges and the State
10 Medicaid agency).”.

11 (f) CHIP ELIGIBILITY FOR CHILDREN INELIGIBLE
12 FOR MEDICAID AS A RESULT OF ELIMINATION OF DIS-
13 REGARDS.—Notwithstanding any other provision of law,
14 a State shall treat any child who is determined to be ineli-
15 gible for medical assistance under the State Medicaid plan
16 or under a waiver of the plan as a result of the elimination
17 of the application of an income disregard based on expense
18 or type of income, as required under section 1902(e)(14)
19 of the Social Security Act (as added by this Act), as a
20 targeted low-income child under section 2110(b) (unless
21 the child is excluded under paragraph (2) of that section)
22 and shall provide child health assistance to the child under
23 the State child health plan (whether implemented under
24 title XIX or XXI, or both, of the Social Security Act).

1 **SEC. 2102. TECHNICAL CORRECTIONS.**

2 (a) CHIPRA.—Effective as if included in the enact-
3 ment of the Children’s Health Insurance Program Reau-
4 thorization Act of 2009 (Public Law 111–3) (in this sec-
5 tion referred to as “CHIPRA”):

6 (1) Section 2104(m) of the Social Security Act,
7 as added by section 102 of CHIPRA, is amended—

8 (A) by redesignating paragraph (7) as
9 paragraph (8); and

10 (B) by inserting after paragraph (6), the
11 following:

12 “(7) ADJUSTMENT OF FISCAL YEAR 2010 AL-
13 LOTMENTS TO ACCOUNT FOR CHANGES IN PRO-
14 JECTED SPENDING FOR CERTAIN PREVIOUSLY AP-
15 PROVED EXPANSION PROGRAMS.—For purposes of
16 recalculating the fiscal year 2010 allotment, in the
17 case of one of the 50 States or the District of Co-
18 lumbia that has an approved State plan amendment
19 effective January 1, 2006, to provide child health as-
20 sistance through the provision of benefits under the
21 State plan under title XIX for children from birth
22 through age 5 whose family income does not exceed
23 200 percent of the poverty line, the Secretary shall
24 increase the allotment by an amount that would be
25 equal to the Federal share of expenditures that
26 would have been claimed at the enhanced FMAP

1 rate rather than the Federal medical assistance per-
2 centage matching rate for such population.”.

3 (2) Section 605 of CHIPRA is amended by
4 striking “legal residents” and insert “lawfully resid-
5 ing in the United States”.

6 (3) Subclauses (I) and (II) of paragraph
7 (3)(C)(i) of section 2105(a) of the Social Security
8 Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by sec-
9 tion 104 of CHIPRA, are each amended by striking
10 “, respectively”.

11 (4) Section 2105(a)(3)(E)(ii) of the Social Se-
12 curity Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added
13 by section 104 of CHIPRA, is amended by striking
14 subclause (IV).

15 (5) Section 2105(c)(9)(B) of the Social Security
16 Act (42 U.S.C. 1397e(c)(9)(B)), as added by section
17 211(c)(1) of CHIPRA, is amended by striking “sec-
18 tion 1903(a)(3)(F)” and inserting “section
19 1903(a)(3)(G)”.

20 (6) Section 2109(b)(2)(B) of the Social Secu-
21 rity Act (42 U.S.C. 1397ii(b)(2)(B)), as added by
22 section 602 of CHIPRA, is amended by striking
23 “the child population growth factor under section
24 2104(m)(5)(B)” and inserting “a high-performing
25 State under section 2111(b)(3)(B)”.

1 (7) Section 2110(c)(9)(B)(v) of the Social Secu-
2 rity Act (42 U.S.C. 1397jj(c)(9)(B)(v)), as added by
3 section 505(b) of CHIPRA, is amended by striking
4 “school or school system” and inserting “local edu-
5 cational agency (as defined under section 9101 of
6 the Elementary and Secondary Education Act of
7 1965”.

8 (8) Section 211(a)(1)(B) of CHIPRA is amend-
9 ed—

10 (A) by striking “is amended” and all that
11 follows through “adding” and inserting “is
12 amended by adding”; and

13 (B) by redesignating the new subpara-
14 graph to be added by such section to section
15 1903(a)(3) of the Social Security Act as a new
16 subparagraph (H).

17 (b) ARRA.—Effective as if included in the enactment
18 of section 5006(a) of division B of the American Recovery
19 and Reinvestment Act of 2009 (Public Law 111–5), the
20 second sentence of section 1916A(a)(1) of the Social Secu-
21 rity Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking
22 “or (i)” and inserting “, (i), or (j)”.

1 **Subtitle C—Medicaid and CHIP**
2 **Enrollment Simplification**

3 **SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINA-**
4 **TION WITH STATE HEALTH INSURANCE EX-**
5 **CHANGES.**

6 Title XIX of the Social Security Act (42 U.S.C.
7 1397aa et seq.) is amended by adding at the end the fol-
8 lowing:

9 **“SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDI-**
10 **NATION WITH STATE HEALTH INSURANCE EX-**
11 **CHANGES.**

12 “(a) **CONDITION FOR PARTICIPATION IN MED-**
13 **ICAID.**—As a condition of the State plan under this title
14 and receipt of any Federal financial assistance under sec-
15 tion 1903(a) for calendar quarters beginning after Janu-
16 ary 1, 2014, a State shall ensure that the requirements
17 of subsection (b) is met.

18 “(b) **ENROLLMENT SIMPLIFICATION AND COORDINA-**
19 **TION WITH STATE HEALTH INSURANCE EXCHANGES AND**
20 **CHIP.**—

21 “(1) **IN GENERAL.**—A State shall establish pro-
22 cedures for—

23 “(A) enabling individuals, through an
24 Internet website that meets the requirements of
25 paragraph (4), to apply for medical assistance

1 under the State plan or under a waiver of the
2 plan, to be enrolled in the State plan or waiver,
3 to renew their enrollment in the plan or waiver,
4 and to consent to enrollment or reenrollment in
5 the State plan through electronic signature;

6 “(B) enrolling, without any further deter-
7 mination by the State and through such
8 website, individuals who are identified by an
9 Exchange established by the State under sec-
10 tion 1311 of the Patient Protection and Afford-
11 able Care Act as being eligible for—

12 “(i) medical assistance under the
13 State plan or under a waiver of the plan;
14 or

15 “(ii) child health assistance under the
16 State child health plan under title XXI;

17 “(C) ensuring that individuals who apply
18 for but are determined to be ineligible for med-
19 ical assistance under the State plan or a waiver
20 or ineligible for child health assistance under
21 the State child health plan under title XXI, are
22 screened for eligibility for enrollment in quali-
23 fied health plans offered through such an Ex-
24 change and, if applicable, premium assistance
25 for the purchase of a qualified health plan

1 under section 36B of the Internal Revenue
2 Code of 1986 (and, if applicable, advance pay-
3 ment of such assistance under section 1412 of
4 the Patient Protection and Affordable Care
5 Act), and, if eligible, enrolled in such a plan
6 without having to submit an additional or sepa-
7 rate application, and that such individuals re-
8 ceive information regarding reduced cost-shar-
9 ing for eligible individuals under section 1402
10 of the Patient Protection and Affordable Care
11 Act, and any other assistance or subsidies avail-
12 able for coverage obtained through the Ex-
13 change;

14 “(D) ensuring that the State agency re-
15 sponsible for administering the State plan
16 under this title (in this section referred to as
17 the ‘State Medicaid agency’), the State agency
18 responsible for administering the State child
19 health plan under title XXI (in this section re-
20 ferred to as the ‘State CHIP agency’) and an
21 Exchange established by the State under sec-
22 tion 1311 of the Patient Protection and Afford-
23 able Care Act utilize a secure electronic inter-
24 face sufficient to allow for a determination of
25 an individual’s eligibility for such medical as-

1 sistance, child health assistance, or premium
2 assistance, and enrollment in the State plan
3 under this title, title XXI, or a qualified health
4 plan, as appropriate;

5 “(E) coordinating, for individuals who are
6 enrolled in the State plan or under a waiver of
7 the plan and who are also enrolled in a quali-
8 fied health plan offered through such an Ex-
9 change, and for individuals who are enrolled in
10 the State child health plan under title XXI and
11 who are also enrolled in a qualified health plan,
12 the provision of medical assistance or child
13 health assistance to such individuals with the
14 coverage provided under the qualified health
15 plan in which they are enrolled, including serv-
16 ices described in section 1905(a)(4)(B) (relating
17 to early and periodic screening, diagnostic, and
18 treatment services defined in section 1905(r))
19 and provided in accordance with the require-
20 ments of section 1902(a)(43); and

21 “(F) conducting outreach to and enrolling
22 vulnerable and underserved populations eligible
23 for medical assistance under this title XIX or
24 for child health assistance under title XXI, in-
25 cluding children, unaccompanied homeless

1 youth, children and youth with special health
2 care needs, pregnant women, racial and ethnic
3 minorities, rural populations, victims of abuse
4 or trauma, individuals with mental health or
5 substance-related disorders, and individuals
6 with HIV/AIDS.

7 “(2) AGREEMENTS WITH STATE HEALTH IN-
8 SURANCE EXCHANGES.—The State Medicaid agency
9 and the State CHIP agency may enter into an
10 agreement with an Exchange established by the
11 State under section 1311 of the Patient Protection
12 and Affordable Care Act under which the State
13 Medicaid agency or State CHIP agency may deter-
14 mine whether a State resident is eligible for pre-
15 mium assistance for the purchase of a qualified
16 health plan under section 36B of the Internal Rev-
17 enue Code of 1986 (and, if applicable, advance pay-
18 ment of such assistance under section 1412 of the
19 Patient Protection and Affordable Care Act), so long
20 as the agreement meets such conditions and require-
21 ments as the Secretary of the Treasury may pre-
22 scribe to reduce administrative costs and the likeli-
23 hood of eligibility errors and disruptions in coverage.

24 “(3) STREAMLINED ENROLLMENT SYSTEM.—
25 The State Medicaid agency and State CHIP agency

1 shall participate in and comply with the require-
2 ments for the system established under section 1413
3 of the Patient Protection and Affordable Care Act
4 (relating to streamlined procedures for enrollment
5 through an Exchange, Medicaid, and CHIP).

6 “(4) ENROLLMENT WEBSITE REQUIREMENTS.—

7 The procedures established by State under para-
8 graph (1) shall include establishing and having in
9 operation, not later than January 1, 2014, an Inter-
10 net website that is linked to any website of an Ex-
11 change established by the State under section 1311
12 of the Patient Protection and Affordable Care Act
13 and to the State CHIP agency (if different from the
14 State Medicaid agency) and allows an individual who
15 is eligible for medical assistance under the State
16 plan or under a waiver of the plan and who is eligi-
17 ble to receive premium credit assistance for the pur-
18 chase of a qualified health plan under section 36B
19 of the Internal Revenue Code of 1986 to compare
20 the benefits, premiums, and cost-sharing applicable
21 to the individual under the State plan or waiver with
22 the benefits, premiums, and cost-sharing available to
23 the individual under a qualified health plan offered
24 through such an Exchange, including, in the case of
25 a child, the coverage that would be provided for the

1 child through the State plan or waiver with the cov-
2 erage that would be provided to the child through
3 enrollment in family coverage under that plan and
4 as supplemental coverage by the State under the
5 State plan or waiver.

6 “(5) CONTINUED NEED FOR ASSESSMENT FOR
7 HOME AND COMMUNITY-BASED SERVICES.—Nothing
8 in paragraph (1) shall limit or modify the require-
9 ment that the State assess an individual for pur-
10 poses of providing home and community-based serv-
11 ices under the State plan or under any waiver of
12 such plan for individuals described in subsection
13 (a)(10)(A)(ii)(VI).”

14 **SEC. 2202. PERMITTING HOSPITALS TO MAKE PRESUMP-**
15 **TIVE ELIGIBILITY DETERMINATIONS FOR**
16 **ALL MEDICAID ELIGIBLE POPULATIONS.**

17 (a) IN GENERAL.—Section 1902(a)(47) of the Social
18 Security Act (42 U.S.C. 1396a(a)(47)) is amended—

19 (1) by striking “at the option of the State, pro-
20 vide” and inserting “provide—

21 “(A) at the option of the State,”;

22 (2) by inserting “and” after the semicolon; and

23 (3) by adding at the end the following:

24 “(B) that any hospital that is a partici-
25 pating provider under the State plan may elect

1 to be a qualified entity for purposes of deter-
2 mining, on the basis of preliminary information,
3 whether any individual is eligible for medical as-
4 sistance under the State plan or under a waiver
5 of the plan for purposes of providing the indi-
6 vidual with medical assistance during a pre-
7 sumptive eligibility period, in the same manner,
8 and subject to the same requirements, as apply
9 to the State options with respect to populations
10 described in section 1920, 1920A, or 1920B
11 (but without regard to whether the State has
12 elected to provide for a presumptive eligibility
13 period under any such sections), subject to such
14 guidance as the Secretary shall establish;”.

15 (b) CONFORMING AMENDMENT.—Section
16 1903(u)(1)(D)(v) of such Act (42 U.S.C.
17 1396b(u)(1)(D)(v)) is amended—

18 (1) by striking “or for” and inserting “for”;

19 and

20 (2) by inserting before the period at the end the
21 following: “, or for medical assistance provided to an
22 individual during a presumptive eligibility period re-
23 sulting from a determination of presumptive eligi-
24 bility made by a hospital that elects under section

1 1902(a)(47)(B) to be a qualified entity for such pur-
2 pose”.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section take effect on January 1, 2014, and apply to
5 services furnished on or after that date.

6 **Subtitle D—Improvements to**
7 **Medicaid Services**

8 **SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER**
9 **SERVICES.**

10 (a) IN GENERAL.—Section 1905 of the Social Secu-
11 rity Act (42 U.S.C. 1396d), is amended—

12 (1) in subsection (a)—

13 (A) in paragraph (27), by striking “and”
14 at the end;

15 (B) by redesignating paragraph (28) as
16 paragraph (29); and

17 (C) by inserting after paragraph (27) the
18 following new paragraph:

19 “(28) freestanding birth center services (as de-
20 fined in subsection (l)(3)(A)) and other ambulatory
21 services that are offered by a freestanding birth cen-
22 ter (as defined in subsection (l)(3)(B)) and that are
23 otherwise included in the plan; and”;

24 (2) in subsection (l), by adding at the end the
25 following new paragraph:

1 “(3)(A) The term ‘freestanding birth center services’
2 means services furnished to an individual at a freestanding
3 birth center (as defined in subparagraph (B)) at such cen-
4 ter.

5 “(B) The term ‘freestanding birth center’ means a
6 health facility—

7 “(i) that is not a hospital;

8 “(ii) where childbirth is planned to occur away
9 from the pregnant woman’s residence;

10 “(iii) that is licensed or otherwise approved by
11 the State to provide prenatal labor and delivery or
12 postpartum care and other ambulatory services that
13 are included in the plan; and

14 “(iv) that complies with such other require-
15 ments relating to the health and safety of individuals
16 furnished services by the facility as the State shall
17 establish.

18 “(C) A State shall provide separate payments to pro-
19 viders administering prenatal labor and delivery or
20 postpartum care in a freestanding birth center (as defined
21 in subparagraph (B)), such as nurse midwives and other
22 providers of services such as birth attendants recognized
23 under State law, as determined appropriate by the Sec-
24 retary. For purposes of the preceding sentence, the term
25 ‘birth attendant’ means an individual who is recognized

1 or registered by the State involved to provide health care
2 at childbirth and who provides such care within the scope
3 of practice under which the individual is legally authorized
4 to perform such care under State law (or the State regu-
5 latory mechanism provided by State law), regardless of
6 whether the individual is under the supervision of, or asso-
7 ciated with, a physician or other health care provider.
8 Nothing in this subparagraph shall be construed as chang-
9 ing State law requirements applicable to a birth attend-
10 ant.”.

11 (b) CONFORMING AMENDMENT.—Section
12 1902(a)(10)(A) of the Social Security Act (42 U.S.C.
13 1396a(a)(10)(A)), is amended in the matter preceding
14 clause (i) by striking “and (21)” and inserting “, (21),
15 and (28)”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—Except as provided in para-
18 graph (2), the amendments made by this section
19 shall take effect on the date of the enactment of this
20 Act and shall apply to services furnished on or after
21 such date.

22 (2) EXCEPTION IF STATE LEGISLATION RE-
23 QUIRED.—In the case of a State plan for medical as-
24 sistance under title XIX of the Social Security Act
25 which the Secretary of Health and Human Services

1 determines requires State legislation (other than leg-
2 islation appropriating funds) in order for the plan to
3 meet the additional requirement imposed by the
4 amendments made by this section, the State plan
5 shall not be regarded as failing to comply with the
6 requirements of such title solely on the basis of its
7 failure to meet this additional requirement before
8 the first day of the first calendar quarter beginning
9 after the close of the first regular session of the
10 State legislature that begins after the date of the en-
11 actment of this Act. For purposes of the previous
12 sentence, in the case of a State that has a 2-year
13 legislative session, each year of such session shall be
14 deemed to be a separate regular session of the State
15 legislature.

16 **SEC. 2302. CONCURRENT CARE FOR CHILDREN.**

17 (a) IN GENERAL.—Section 1905(o)(1) of the Social
18 Security Act (42 U.S.C. 1396d(o)(1)) is amended—

19 (1) in subparagraph (A), by striking “subpara-
20 graph (B)” and inserting “subparagraphs (B) and
21 (C)”; and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(C) A voluntary election to have payment made for
25 hospice care for a child (as defined by the State) shall

1 not constitute a waiver of any rights of the child to be
 2 provided with, or to have payment made under this title
 3 for, services that are related to the treatment of the child’s
 4 condition for which a diagnosis of terminal illness has been
 5 made.”.

6 (b) APPLICATION TO CHIP.—Section 2110(a)(23) of
 7 the Social Security Act (42 U.S.C. 1397jj(a)(23)) is
 8 amended by inserting “(concurrent, in the case of an indi-
 9 vidual who is a child, with care related to the treatment
 10 of the child’s condition with respect to which a diagnosis
 11 of terminal illness has been made” after “hospice care”.

12 **SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLAN-**
 13 **NING SERVICES.**

14 (a) COVERAGE AS OPTIONAL CATEGORICALLY
 15 NEEDY GROUP.—

16 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
 17 of the Social Security Act (42 U.S.C.
 18 1396a(a)(10)(A)(ii)), as amended by section
 19 2001(e), is amended—

20 (A) in subclause (XIX), by striking “or” at
 21 the end;

22 (B) in subclause (XX), by adding “or” at
 23 the end; and

24 (C) by adding at the end the following new
 25 subclause:

1 “(XXI) who are described in sub-
2 section (ii) (relating to individuals
3 who meet certain income standards);”.

4 (2) GROUP DESCRIBED.—Section 1902 of such
5 Act (42 U.S.C. 1396a), as amended by section
6 2001(d), is amended by adding at the end the fol-
7 lowing new subsection:

8 “(ii)(1) Individuals described in this subsection are
9 individuals—

10 “(A) whose income does not exceed an in-
11 come eligibility level established by the State
12 that does not exceed the highest income eligi-
13 bility level established under the State plan
14 under this title (or under its State child health
15 plan under title XXI) for pregnant women; and

16 “(B) who are not pregnant.

17 “(2) At the option of a State, individuals de-
18 scribed in this subsection may include individuals
19 who, had individuals applied on or before January 1,
20 2007, would have been made eligible pursuant to the
21 standards and processes imposed by that State for
22 benefits described in clause (XV) of the matter fol-
23 lowing subparagraph (G) of section subsection
24 (a)(10) pursuant to a waiver granted under section
25 1115.

1 “(3) At the option of a State, for purposes of
2 subsection (a)(17)(B), in determining eligibility for
3 services under this subsection, the State may con-
4 sider only the income of the applicant or recipient.”.

5 (3) LIMITATION ON BENEFITS.—Section
6 1902(a)(10) of the Social Security Act (42 U.S.C.
7 1396a(a)(10)), as amended by section
8 2001(a)(5)(A), is amended in the matter following
9 subparagraph (G)—

10 (A) by striking “and (XV)” and inserting
11 “(XV)”; and

12 (B) by inserting “, and (XVI) the medical
13 assistance made available to an individual de-
14 scribed in subsection (ii) shall be limited to
15 family planning services and supplies described
16 in section 1905(a)(4)(C) including medical di-
17 agnosis and treatment services that are pro-
18 vided pursuant to a family planning service in
19 a family planning setting” before the semicolon.

20 (4) CONFORMING AMENDMENTS.—

21 (A) Section 1905(a) of the Social Security
22 Act (42 U.S.C. 1396d(a)), as amended by sec-
23 tion 2001(e)(2)(A), is amended in the matter
24 preceding paragraph (1)—

1 (i) in clause (xiv), by striking “or” at
2 the end;

3 (ii) in clause (xv), by adding “or” at
4 the end; and

5 (iii) by inserting after clause (xv) the
6 following:

7 “(xvi) individuals described in section
8 1902(ii),”.

9 (B) Section 1903(f)(4) of such Act (42
10 U.S.C. 1396b(f)(4)), as amended by section
11 2001(e)(2)(B), is amended by inserting
12 “1902(a)(10)(A)(ii)(XXI),” after
13 “1902(a)(10)(A)(ii)(XX),”.

14 (b) PRESUMPTIVE ELIGIBILITY.—

15 (1) IN GENERAL.—Title XIX of the Social Se-
16 curity Act (42 U.S.C. 1396 et seq.) is amended by
17 inserting after section 1920B the following:

18 “PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING
19 SERVICES

20 “SEC. 1920C. (a) STATE OPTION.—State plan ap-
21 proved under section 1902 may provide for making med-
22 ical assistance available to an individual described in sec-
23 tion 1902(ii) (relating to individuals who meet certain in-
24 come eligibility standard) during a presumptive eligibility
25 period. In the case of an individual described in section
26 1902(ii), such medical assistance shall be limited to family

1 planning services and supplies described in 1905(a)(4)(C)
2 and, at the State’s option, medical diagnosis and treat-
3 ment services that are provided in conjunction with a fam-
4 ily planning service in a family planning setting.

5 “(b) DEFINITIONS.—For purposes of this section:

6 “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
7 term ‘presumptive eligibility period’ means, with re-
8 spect to an individual described in subsection (a),
9 the period that—

10 “(A) begins with the date on which a
11 qualified entity determines, on the basis of pre-
12 liminary information, that the individual is de-
13 scribed in section 1902(ii); and

14 “(B) ends with (and includes) the earlier
15 of—

16 “(i) the day on which a determination
17 is made with respect to the eligibility of
18 such individual for services under the State
19 plan; or

20 “(ii) in the case of such an individual
21 who does not file an application by the last
22 day of the month following the month dur-
23 ing which the entity makes the determina-
24 tion referred to in subparagraph (A), such
25 last day.

1 “(2) QUALIFIED ENTITY.—

2 “(A) IN GENERAL.—Subject to subpara-
3 graph (B), the term ‘qualified entity’ means
4 any entity that—

5 “(i) is eligible for payments under a
6 State plan approved under this title; and

7 “(ii) is determined by the State agen-
8 cy to be capable of making determinations
9 of the type described in paragraph (1)(A).

10 “(B) RULE OF CONSTRUCTION.—Nothing
11 in this paragraph shall be construed as pre-
12 venting a State from limiting the classes of en-
13 tities that may become qualified entities in
14 order to prevent fraud and abuse.

15 “(c) ADMINISTRATION.—

16 “(1) IN GENERAL.—The State agency shall pro-
17 vide qualified entities with—

18 “(A) such forms as are necessary for an
19 application to be made by an individual de-
20 scribed in subsection (a) for medical assistance
21 under the State plan; and

22 “(B) information on how to assist such in-
23 dividuals in completing and filing such forms.

24 “(2) NOTIFICATION REQUIREMENTS.—A quali-
25 fied entity that determines under subsection

1 (b)(1)(A) that an individual described in subsection
2 (a) is presumptively eligible for medical assistance
3 under a State plan shall—

4 “(A) notify the State agency of the deter-
5 mination within 5 working days after the date
6 on which determination is made; and

7 “(B) inform such individual at the time
8 the determination is made that an application
9 for medical assistance is required to be made by
10 not later than the last day of the month fol-
11 lowing the month during which the determina-
12 tion is made.

13 “(3) APPLICATION FOR MEDICAL ASSIST-
14 ANCE.—In the case of an individual described in
15 subsection (a) who is determined by a qualified enti-
16 ty to be presumptively eligible for medical assistance
17 under a State plan, the individual shall apply for
18 medical assistance by not later than the last day of
19 the month following the month during which the de-
20 termination is made.

21 “(d) PAYMENT.—Notwithstanding any other provi-
22 sion of law, medical assistance that—

23 “(1) is furnished to an individual described in
24 subsection (a)—

1 “(A) during a presumptive eligibility pe-
2 riod; and

3 “(B) by a entity that is eligible for pay-
4 ments under the State plan; and

5 “(2) is included in the care and services covered
6 by the State plan,

7 shall be treated as medical assistance provided by such
8 plan for purposes of clause (4) of the first sentence of
9 section 1905(b).”.

10 (2) CONFORMING AMENDMENTS.—

11 (A) Section 1902(a)(47) of the Social Se-
12 curity Act (42 U.S.C. 1396a(a)(47)), as amend-
13 ed by section 2202(a), is amended—

14 (i) in subparagraph (A), by inserting
15 before the semicolon at the end the fol-
16 lowing: “and provide for making medical
17 assistance available to individuals described
18 in subsection (a) of section 1920C during
19 a presumptive eligibility period in accord-
20 ance with such section”; and

21 (ii) in subparagraph (B), by striking
22 “or 1920B” and inserting “1920B, or
23 1920C”.

24 (B) Section 1903(u)(1)(D)(v) of such Act
25 (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by

1 section 2202(b), is amended by inserting “or
2 for medical assistance provided to an individual
3 described in subsection (a) of section 1920C
4 during a presumptive eligibility period under
5 such section,” after “1920B during a presump-
6 tive eligibility period under such section,”.

7 (c) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
8 NING SERVICES AND SUPPLIES.—Section 1937(b) of the
9 Social Security Act (42 U.S.C. 1396u–7(b)), as amended
10 by section 2001(c), is amended by adding at the end the
11 following:

12 “(7) COVERAGE OF FAMILY PLANNING SERV-
13 ICES AND SUPPLIES.—Notwithstanding the previous
14 provisions of this section, a State may not provide
15 for medical assistance through enrollment of an indi-
16 vidual with benchmark coverage or benchmark-equiv-
17 alent coverage under this section unless such cov-
18 erage includes for any individual described in section
19 1905(a)(4)(C), medical assistance for family plan-
20 ning services and supplies in accordance with such
21 section.”.

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section take effect on the date of the enactment of
24 this Act and shall apply to items and services furnished
25 on or after such date.

1 **SEC. 2304. CLARIFICATION OF DEFINITION OF MEDICAL AS-**
 2 **SISTANCE.**

3 Section 1905(a) of the Social Security Act (42 U.S.C.
 4 1396d(a)) is amended by inserting “or the care and serv-
 5 ices themselves, or both” before “(if provided in or after”.

6 **Subtitle E—New Options for States**
 7 **to Provide Long-Term Services**
 8 **and Supports**

9 **SEC. 2401. COMMUNITY FIRST CHOICE OPTION.**

10 Section 1915 of the Social Security Act (42 U.S.C.
 11 1396n) is amended by adding at the end the following:

12 “(k) STATE PLAN OPTION TO PROVIDE HOME AND
 13 COMMUNITY-BASED ATTENDANT SERVICES AND SUP-
 14 PORTS.—

15 “(1) IN GENERAL.—Subject to the succeeding
 16 provisions of this subsection, beginning October 1,
 17 2010, a State may provide through a State plan
 18 amendment for the provision of medical assistance
 19 for home and community-based attendant services
 20 and supports for individuals who are eligible for
 21 medical assistance under the State plan whose in-
 22 come does not exceed 150 percent of the poverty line
 23 (as defined in section 2110(c)(5)) or, if greater, the
 24 income level applicable for an individual who has
 25 been determined to require an institutional level of
 26 care to be eligible for nursing facility services under

1 the State plan and with respect to whom there has
2 been a determination that, but for the provision of
3 such services, the individuals would require the level
4 of care provided in a hospital, a nursing facility, an
5 intermediate care facility for the mentally retarded,
6 or an institution for mental diseases, the cost of
7 which could be reimbursed under the State plan, but
8 only if the individual chooses to receive such home
9 and community-based attendant services and sup-
10 ports, and only if the State meets the following re-
11 quirements:

12 “(A) AVAILABILITY.—The State shall
13 make available home and community-based at-
14 tendant services and supports to eligible indi-
15 viduals, as needed, to assist in accomplishing
16 activities of daily living, instrumental activities
17 of daily living, and health-related tasks through
18 hands-on assistance, supervision, or cueing—

19 “(i) under a person-centered plan of
20 services and supports that is based on an
21 assessment of functional need and that is
22 agreed to in writing by the individual or,
23 as appropriate, the individual’s representa-
24 tive;

1 “(ii) in a home or community setting,
2 which does not include a nursing facility,
3 institution for mental diseases, or an inter-
4 mediate care facility for the mentally re-
5 tarded;

6 “(iii) under an agency-provider model
7 or other model (as defined in paragraph
8 (6)(C)); and

9 “(iv) the furnishing of which—

10 “(I) is selected, managed, and
11 dismissed by the individual, or, as ap-
12 propriate, with assistance from the in-
13 dividual’s representative;

14 “(II) is controlled, to the max-
15 imum extent possible, by the indi-
16 vidual or where appropriate, the indi-
17 vidual’s representative, regardless of
18 who may act as the employer of
19 record; and

20 “(III) provided by an individual
21 who is qualified to provide such serv-
22 ices, including family members (as de-
23 fined by the Secretary).

24 “(B) INCLUDED SERVICES AND SUP-
25 PORTS.—In addition to assistance in accom-

1 plishing activities of daily living, instrumental
2 activities of daily living, and health related
3 tasks, the home and community-based attend-
4 ant services and supports made available in-
5 clude—

6 “(i) the acquisition, maintenance, and
7 enhancement of skills necessary for the in-
8 dividual to accomplish activities of daily
9 living, instrumental activities of daily liv-
10 ing, and health related tasks;

11 “(ii) back-up systems or mechanisms
12 (such as the use of beepers or other elec-
13 tronic devices) to ensure continuity of serv-
14 ices and supports; and

15 “(iii) voluntary training on how to se-
16 lect, manage, and dismiss attendants.

17 “(C) EXCLUDED SERVICES AND SUP-
18 PORTS.—Subject to subparagraph (D), the
19 home and community-based attendant services
20 and supports made available do not include—

21 “(i) room and board costs for the in-
22 dividual;

23 “(ii) special education and related
24 services provided under the Individuals
25 with Disabilities Education Act and voca-

1 tional rehabilitation services provided
2 under the Rehabilitation Act of 1973;

3 “(iii) assistive technology devices and
4 assistive technology services other than
5 those under (1)(B)(ii);

6 “(iv) medical supplies and equipment;
7 or

8 “(v) home modifications.

9 “(D) PERMISSIBLE SERVICES AND SUP-
10 PORTS.—The home and community-based at-
11 tendant services and supports may include—

12 “(i) expenditures for transition costs
13 such as rent and utility deposits, first
14 month’s rent and utilities, bedding, basic
15 kitchen supplies, and other necessities re-
16 quired for an individual to make the tran-
17 sition from a nursing facility, institution
18 for mental diseases, or intermediate care
19 facility for the mentally retarded to a com-
20 munity-based home setting where the indi-
21 vidual resides; and

22 “(ii) expenditures relating to a need
23 identified in an individual’s person-cen-
24 tered plan of services that increase inde-
25 pendence or substitute for human assist-

1 ance, to the extent that expenditures would
2 otherwise be made for the human assist-
3 ance.

4 “(2) INCREASED FEDERAL FINANCIAL PARTICI-
5 PATION.—For purposes of payments to a State
6 under section 1903(a)(1), with respect to amounts
7 expended by the State to provide medical assistance
8 under the State plan for home and community-based
9 attendant services and supports to eligible individ-
10 uals in accordance with this subsection during a fis-
11 cal year quarter occurring during the period de-
12 scribed in paragraph (1), the Federal medical assist-
13 ance percentage applicable to the State (as deter-
14 mined under section 1905(b)) shall be increased by
15 6 percentage points.

16 “(3) STATE REQUIREMENTS.—In order for a
17 State plan amendment to be approved under this
18 subsection, the State shall—

19 “(A) develop and implement such amend-
20 ment in collaboration with a Development and
21 Implementation Council established by the
22 State that includes a majority of members with
23 disabilities, elderly individuals, and their rep-
24 resentatives and consults and collaborates with
25 such individuals;

1 “(B) provide consumer controlled home
2 and community-based attendant services and
3 supports to individuals on a statewide basis, in
4 a manner that provides such services and sup-
5 ports in the most integrated setting appropriate
6 to the individual’s needs, and without regard to
7 the individual’s age, type or nature of disability,
8 severity of disability, or the form of home and
9 community-based attendant services and sup-
10 ports that the individual requires in order to
11 lead an independent life;

12 “(C) with respect to expenditures during
13 the first full fiscal year in which the State plan
14 amendment is implemented, maintain or exceed
15 the level of State expenditures for medical as-
16 sistance that is provided under section 1905(a),
17 section 1915, section 1115, or otherwise to indi-
18 viduals with disabilities or elderly individuals
19 attributable to the preceding fiscal year;

20 “(D) establish and maintain a comprehen-
21 sive, continuous quality assurance system with
22 respect to community- based attendant services
23 and supports that—

24 “(i) includes standards for agency-
25 based and other delivery models with re-

1 spect to training, appeals for denials and
2 reconsideration procedures of an individual
3 plan, and other factors as determined by
4 the Secretary;

5 “(ii) incorporates feedback from con-
6 sumers and their representatives, disability
7 organizations, providers, families of dis-
8 abled or elderly individuals, members of
9 the community, and others and maximizes
10 consumer independence and consumer con-
11 trol;

12 “(iii) monitors the health and well-
13 being of each individual who receives home
14 and community-based attendant services
15 and supports, including a process for the
16 mandatory reporting, investigation, and
17 resolution of allegations of neglect, abuse,
18 or exploitation in connection with the pro-
19 vision of such services and supports; and

20 “(iv) provides information about the
21 provisions of the quality assurance re-
22 quired under clauses (i) through (iii) to
23 each individual receiving such services; and

24 “(E) collect and report information, as de-
25 termined necessary by the Secretary, for the

1 purposes of approving the State plan amend-
2 ment, providing Federal oversight, and con-
3 ducting an evaluation under paragraph (5)(A),
4 including data regarding how the State provides
5 home and community-based attendant services
6 and supports and other home and community-
7 based services, the cost of such services and
8 supports, and how the State provides individ-
9 uals with disabilities who otherwise qualify for
10 institutional care under the State plan or under
11 a waiver the choice to instead receive home and
12 community-based services in lieu of institutional
13 care.

14 “(4) COMPLIANCE WITH CERTAIN LAWS.—A
15 State shall ensure that, regardless of whether the
16 State uses an agency-provider model or other models
17 to provide home and community-based attendant
18 services and supports under a State plan amend-
19 ment under this subsection, such services and sup-
20 ports are provided in accordance with the require-
21 ments of the Fair Labor Standards Act of 1938 and
22 applicable Federal and State laws regarding—

23 “(A) withholding and payment of Federal
24 and State income and payroll taxes;

1 “(B) the provision of unemployment and
2 workers compensation insurance;

3 “(C) maintenance of general liability insur-
4 ance; and

5 “(D) occupational health and safety.

6 “(5) EVALUATION, DATA COLLECTION, AND RE-
7 PORT TO CONGRESS.—

8 “(A) EVALUATION.—The Secretary shall
9 conduct an evaluation of the provision of home
10 and community-based attendant services and
11 supports under this subsection in order to de-
12 termine the effectiveness of the provision of
13 such services and supports in allowing the indi-
14 viduals receiving such services and supports to
15 lead an independent life to the maximum extent
16 possible; the impact on the physical and emo-
17 tional health of the individuals who receive such
18 services; and an comparative analysis of the
19 costs of services provided under the State plan
20 amendment under this subsection and those
21 provided under institutional care in a nursing
22 facility, institution for mental diseases, or an
23 intermediate care facility for the mentally re-
24 tarded.

1 “(B) DATA COLLECTION.—The State shall
2 provide the Secretary with the following infor-
3 mation regarding the provision of home and
4 community-based attendant services and sup-
5 ports under this subsection for each fiscal year
6 for which such services and supports are pro-
7 vided:

8 “(i) The number of individuals who
9 are estimated to receive home and commu-
10 nity-based attendant services and supports
11 under this subsection during the fiscal
12 year.

13 “(ii) The number of individuals that
14 received such services and supports during
15 the preceding fiscal year.

16 “(iii) The specific number of individ-
17 uals served by type of disability, age, gen-
18 der, education level, and employment sta-
19 tus.

20 “(iv) Whether the specific individuals
21 have been previously served under any
22 other home and community based services
23 program under the State plan or under a
24 waiver.

25 “(C) REPORTS.—Not later than—

1 “(i) December 31, 2013, the Sec-
2 retary shall submit to Congress and make
3 available to the public an interim report on
4 the findings of the evaluation under sub-
5 paragraph (A); and

6 “(ii) December 31, 2015, the Sec-
7 retary shall submit to Congress and make
8 available to the public a final report on the
9 findings of the evaluation under subpara-
10 graph (A).

11 “(6) DEFINITIONS.—In this subsection:

12 “(A) ACTIVITIES OF DAILY LIVING.—The
13 term ‘activities of daily living’ includes tasks
14 such as eating, toileting, grooming, dressing,
15 bathing, and transferring.

16 “(B) CONSUMER CONTROLLED.—The term
17 ‘consumer controlled’ means a method of select-
18 ing and providing services and supports that
19 allow the individual, or where appropriate, the
20 individual’s representative, maximum control of
21 the home and community-based attendant serv-
22 ices and supports, regardless of who acts as the
23 employer of record.

24 “(C) DELIVERY MODELS.—

1 “(i) AGENCY-PROVIDER MODEL.—The
2 term ‘agency-provider model’ means, with
3 respect to the provision of home and com-
4 munity-based attendant services and sup-
5 ports for an individual, subject to para-
6 graph (4), a method of providing consumer
7 controlled services and supports under
8 which entities contract for the provision of
9 such services and supports.

10 “(ii) OTHER MODELS.—The term
11 ‘other models’ means, subject to paragraph
12 (4), methods, other than an agency-pro-
13 vider model, for the provision of consumer
14 controlled services and supports. Such
15 models may include the provision of vouch-
16 ers, direct cash payments, or use of a fiscal
17 agent to assist in obtaining services.

18 “(D) HEALTH-RELATED TASKS.—The
19 term ‘health-related tasks’ means specific tasks
20 related to the needs of an individual, which can
21 be delegated or assigned by licensed health-care
22 professionals under State law to be performed
23 by an attendant.

24 “(E) INDIVIDUAL’S REPRESENTATIVE.—
25 The term ‘individual’s representative’ means a

1 parent, family member, guardian, advocate, or
2 other authorized representative of an individual

3 “(F) INSTRUMENTAL ACTIVITIES OF DAILY
4 LIVING.—The term ‘instrumental activities of
5 daily living’ includes (but is not limited to) meal
6 planning and preparation, managing finances,
7 shopping for food, clothing, and other essential
8 items, performing essential household chores,
9 communicating by phone or other media, and
10 traveling around and participating in the com-
11 munity.”.

12 **SEC. 2402. REMOVAL OF BARRIERS TO PROVIDING HOME**
13 **AND COMMUNITY-BASED SERVICES.**

14 (a) **OVERSIGHT AND ASSESSMENT OF THE ADMINIS-**
15 **TRATION OF HOME AND COMMUNITY-BASED SERVICES.—**

16 The Secretary of Health and Human Services shall pro-
17 mulgate regulations to ensure that all States develop serv-
18 ice systems that are designed to—

19 (1) allocate resources for services in a manner
20 that is responsive to the changing needs and choices
21 of beneficiaries receiving non-institutionally-based
22 long-term services and supports (including such
23 services and supports that are provided under pro-
24 grams other the State Medicaid program), and that
25 provides strategies for beneficiaries receiving such

1 services to maximize their independence, including
2 through the use of client-employed providers;

3 (2) provide the support and coordination needed
4 for a beneficiary in need of such services (and their
5 family caregivers or representative, if applicable) to
6 design an individualized, self-directed, community-
7 supported life; and

8 (3) improve coordination among, and the regu-
9 lation of, all providers of such services under feder-
10 ally and State-funded programs in order to—

11 (A) achieve a more consistent administra-
12 tion of policies and procedures across programs
13 in relation to the provision of such services; and

14 (B) oversee and monitor all service system
15 functions to assure—

16 (i) coordination of, and effectiveness
17 of, eligibility determinations and individual
18 assessments;

19 (ii) development and service moni-
20 toring of a complaint system, a manage-
21 ment system, a system to qualify and mon-
22 itor providers, and systems for role-setting
23 and individual budget determinations; and

1 (iii) an adequate number of qualified
2 direct care workers to provide self-directed
3 personal assistance services.

4 (b) ADDITIONAL STATE OPTIONS.—Section 1915(i)
5 of the Social Security Act (42 U.S.C. 1396n(i)) is amend-
6 ed by adding at the end the following new paragraphs:

7 “(6) STATE OPTION TO PROVIDE HOME AND
8 COMMUNITY-BASED SERVICES TO INDIVIDUALS ELI-
9 GIBLE FOR SERVICES UNDER A WAIVER.—

10 “(A) IN GENERAL.—A State that provides
11 home and community-based services in accord-
12 ance with this subsection to individuals who
13 satisfy the needs-based criteria for the receipt
14 of such services established under paragraph
15 (1)(A) may, in addition to continuing to provide
16 such services to such individuals, elect to pro-
17 vide home and community-based services in ac-
18 cordance with the requirements of this para-
19 graph to individuals who are eligible for home
20 and community-based services under a waiver
21 approved for the State under subsection (c),
22 (d), or (e) or under section 1115 to provide
23 such services, but only for those individuals
24 whose income does not exceed 300 percent of

1 the supplemental security income benefit rate
2 established by section 1611(b)(1).

3 “(B) APPLICATION OF SAME REQUIRE-
4 MENTS FOR INDIVIDUALS SATISFYING NEEDS-
5 BASED CRITERIA.—Subject to subparagraph
6 (C), a State shall provide home and community-
7 based services to individuals under this para-
8 graph in the same manner and subject to the
9 same requirements as apply under the other
10 paragraphs of this subsection to the provision
11 of home and community-based services to indi-
12 viduals who satisfy the needs-based criteria es-
13 tablished under paragraph (1)(A).

14 “(C) AUTHORITY TO OFFER DIFFERENT
15 TYPE, AMOUNT, DURATION, OR SCOPE OF HOME
16 AND COMMUNITY-BASED SERVICES.—A State
17 may offer home and community-based services
18 to individuals under this paragraph that differ
19 in type, amount, duration, or scope from the
20 home and community-based services offered for
21 individuals who satisfy the needs-based criteria
22 established under paragraph (1)(A), so long as
23 such services are within the scope of services
24 described in paragraph (4)(B) of subsection (c)
25 for which the Secretary has the authority to ap-

1 prove a waiver and do not include room or
2 board.

3 “(7) STATE OPTION TO OFFER HOME AND COM-
4 MUNITY-BASED SERVICES TO SPECIFIC, TARGETED
5 POPULATIONS.—

6 “(A) IN GENERAL.—A State may elect in
7 a State plan amendment under this subsection
8 to target the provision of home and community-
9 based services under this subsection to specific
10 populations and to differ the type, amount, du-
11 ration, or scope of such services to such specific
12 populations.

13 “(B) 5-YEAR TERM.—

14 “(i) IN GENERAL.—An election by a
15 State under this paragraph shall be for a
16 period of 5 years.

17 “(ii) PHASE-IN OF SERVICES AND ELI-
18 GIBILITY PERMITTED DURING INITIAL 5-
19 YEAR PERIOD.—A State making an elec-
20 tion under this paragraph may, during the
21 first 5-year period for which the election is
22 made, phase-in the enrollment of eligible
23 individuals, or the provision of services to
24 such individuals, or both, so long as all eli-
25 gible individuals in the State for such serv-

1 ices are enrolled, and all such services are
 2 provided, before the end of the initial 5-
 3 year period.

4 “(C) RENEWAL.—An election by a State
 5 under this paragraph may be renewed for addi-
 6 tional 5-year terms if the Secretary determines,
 7 prior to beginning of each such renewal period,
 8 that the State has—

9 “(i) adhered to the requirements of
 10 this subsection and paragraph in providing
 11 services under such an election; and

12 “(ii) met the State’s objectives with
 13 respect to quality improvement and bene-
 14 ficiary outcomes.”.

15 (c) REMOVAL OF LIMITATION ON SCOPE OF SERV-
 16 ICES.—Paragraph (1) of section 1915(i) of the Social Se-
 17 curity Act (42 U.S.C. 1396n(i)), as amended by sub-
 18 section (a), is amended by striking “or such other services
 19 requested by the State as the Secretary may approve”.

20 (d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE
 21 FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING
 22 HOME AND COMMUNITY-BASED SERVICES UNDER A
 23 STATE PLAN AMENDMENT.—

24 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
 25 of the Social Security Act (42 U.S.C.

1 1396a(a)(10)(A)(ii)), as amended by section
2 2304(a)(1), is amended—

3 (A) in subclause (XX), by striking “or” at
4 the end;

5 (B) in subclause (XXI), by adding “or” at
6 the end; and

7 (C) by inserting after subclause (XXI), the
8 following new subclause:

9 “(XXII) who are eligible for
10 home and community-based services
11 under needs-based criteria established
12 under paragraph (1)(A) of section
13 1915(i), or who are eligible for home
14 and community-based services under
15 paragraph (6) of such section, and
16 who will receive home and community-
17 based services pursuant to a State
18 plan amendment under such sub-
19 section;”.

20 (2) CONFORMING AMENDMENTS.—

21 (A) Section 1903(f)(4) of the Social Secu-
22 rity Act (42 U.S.C. 1396b(f)(4)), as amended
23 by section 2304(a)(4)(B), is amended in the
24 matter preceding subparagraph (A), by insert-

1 ing “1902(a)(10)(A)(ii)(XXII),” after
2 “1902(a)(10)(A)(ii)(XXI),”.

3 (B) Section 1905(a) of the Social Security
4 Act (42 U.S.C. 1396d(a)), as so amended, is
5 amended in the matter preceding paragraph
6 (1)—

7 (i) in clause (xv), by striking “or” at
8 the end;

9 (ii) in clause (xvi), by adding “or” at
10 the end; and

11 (iii) by inserting after clause (xvi) the
12 following new clause:

13 “(xvii) individuals who are eligible for home and
14 community-based services under needs-based criteria
15 established under paragraph (1)(A) of section
16 1915(i), or who are eligible for home and commu-
17 nity-based services under paragraph (6) of such sec-
18 tion, and who will receive home and community-
19 based services pursuant to a State plan amendment
20 under such subsection,”.

21 (e) ELIMINATION OF OPTION TO LIMIT NUMBER OF
22 ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR
23 GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA
24 IS MODIFIED.—Paragraph (1) of section 1915(i) of such
25 Act (42 U.S.C. 1396n(i)) is amended—

1 (1) by striking subparagraph (C) and inserting
2 the following:

3 “(C) PROJECTION OF NUMBER OF INDI-
4 VIDUALS TO BE PROVIDED HOME AND COMMU-
5 NITY-BASED SERVICES.—The State submits to
6 the Secretary, in such form and manner, and
7 upon such frequency as the Secretary shall
8 specify, the projected number of individuals to
9 be provided home and community-based serv-
10 ices.”; and

11 (2) in subclause (II) of subparagraph (D)(ii),
12 by striking “to be eligible for such services for a pe-
13 riod of at least 12 months beginning on the date the
14 individual first received medical assistance for such
15 services” and inserting “to continue to be eligible for
16 such services after the effective date of the modifica-
17 tion and until such time as the individual no longer
18 meets the standard for receipt of such services under
19 such pre-modified criteria”.

20 (f) ELIMINATION OF OPTION TO WAIVE
21 STATEWIDENESS; ADDITION OF OPTION TO WAIVE COM-
22 PARABILITY.—Paragraph (3) of section 1915(i) of such
23 Act (42 U.S.C. 1396n(3)) is amended by striking
24 “1902(a)(1) (relating to statewideness)” and inserting
25 “1902(a)(10)(B) (relating to comparability)”.

1 (g) EFFECTIVE DATE.—The amendments made by
2 subsections (b) through (f) take effect on the first day of
3 the first fiscal year quarter that begins after the date of
4 enactment of this Act.

5 **SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING**
6 **DEMONSTRATION.**

7 (a) EXTENSION OF DEMONSTRATION.—

8 (1) IN GENERAL.—Section 6071(h) of the Def-
9 icit Reduction Act of 2005 (42 U.S.C. 1396a note)
10 is amended—

11 (A) in paragraph (1)(E), by striking “fis-
12 cal year 2011” and inserting “each of fiscal
13 years 2011 through 2016”; and

14 (B) in paragraph (2), by striking “2011”
15 and inserting “2016”.

16 (2) EVALUATION.—Paragraphs (2) and (3) of
17 section 6071(g) of such Act is amended are each
18 amended by striking “2011” and inserting “2016”.

19 (b) REDUCTION OF INSTITUTIONAL RESIDENCY PE-
20 RIOD.—

21 (1) IN GENERAL.—Section 6071(b)(2) of the
22 Deficit Reduction Act of 2005 (42 U.S.C. 1396a
23 note) is amended—

24 (A) in subparagraph (A)(i), by striking “,
25 for a period of not less than 6 months or for

1 such longer minimum period, not to exceed 2
2 years, as may be specified by the State” and in-
3 serting “for a period of not less than 90 con-
4 secutive days”; and

5 (B) by adding at the end the following:

6 “Any days that an individual resides in an institu-
7 tion on the basis of having been admitted solely for
8 purposes of receiving short-term rehabilitative serv-
9 ices for a period for which payment for such services
10 is limited under title XVIII shall not be taken into
11 account for purposes of determining the 90-day pe-
12 riod required under subparagraph (A)(i).”.

13 (2) EFFECTIVE DATE.—The amendments made
14 by this subsection take effect 30 days after the date
15 of enactment of this Act.

16 **SEC. 2404. PROTECTION FOR RECIPIENTS OF HOME AND**
17 **COMMUNITY-BASED SERVICES AGAINST**
18 **SPOUSAL IMPOVERISHMENT.**

19 During the 5-year period that begins on January 1,
20 2014, section 1924(h)(1)(A) of the Social Security Act (42
21 U.S.C. 1396r-5(h)(1)(A)) shall be applied as though “is
22 eligible for medical assistance for home and community-
23 based services provided under subsection (c), (d), or (i)
24 of section 1915, under a waiver approved under section
25 1115, or who is eligible for such medical assistance by rea-

1 son of being determined eligible under section
2 1902(a)(10)(C) or by reason of section 1902(f) or other-
3 wise on the basis of a reduction of income based on costs
4 incurred for medical or other remedial care, or who is eligi-
5 ble for medical assistance for home and community-based
6 attendant services and supports under section 1915(k)”
7 were substituted in such section for “(at the option of the
8 State) is described in section 1902(a)(10)(A)(ii)(VI)”.

9 **SEC. 2405. FUNDING TO EXPAND STATE AGING AND DIS-**
10 **ABILITY RESOURCE CENTERS.**

11 Out of any funds in the Treasury not otherwise ap-
12 propriated, there is appropriated to the Secretary of
13 Health and Human Services, acting through the Assistant
14 Secretary for Aging, \$10,000,000 for each of fiscal years
15 2010 through 2014, to carry out subsections
16 (a)(20)(B)(iii) and (b)(8) of section 202 of the Older
17 Americans Act of 1965 (42 U.S.C. 3012).

18 **SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM**
19 **CARE.**

20 (a) FINDINGS.—The Senate makes the following
21 findings:

22 (1) Nearly 2 decades have passed since Con-
23 gress seriously considered long-term care reform.
24 The United States Bipartisan Commission on Com-
25 prehensive Health Care, also know as the “Pepper

1 Commission”, released its “Call for Action” blue-
2 print for health reform in September 1990. In the
3 20 years since those recommendations were made,
4 Congress has never acted on the report.

5 (2) In 1999, under the United States Supreme
6 Court’s decision in *Olmstead v. L.C.*, 527 U.S. 581
7 (1999), individuals with disabilities have the right to
8 choose to receive their long-term services and sup-
9 ports in the community, rather than in an institu-
10 tional setting.

11 (3) Despite the Pepper Commission and
12 *Olmstead* decision, the long-term care provided to
13 our Nation’s elderly and disabled has not improved.
14 In fact, for many, it has gotten far worse.

15 (4) In 2007, 69 percent of Medicaid long-term
16 care spending for elderly individuals and adults with
17 physical disabilities paid for institutional services.
18 Only 6 states spent 50 percent or more of their
19 Medicaid long-term care dollars on home and com-
20 munity-based services for elderly individuals and
21 adults with physical disabilities while ½ of the
22 States spent less than 25 percent. This disparity
23 continues even though, on average, it is estimated
24 that Medicaid dollars can support nearly 3 elderly
25 individuals and adults with physical disabilities in

1 home and community-based services for every indi-
 2 vidual in a nursing home. Although every State has
 3 chosen to provide certain services under home and
 4 community-based waivers, these services are un-
 5 evenly available within and across States, and reach
 6 a small percentage of eligible individuals.

7 (b) SENSE OF THE SENATE.—It is the sense of the
 8 Senate that—

9 (1) during the 111th session of Congress, Con-
 10 gress should address long-term services and supports
 11 in a comprehensive way that guarantees elderly and
 12 disabled individuals the care they need; and

13 (2) long term services and supports should be
 14 made available in the community in addition to in
 15 institutions.

16 **Subtitle F—Medicaid Prescription** 17 **Drug Coverage**

18 **SEC. 2501. PRESCRIPTION DRUG REBATES.**

19 (a) INCREASE IN MINIMUM REBATE PERCENTAGE
 20 FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE
 21 SOURCE DRUGS.—

22 (1) IN GENERAL.—Section 1927(c)(1)(B) of the
 23 Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is
 24 amended—

25 (A) in clause (i)—

1 (i) in subclause (IV), by striking
2 “and” at the end;

3 (ii) in subclause (V)—

4 (I) by inserting “and before Jan-
5 uary 1, 2010” after “December 31,
6 1995,”; and

7 (II) by striking the period at the
8 end and inserting “; and”; and

9 (iii) by adding at the end the fol-
10 lowing new subclause:

11 “(VI) except as provided in
12 clause (iii), after December 31, 2009,
13 23.1 percent.”; and

14 (B) by adding at the end the following new
15 clause:

16 “(iii) MINIMUM REBATE PERCENTAGE
17 FOR CERTAIN DRUGS.—

18 “(I) IN GENERAL.—In the case
19 of a single source drug or an inno-
20 vator multiple source drug described
21 in subclause (II), the minimum rebate
22 percentage for rebate periods specified
23 in clause (i)(VI) is 17.1 percent.

24 “(II) DRUG DESCRIBED.—For
25 purposes of subclause (I), a single

1 source drug or an innovator multiple
2 source drug described in this sub-
3 clause is any of the following drugs:

4 “(aa) A clotting factor for
5 which a separate furnishing pay-
6 ment is made under section
7 1842(o)(5) and which is included
8 on a list of such factors specified
9 and updated regularly by the
10 Secretary.

11 “(bb) A drug approved by
12 the Food and Drug Administra-
13 tion exclusively for pediatric indi-
14 cations.”.

15 (2) RECAPTURE OF TOTAL SAVINGS DUE TO IN-
16 CREASE.—Section 1927(b)(1) of such Act (42
17 U.S.C. 1396r–8(b)(1)) is amended by adding at the
18 end the following new subparagraph:

19 “(C) SPECIAL RULE FOR INCREASED MIN-
20 IMUM REBATE PERCENTAGE.—

21 “(i) IN GENERAL.—In addition to the
22 amounts applied as a reduction under sub-
23 paragraph (B), for rebate periods begin-
24 ning on or after January 1, 2010, during
25 a fiscal year, the Secretary shall reduce

1 payments to a State under section 1903(a)
2 in the manner specified in clause (ii), in an
3 amount equal to the product of—

4 “(I) 100 percent minus the Fed-
5 eral medical assistance percentage ap-
6 plicable to the rebate period for the
7 State; and

8 “(II) the amounts received by the
9 State under such subparagraph that
10 are attributable (as estimated by the
11 Secretary based on utilization and
12 other data) to the increase in the min-
13 imum rebate percentage effected by
14 the amendments made by subsections
15 (a)(1), (b), and (d) of section 2501 of
16 the Patient Protection and Affordable
17 Care Act, taking into account the ad-
18 ditional drugs included under the
19 amendments made by subsection (c)
20 of section 2501 of such Act.

21 The Secretary shall adjust such payment
22 reduction for a calendar quarter to the ex-
23 tent the Secretary determines, based upon
24 subsequent utilization and other data, that
25 the reduction for such quarter was greater

1 or less than the amount of payment reduc-
 2 tion that should have been made.

3 “(ii) MANNER OF PAYMENT REDUC-
 4 TION.—The amount of the payment reduc-
 5 tion under clause (i) for a State for a
 6 quarter shall be deemed an overpayment to
 7 the State under this title to be disallowed
 8 against the State’s regular quarterly draw
 9 for all Medicaid spending under section
 10 1903(d)(2). Such a disallowance is not
 11 subject to a reconsideration under section
 12 1116(d).”.

13 (b) INCREASE IN REBATE FOR OTHER DRUGS.—Sec-
 14 tion 1927(c)(3)(B) of such Act (42 U.S.C. 1396r-
 15 8(c)(3)(B)) is amended—

16 (1) in clause (i), by striking “and” at the end;

17 (2) in clause (ii)—

18 (A) by inserting “and before January 1,
 19 2010,” after “December 31, 1993,”; and

20 (B) by striking the period and inserting “;
 21 and”; and

22 (3) by adding at the end the following new
 23 clause:

24 “(iii) after December 31, 2009, is 13
 25 percent.”.

1 (c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS
2 TO ENROLLEES OF MEDICAID MANAGED CARE ORGANI-
3 ZATIONS.—

4 (1) IN GENERAL.—Section 1903(m)(2)(A) of
5 such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

6 (A) in clause (xi), by striking “and” at the
7 end;

8 (B) in clause (xii), by striking the period
9 at the end and inserting “; and”; and

10 (C) by adding at the end the following:

11 “(xiii) such contract provides that (I)
12 covered outpatient drugs dispensed to indi-
13 viduals eligible for medical assistance who
14 are enrolled with the entity shall be subject
15 to the same rebate required by the agree-
16 ment entered into under section 1927 as
17 the State is subject to and that the State
18 shall collect such rebates from manufactur-
19 ers, (II) capitation rates paid to the entity
20 shall be based on actual cost experience re-
21 lated to rebates and subject to the Federal
22 regulations requiring actuarially sound
23 rates, and (III) the entity shall report to
24 the State, on such timely and periodic
25 basis as specified by the Secretary in order

1 to include in the information submitted by
2 the State to a manufacturer and the Sec-
3 retary under section 1927(b)(2)(A), infor-
4 mation on the total number of units of
5 each dosage form and strength and pack-
6 age size by National Drug Code of each
7 covered outpatient drug dispensed to indi-
8 viduals eligible for medical assistance who
9 are enrolled with the entity and for which
10 the entity is responsible for coverage of
11 such drug under this subsection (other
12 than covered outpatient drugs that under
13 subsection (j)(1) of section 1927 are not
14 subject to the requirements of that section)
15 and such other data as the Secretary de-
16 termines necessary to carry out this sub-
17 section.”.

18 (2) CONFORMING AMENDMENTS.—Section 1927
19 (42 U.S.C. 1396r–8) is amended—

20 (A) in subsection (b)—

21 (i) in paragraph (1)(A), in the first
22 sentence, by inserting “, including such
23 drugs dispensed to individuals enrolled
24 with a medicaid managed care organization
25 if the organization is responsible for cov-

1 erage of such drugs” before the period;
2 and

3 (ii) in paragraph (2)(A), by inserting
4 “including such information reported by
5 each medicaid managed care organization,”
6 after “for which payment was made under
7 the plan during the period,”; and

8 (B) in subsection (j), by striking para-
9 graph (1) and inserting the following:

10 “(1) Covered outpatient drugs are not subject
11 to the requirements of this section if such drugs
12 are—

13 “(A) dispensed by health maintenance or-
14 ganizations, including Medicaid managed care
15 organizations that contract under section
16 1903(m); and

17 “(B) subject to discounts under section
18 340B of the Public Health Service Act.”.

19 (d) ADDITIONAL REBATE FOR NEW FORMULATIONS
20 OF EXISTING DRUGS.—

21 (1) IN GENERAL.—Section 1927(c)(2) of the
22 Social Security Act (42 U.S.C. 1396r–8(c)(2)) is
23 amended by adding at the end the following new
24 subparagraph:

1 “(C) TREATMENT OF NEW FORMULA-
2 TIONS.—

3 “(i) IN GENERAL.—Except as pro-
4 vided in clause (ii), in the case of a drug
5 that is a new formulation, such as an ex-
6 tended-release formulation, of a single
7 source drug or an innovator multiple
8 source drug, the rebate obligation with re-
9 spect to the drug under this section shall
10 be the amount computed under this section
11 for the new formulation of the drug or, if
12 greater, the product of—

13 “(I) the average manufacturer
14 price for each dosage form and
15 strength of the new formulation of the
16 single source drug or innovator mul-
17 tiple source drug;

18 “(II) the highest additional re-
19 bate (calculated as a percentage of av-
20 erage manufacturer price) under this
21 section for any strength of the origi-
22 nal single source drug or innovator
23 multiple source drug; and

24 “(III) the total number of units
25 of each dosage form and strength of

1 the new formulation paid for under
2 the State plan in the rebate period (as
3 reported by the State).

4 “(ii) NO APPLICATION TO NEW FOR-
5 MULATIONS OF ORPHAN DRUGS.—Clause
6 (i) shall not apply to a new formulation of
7 a covered outpatient drug that is or has
8 been designated under section 526 of the
9 Federal Food, Drug, and Cosmetic Act (21
10 U.S.C. 360bb) for a rare disease or condi-
11 tion, without regard to whether the period
12 of market exclusivity for the drug under
13 section 527 of such Act has expired or the
14 specific indication for use of the drug.”.

15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall apply to drugs that are paid
17 for by a State after December 31, 2009.

18 (e) MAXIMUM REBATE AMOUNT.—Section
19 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as
20 amended by subsection (d), is amended by adding at the
21 end the following new subparagraph:

22 “(D) MAXIMUM REBATE AMOUNT.—In no
23 case shall the sum of the amounts applied
24 under paragraph (1)(A)(ii) and this paragraph
25 with respect to each dosage form and strength

1 of a single source drug or an innovator multiple
2 source drug for a rebate period beginning after
3 December 31, 2009, exceed 100 percent of the
4 average manufacturer price of the drug.”.

5 (f) CONFORMING AMENDMENTS.—

6 (1) IN GENERAL.—Section 340B of the Public
7 Health Service Act (42 U.S.C. 256b) is amended—

8 (A) in subsection (a)(2)(B)(i), by striking
9 “1927(c)(4)” and inserting “1927(c)(3)”; and

10 (B) by striking subsection (c); and

11 (C) redesignating subsection (d) as sub-
12 section (e).

13 (2) EFFECTIVE DATE.—The amendments made
14 by this subsection take effect on January 1, 2010.

15 **SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF**
16 **CERTAIN DRUGS.**

17 (a) IN GENERAL.—Section 1927(d) of the Social Se-
18 curity Act (42 U.S.C. 1397r–8(d)) is amended—

19 (1) in paragraph (2)—

20 (A) by striking subparagraphs (E), (I),
21 and (J), respectively; and

22 (B) by redesignating subparagraphs (F),
23 (G), (H), and (K) as subparagraphs (E), (F),
24 (G), and (H), respectively; and

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

3 “(7) NON-EXCLUDABLE DRUGS.—The following
4 drugs or classes of drugs, or their medical uses, shall
5 not be excluded from coverage:

6 “(A) Agents when used to promote smok-
7 ing cessation, including agents approved by the
8 Food and Drug Administration under the over-
9 the-counter monograph process for purposes of
10 promoting, and when used to promote, tobacco
11 cessation.

12 “(B) Barbiturates.

13 “(C) Benzodiazepines.”.

14 (b) EFFECTIVE DATE.—The amendments made by
15 this section shall apply to services furnished on or after
16 January 1, 2014.

17 **SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSE-**
18 **MENT.**

19 (a) PHARMACY REIMBURSEMENT LIMITS.—

20 (1) IN GENERAL.—Section 1927(e) of the So-
21 cial Security Act (42 U.S.C. 1396r–8(e)) is amend-
22 ed—

23 (A) in paragraph (4), by striking “(or, ef-
24 fective January 1, 2007, two or more)”; and

1 (B) by striking paragraph (5) and insert-
2 ing the following:

3 “(5) USE OF AMP IN UPPER PAYMENT LIM-
4 ITS.—The Secretary shall calculate the Federal
5 upper reimbursement limit established under para-
6 graph (4) as no less than 175 percent of the weight-
7 ed average (determined on the basis of utilization) of
8 the most recently reported monthly average manu-
9 facturer prices for pharmaceutically and therapeuti-
10 cally equivalent multiple source drug products that
11 are available for purchase by retail community phar-
12 macies on a nationwide basis. The Secretary shall
13 implement a smoothing process for average manu-
14 facturer prices. Such process shall be similar to the
15 smoothing process used in determining the average
16 sales price of a drug or biological under section
17 1847A.”.

18 (2) DEFINITION OF AMP.—Section 1927(k)(1)
19 of such Act (42 U.S.C. 1396r–8(k)(1)) is amend-
20 ed—

21 (A) in subparagraph (A), by striking “by”
22 and all that follows through the period and in-
23 serting “by—

24 “(i) wholesalers for drugs distributed
25 to retail community pharmacies; and

1 “(ii) retail community pharmacies
2 that purchase drugs directly from the man-
3 ufacturer.”; and

4 (B) by striking subparagraph (B) and in-
5 serting the following:

6 “(B) EXCLUSION OF CUSTOMARY PROMPT
7 PAY DISCOUNTS AND OTHER PAYMENTS.—

8 “(i) IN GENERAL.—The average man-
9 ufacturer price for a covered outpatient
10 drug shall exclude—

11 “(I) customary prompt pay dis-
12 counts extended to wholesalers;

13 “(II) bona fide service fees paid
14 by manufacturers to wholesalers or re-
15 tail community pharmacies, including
16 (but not limited to) distribution serv-
17 ice fees, inventory management fees,
18 product stocking allowances, and fees
19 associated with administrative services
20 agreements and patient care programs
21 (such as medication compliance pro-
22 grams and patient education pro-
23 grams);

24 “(III) reimbursement by manu-
25 facturers for recalled, damaged, ex-

1 pired, or otherwise unsalable returned
2 goods, including (but not limited to)
3 reimbursement for the cost of the
4 goods and any reimbursement of costs
5 associated with return goods handling
6 and processing, reverse logistics, and
7 drug destruction; and

8 “(IV) payments received from,
9 and rebates or discounts provided to,
10 pharmacy benefit managers, managed
11 care organizations, health mainte-
12 nance organizations, insurers, hos-
13 pitals, clinics, mail order pharmacies,
14 long term care providers, manufactur-
15 ers, or any other entity that does not
16 conduct business as a wholesaler or a
17 retail community pharmacy.

18 “(ii) INCLUSION OF OTHER DIS-
19 COUNTS AND PAYMENTS.—Notwith-
20 standing clause (i), any other discounts,
21 rebates, payments, or other financial trans-
22 actions that are received by, paid by, or
23 passed through to, retail community phar-
24 macies shall be included in the average

1 manufacturer price for a covered out-
2 patient drug.”; and

3 (C) in subparagraph (C), by striking “the
4 retail pharmacy class of trade” and inserting
5 “retail community pharmacies”.

6 (3) DEFINITION OF MULTIPLE SOURCE
7 DRUG.—Section 1927(k)(7) of such Act (42 U.S.C.
8 1396r–8(k)(7)) is amended—

9 (A) in subparagraph (A)(i)(III), by strik-
10 ing “the State” and inserting “the United
11 States”; and

12 (B) in subparagraph (C)—

13 (i) in clause (i), by inserting “and”
14 after the semicolon;

15 (ii) in clause (ii), by striking “; and”
16 and inserting a period; and

17 (iii) by striking clause (iii).

18 (4) DEFINITIONS OF RETAIL COMMUNITY PHAR-
19 MACY; WHOLESALER.—Section 1927(k) of such Act
20 (42 U.S.C. 1396r–8(k)) is amended by adding at the
21 end the following new paragraphs:

22 “(10) RETAIL COMMUNITY PHARMACY.—The
23 term ‘retail community pharmacy’ means an inde-
24 pendent pharmacy, a chain pharmacy, a super-
25 market pharmacy, or a mass merchandiser phar-

1 macy that is licensed as a pharmacy by the State
2 and that dispenses medications to the general public
3 at retail prices. Such term does not include a phar-
4 macy that dispenses prescription medications to pa-
5 tients primarily through the mail, nursing home
6 pharmacies, long-term care facility pharmacies, hos-
7 pital pharmacies, clinics, charitable or not-for-profit
8 pharmacies, government pharmacies, or pharmacy
9 benefit managers.

10 “(11) WHOLESALER.—The term ‘wholesaler’
11 means a drug wholesaler that is engaged in whole-
12 sale distribution of prescription drugs to retail com-
13 munity pharmacies, including (but not limited to)
14 manufacturers, repackers, distributors, own-label
15 distributors, private-label distributors, jobbers, bro-
16 kers, warehouses (including manufacturer’s and dis-
17 tributor’s warehouses, chain drug warehouses, and
18 wholesale drug warehouses) independent wholesale
19 drug traders, and retail community pharmacies that
20 conduct wholesale distributions.”.

21 (b) DISCLOSURE OF PRICE INFORMATION TO THE
22 PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C.
23 1396r–8(b)(3)) is amended—

24 (1) in subparagraph (A)—

1 (A) in the first sentence, by inserting after
2 clause (iii) the following:

3 “(iv) not later than 30 days after the
4 last day of each month of a rebate period
5 under the agreement, on the manufactur-
6 er’s total number of units that are used to
7 calculate the monthly average manufac-
8 turer price for each covered outpatient
9 drug;”; and

10 (B) in the second sentence, by inserting
11 “(relating to the weighted average of the most
12 recently reported monthly average manufacturer
13 prices)” after “(D)(v)”; and

14 (2) in subparagraph (D)(v), by striking “aver-
15 age manufacturer prices” and inserting “the weight-
16 ed average of the most recently reported monthly av-
17 erage manufacturer prices and the average retail
18 survey price determined for each multiple source
19 drug in accordance with subsection (f)”.

20 (c) CLARIFICATION OF APPLICATION OF SURVEY OF
21 RETAIL PRICES.—Section 1927(f)(1) of such Act (42
22 U.S.C. 1396r–8(b)(1)) is amended—

23 (1) in subparagraph (A)(i), by inserting “with
24 respect to a retail community pharmacy,” before
25 “the determination”; and

1 (2) in subparagraph (C)(ii), by striking “retail
2 pharmacies” and inserting “retail community phar-
3 macies”.

4 (d) EFFECTIVE DATE.—The amendments made by
5 this section shall take effect on the first day of the first
6 calendar year quarter that begins at least 180 days after
7 the date of enactment of this Act, without regard to
8 whether or not final regulations to carry out such amend-
9 ments have been promulgated by such date.

10 **Subtitle G—Medicaid Dispropor-**
11 **tionate Share Hospital (DSH)**
12 **Payments**

13 **SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAY-**
14 **MENTS.**

15 (a) IN GENERAL.—Section 1923(f) of the Social Se-
16 curity Act (42 U.S.C. 1396r-4(f)) is amended—

17 (1) in paragraph (1), by striking “and (3)” and
18 inserting “, (3), and (7)”;

19 (2) in paragraph (3)(A), by striking “paragraph
20 (6)” and inserting “paragraphs (6) and (7)”;

21 (3) by redesignating paragraph (7) as para-
22 graph (8); and

23 (4) by inserting after paragraph (6) the fol-
24 lowing new paragraph:

1 “(7) REDUCTION OF STATE DSH ALLOTMENTS
2 ONCE REDUCTION IN UNINSURED THRESHOLD
3 REACHED.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (E), the DSH allotment for a State for
6 fiscal years beginning with the fiscal year de-
7 scribed in subparagraph (C) (with respect to
8 the State), is equal to—

9 “(i) in the case of the first fiscal year
10 described in subparagraph (C) with respect
11 to a State, the DSH allotment that would
12 be determined under this subsection for
13 the State for the fiscal year without appli-
14 cation of this paragraph (but after the ap-
15 plication of subparagraph (D)), reduced by
16 the applicable percentage determined for
17 the State for the fiscal year under sub-
18 paragraph (B)(i); and

19 “(ii) in the case of any subsequent fis-
20 cal year with respect to the State, the
21 DSH allotment determined under this
22 paragraph for the State for the preceding
23 fiscal year, reduced by the applicable per-
24 centage determined for the State for the
25 fiscal year under subparagraph (B)(ii).

1 “(B) APPLICABLE PERCENTAGE.—For
2 purposes of subparagraph (A), the applicable
3 percentage for a State for a fiscal year is the
4 following:

5 “(i) UNINSURED REDUCTION THRESH-
6 OLD FISCAL YEAR.—In the case of the first
7 fiscal year described in subparagraph (C)
8 with respect to the State—

9 “(I) if the State is a low DSH
10 State described in paragraph (5)(B),
11 the applicable percentage is equal to
12 25 percent; and

13 “(II) if the State is any other
14 State, the applicable percentage is 50
15 percent.

16 “(ii) SUBSEQUENT FISCAL YEARS IN
17 WHICH THE PERCENTAGE OF UNINSURED
18 DECREASES.—In the case of any fiscal
19 year after the first fiscal year described in
20 subparagraph (C) with respect to a State,
21 if the Secretary determines on the basis of
22 the most recent American Community Sur-
23 vey of the Bureau of the Census, that the
24 percentage of uncovered individuals resid-
25 ing in the State is less than the percentage

1 of such individuals determined for the
2 State for the preceding fiscal year—

3 “(I) if the State is a low DSH
4 State described in paragraph (5)(B),
5 the applicable percentage is equal to
6 the product of the percentage reduc-
7 tion in uncovered individuals for the
8 fiscal year from the preceding fiscal
9 year and 25 percent; and

10 “(II) if the State is any other
11 State, the applicable percentage is
12 equal to the product of the percentage
13 reduction in uncovered individuals for
14 the fiscal year from the preceding fis-
15 cal year and 50 percent.

16 “(C) FISCAL YEAR DESCRIBED.—For pur-
17 poses of subparagraph (A), the fiscal year de-
18 scribed in this subparagraph with respect to a
19 State is the first fiscal year that occurs after
20 fiscal year 2012 for which the Secretary deter-
21 mines, on the basis of the most recent Amer-
22 ican Community Survey of the Bureau of the
23 Census, that the percentage of uncovered indi-
24 viduals residing in the State is at least 45 per-
25 cent less than the percentage of such individ-

1 uals determined for the State for fiscal year
2 2009.

3 “(D) EXCLUSION OF PORTIONS DIVERTED
4 FOR COVERAGE EXPANSIONS.—For purposes of
5 applying the applicable percentage reduction
6 under subparagraph (A) to the DSH allotment
7 for a State for a fiscal year, the DSH allotment
8 for a State that would be determined under this
9 subsection for the State for the fiscal year with-
10 out the application of this paragraph (and prior
11 to any such reduction) shall not include any
12 portion of the allotment for which the Secretary
13 has approved the State’s diversion to the costs
14 of providing medical assistance or other health
15 benefits coverage under a waiver that is in ef-
16 fect on July 2009.

17 “(E) MINIMUM ALLOTMENT.—In no event
18 shall the DSH allotment determined for a State
19 in accordance with this paragraph for fiscal
20 year 2013 or any succeeding fiscal year be less
21 than the amount equal to 35 percent of the
22 DSH allotment determined for the State for fis-
23 cal year 2012 under this subsection (and after
24 the application of this paragraph, if applicable),
25 increased by the percentage change in the con-

1 consumer price index for all urban consumers (all
2 items, U.S. city average) for each previous fis-
3 cal year occurring before the fiscal year.

4 “(F) UNCOVERED INDIVIDUALS.—In this
5 paragraph, the term ‘uncovered individuals’
6 means individuals with no health insurance cov-
7 erage at any time during a year (as determined
8 by the Secretary based on the most recent data
9 available).”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) take effect on October 1, 2011.

12 **Subtitle H—Improved Coordina-**
13 **tion for Dual Eligible Bene-**
14 **ficiaries**

15 **SEC. 2601. 5-YEAR PERIOD FOR DEMONSTRATION**
16 **PROJECTS.**

17 (a) IN GENERAL.—Section 1915(h) of the Social Se-
18 curity Act (42 U.S.C. 1396n(h)) is amended—

19 (1) by inserting “(1)” after “(h)”;

20 (2) by inserting “, or a waiver described in
21 paragraph (2)” after “(e)”; and

22 (3) by adding at the end the following new
23 paragraph:

24 “(2)(A) Notwithstanding subsections (c)(3) and (d)
25 (3), any waiver under subsection (b), (c), or (d), or a waiv-

1 er under section 1115, that provides medical assistance
2 for dual eligible individuals (including any such waivers
3 under which non dual eligible individuals may be enrolled
4 in addition to dual eligible individuals) may be conducted
5 for a period of 5 years and, upon the request of the State,
6 may be extended for additional 5-year periods unless the
7 Secretary determines that for the previous waiver period
8 the conditions for the waiver have not been met or it would
9 no longer be cost-effective and efficient, or consistent with
10 the purposes of this title, to extend the waiver.

11 “(B) In this paragraph, the term ‘dual eligible indi-
12 vidual’ means an individual who is entitled to, or enrolled
13 for, benefits under part A of title XVIII, or enrolled for
14 benefits under part B of title XVIII, and is eligible for
15 medical assistance under the State plan under this title
16 or under a waiver of such plan.”.

17 (b) CONFORMING AMENDMENTS.—

18 (1) Section 1915 of such Act (42 U.S.C.
19 1396n) is amended—

20 (A) in subsection (b), by adding at the end
21 the following new sentence: “Subsection (h)(2)
22 shall apply to a waiver under this subsection.”;

23 (B) in subsection (e)(3), in the second sen-
24 tence, by inserting “(other than a waiver de-

1 scribed in subsection (h)(2))” after “A waiver
2 under this subsection”;

3 (C) in subsection (d)(3), in the second sen-
4 tence, by inserting “(other than a waiver de-
5 scribed in subsection (h)(2))” after “A waiver
6 under this subsection”.

7 (2) Section 1115 of such Act (42 U.S.C. 1315)
8 is amended—

9 (A) in subsection (e)(2), by inserting “(5
10 years, in the case of a waiver described in sec-
11 tion 1915(h)(2))” after “3 years”; and

12 (B) in subsection (f)(6), by inserting “(5
13 years, in the case of a waiver described in sec-
14 tion 1915(h)(2))” after “3 years”.

15 **SEC. 2602. PROVIDING FEDERAL COVERAGE AND PAYMENT**
16 **COORDINATION FOR DUAL ELIGIBLE BENE-**
17 **FICIARIES.**

18 (a) ESTABLISHMENT OF FEDERAL COORDINATED
19 HEALTH CARE OFFICE.—

20 (1) IN GENERAL.—Not later than March 1,
21 2010, the Secretary of Health and Human Services
22 (in this section referred to as the “Secretary”) shall
23 establish a Federal Coordinated Health Care Office.

1 (2) ESTABLISHMENT AND REPORTING TO CMS
2 ADMINISTRATOR.—The Federal Coordinated Health
3 Care Office—

4 (A) shall be established within the Centers
5 for Medicare & Medicaid Services; and

6 (B) have as the Office a Director who shall
7 be appointed by, and be in direct line of author-
8 ity to, the Administrator of the Centers for
9 Medicare & Medicaid Services.

10 (b) PURPOSE.—The purpose of the Federal Coordi-
11 nated Health Care Office is to bring together officers and
12 employees of the Medicare and Medicaid programs at the
13 Centers for Medicare & Medicaid Services in order to—

14 (1) more effectively integrate benefits under the
15 Medicare program under title XVIII of the Social
16 Security Act and the Medicaid program under title
17 XIX of such Act; and

18 (2) improve the coordination between the Fed-
19 eral Government and States for individuals eligible
20 for benefits under both such programs in order to
21 ensure that such individuals get full access to the
22 items and services to which they are entitled under
23 titles XVIII and XIX of the Social Security Act.

24 (c) GOALS.—The goals of the Federal Coordinated
25 Health Care Office are as follows:

1 (1) Providing dual eligible individuals full ac-
2 cess to the benefits to which such individuals are en-
3 titled under the Medicare and Medicaid programs.

4 (2) Simplifying the processes for dual eligible
5 individuals to access the items and services they are
6 entitled to under the Medicare and Medicaid pro-
7 grams.

8 (3) Improving the quality of health care and
9 long-term services for dual eligible individuals.

10 (4) Increasing dual eligible individuals' under-
11 standing of and satisfaction with coverage under the
12 Medicare and Medicaid programs.

13 (5) Eliminating regulatory conflicts between
14 rules under the Medicare and Medicaid programs.

15 (6) Improving care continuity and ensuring safe
16 and effective care transitions for dual eligible indi-
17 viduals.

18 (7) Eliminating cost-shifting between the Medi-
19 care and Medicaid program and among related
20 health care providers.

21 (8) Improving the quality of performance of
22 providers of services and suppliers under the Medi-
23 care and Medicaid programs.

1 (d) SPECIFIC RESPONSIBILITIES.—The specific re-
2 sponsibilities of the Federal Coordinated Health Care Of-
3 fice are as follows:

4 (1) Providing States, specialized MA plans for
5 special needs individuals (as defined in section
6 1859(b)(6) of the Social Security Act (42 U.S.C.
7 1395w–28(b)(6))), physicians and other relevant en-
8 tities or individuals with the education and tools nec-
9 essary for developing programs that align benefits
10 under the Medicare and Medicaid programs for dual
11 eligible individuals.

12 (2) Supporting State efforts to coordinate and
13 align acute care and long-term care services for dual
14 eligible individuals with other items and services fur-
15 nished under the Medicare program.

16 (3) Providing support for coordination of con-
17 tracting and oversight by States and the Centers for
18 Medicare & Medicaid Services with respect to the in-
19 tegration of the Medicare and Medicaid programs in
20 a manner that is supportive of the goals described
21 in paragraph (3).

22 (4) To consult and coordinate with the Medi-
23 care Payment Advisory Commission established
24 under section 1805 of the Social Security Act (42
25 U.S.C. 1395b–6) and the Medicaid and CHIP Pay-

1 ment and Access Commission established under sec-
2 tion 1900 of such Act (42 U.S.C. 1396) with respect
3 to policies relating to the enrollment in, and provi-
4 sion of, benefits to dual eligible individuals under the
5 Medicare program under title XVIII of the Social
6 Security Act and the Medicaid program under title
7 XIX of such Act.

8 (5) To study the provision of drug coverage for
9 new full-benefit dual eligible individuals (as defined
10 in section 1935(c)(6) of the Social Security Act (42
11 U.S.C. 1396u-5(c)(6)), as well as to monitor and re-
12 port annual total expenditures, health outcomes, and
13 access to benefits for all dual eligible individuals.

14 (e) REPORT.—The Secretary shall, as part of the
15 budget transmitted under section 1105(a) of title 31,
16 United States Code, submit to Congress an annual report
17 containing recommendations for legislation that would im-
18 prove care coordination and benefits for dual eligible indi-
19 viduals.

20 (f) DUAL ELIGIBLE DEFINED.—In this section, the
21 term “dual eligible individual” means an individual who
22 is entitled to, or enrolled for, benefits under part A of title
23 XVIII of the Social Security Act, or enrolled for benefits
24 under part B of title XVIII of such Act, and is eligible

1 for medical assistance under a State plan under title XIX
2 of such Act or under a waiver of such plan.

3 **Subtitle I—Improving the Quality**
4 **of Medicaid for Patients and**
5 **Providers**

6 **SEC. 2701. ADULT HEALTH QUALITY MEASURES.**

7 Title XI of the Social Security Act (42 U.S.C. 1301
8 et seq.), as amended by section 401 of the Children’s
9 Health Insurance Program Reauthorization Act of 2009
10 (Public Law 111-3), is amended by inserting after section
11 1139A the following new section:

12 **“SEC. 1139B. ADULT HEALTH QUALITY MEASURES.**

13 “(a) DEVELOPMENT OF CORE SET OF HEALTH CARE
14 QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENE-
15 FITS UNDER MEDICAID.—The Secretary shall identify
16 and publish a recommended core set of adult health qual-
17 ity measures for Medicaid eligible adults in the same man-
18 ner as the Secretary identifies and publishes a core set
19 of child health quality measures under section 1139A, in-
20 cluding with respect to identifying and publishing existing
21 adult health quality measures that are in use under public
22 and privately sponsored health care coverage arrange-
23 ments, or that are part of reporting systems that measure
24 both the presence and duration of health insurance cov-

1 erage over time, that may be applicable to Medicaid eligi-
2 ble adults.

3 “(b) DEADLINES.—

4 “(1) RECOMMENDED MEASURES.—Not later
5 than January 1, 2011, the Secretary shall identify
6 and publish for comment a recommended core set of
7 adult health quality measures for Medicaid eligible
8 adults.

9 “(2) DISSEMINATION.—Not later than January
10 1, 2012, the Secretary shall publish an initial core
11 set of adult health quality measures that are appli-
12 cable to Medicaid eligible adults.

13 “(3) STANDARDIZED REPORTING.—Not later
14 than January 1, 2013, the Secretary, in consultation
15 with States, shall develop a standardized format for
16 reporting information based on the initial core set of
17 adult health quality measures and create procedures
18 to encourage States to use such measures to volun-
19 tarily report information regarding the quality of
20 health care for Medicaid eligible adults.

21 “(4) REPORTS TO CONGRESS.—Not later than
22 January 1, 2014, and every 3 years thereafter, the
23 Secretary shall include in the report to Congress re-
24 quired under section 1139A(a)(6) information simi-
25 lar to the information required under that section

1 with respect to the measures established under this
2 section.

3 “(5) ESTABLISHMENT OF MEDICAID QUALITY
4 MEASUREMENT PROGRAM.—

5 “(A) IN GENERAL.—Not later than 12
6 months after the release of the recommended
7 core set of adult health quality measures under
8 paragraph (1)), the Secretary shall establish a
9 Medicaid Quality Measurement Program in the
10 same manner as the Secretary establishes the
11 pediatric quality measures program under sec-
12 tion 1139A(b). The aggregate amount awarded
13 by the Secretary for grants and contracts for
14 the development, testing, and validation of
15 emerging and innovative evidence-based meas-
16 ures under such program shall equal the aggre-
17 gate amount awarded by the Secretary for
18 grants under section 1139A(b)(4)(A)

19 “(B) REVISING, STRENGTHENING, AND IM-
20 PROVING INITIAL CORE MEASURES.—Beginning
21 not later than 24 months after the establish-
22 ment of the Medicaid Quality Measurement
23 Program, and annually thereafter, the Sec-
24 retary shall publish recommended changes to
25 the initial core set of adult health quality meas-

1 ures that shall reflect the results of the testing,
2 validation, and consensus process for the devel-
3 opment of adult health quality measures.

4 “(c) CONSTRUCTION.—Nothing in this section shall
5 be construed as supporting the restriction of coverage,
6 under title XIX or XXI or otherwise, to only those services
7 that are evidence-based, or in anyway limiting available
8 services.

9 “(d) ANNUAL STATE REPORTS REGARDING STATE-
10 SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER
11 MEDICAID.—

12 “(1) ANNUAL STATE REPORTS.—Each State
13 with a State plan or waiver approved under title
14 XIX shall annually report (separately or as part of
15 the annual report required under section 1139A(c)),
16 to the Secretary on the—

17 “(A) State-specific adult health quality
18 measures applied by the State under the such
19 plan, including measures described in sub-
20 section (a)(5); and

21 “(B) State-specific information on the
22 quality of health care furnished to Medicaid eli-
23 gible adults under such plan, including informa-
24 tion collected through external quality reviews

1 of managed care organizations under section
2 1932 and benchmark plans under section 1937.

3 “(2) PUBLICATION.—Not later than September
4 30, 2014, and annually thereafter, the Secretary
5 shall collect, analyze, and make publicly available the
6 information reported by States under paragraph (1).

7 “(e) APPROPRIATION.—Out of any funds in the
8 Treasury not otherwise appropriated, there is appro-
9 priated for each of fiscal years 2010 through 2014,
10 \$60,000,000 for the purpose of carrying out this section.
11 Funds appropriated under this subsection shall remain
12 available until expended.”.

13 **SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-AC-**
14 **QUIRED CONDITIONS.**

15 (a) IN GENERAL.—The Secretary of Health and
16 Human Services (in this subsection referred to as the
17 “Secretary”) shall identify current State practices that
18 prohibit payment for health care-acquired conditions and
19 shall incorporate the practices identified, or elements of
20 such practices, which the Secretary determines appro-
21 priate for application to the Medicaid program in regula-
22 tions. Such regulations shall be effective as of July 1,
23 2011, and shall prohibit payments to States under section
24 1903 of the Social Security Act for any amounts expended
25 for providing medical assistance for health care-acquired

1 conditions specified in the regulations. The regulations
2 shall ensure that the prohibition on payment for health
3 care-acquired conditions shall not result in a loss of access
4 to care or services for Medicaid beneficiaries.

5 (b) HEALTH CARE-ACQUIRED CONDITION.—In this
6 section, the term “health care-acquired condition” means
7 a medical condition for which an individual was diagnosed
8 that could be identified by a secondary diagnostic code de-
9 scribed in section 1886(d)(4)(D)(iv) of the Social Security
10 Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

11 (c) MEDICARE PROVISIONS.—In carrying out this
12 section, the Secretary shall apply to State plans (or waiv-
13 ers) under title XIX of the Social Security Act the regula-
14 tions promulgated pursuant to section 1886(d)(4)(D) of
15 such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the
16 prohibition of payments based on the presence of a sec-
17 ondary diagnosis code specified by the Secretary in such
18 regulations, as appropriate for the Medicaid program. The
19 Secretary may exclude certain conditions identified under
20 title XVIII of the Social Security Act for non-payment
21 under title XIX of such Act when the Secretary finds the
22 inclusion of such conditions to be inapplicable to bene-
23 ficiaries under title XIX.

1 **SEC. 2703. STATE OPTION TO PROVIDE HEALTH HOMES**
2 **FOR ENROLLEES WITH CHRONIC CONDI-**
3 **TIONS.**

4 (a) STATE PLAN AMENDMENT.—Title XIX of the So-
5 cial Security Act (42 U.S.C. 1396a et seq.), as amended
6 by sections 2201 and 2305, is amended by adding at the
7 end the following new section:

8 “SEC. 1945. STATE OPTION TO PROVIDE COORDI-
9 NATED CARE THROUGH A HEALTH HOME FOR INDIVID-
10 UALS WITH CHRONIC CONDITIONS.—

11 “(a) IN GENERAL.—Notwithstanding section
12 1902(a)(1) (relating to statewideness), section
13 1902(a)(10)(B) (relating to comparability), and any other
14 provision of this title for which the Secretary determines
15 it is necessary to waive in order to implement this section,
16 beginning January 1, 2011, a State, at its option as a
17 State plan amendment, may provide for medical assistance
18 under this title to eligible individuals with chronic condi-
19 tions who select a designated provider (as described under
20 subsection (h)(5)), a team of health care professionals (as
21 described under subsection (h)(6)) operating with such a
22 provider, or a health team (as described under subsection
23 (h)(7)) as the individual’s health home for purposes of
24 providing the individual with health home services.

25 “(b) HEALTH HOME QUALIFICATION STANDARDS.—
26 The Secretary shall establish standards for qualification

1 as a designated provider for the purpose of being eligible
2 to be a health home for purposes of this section.

3 “(c) PAYMENTS.—

4 “(1) IN GENERAL.—A State shall provide a des-
5 ignated provider, a team of health care professionals
6 operating with such a provider, or a health team
7 with payments for the provision of health home serv-
8 ices to each eligible individual with chronic condi-
9 tions that selects such provider, team of health care
10 professionals, or health team as the individual’s
11 health home. Payments made to a designated pro-
12 vider, a team of health care professionals operating
13 with such a provider, or a health team for such serv-
14 ices shall be treated as medical assistance for pur-
15 poses of section 1903(a), except that, during the
16 first 8 fiscal year quarters that the State plan
17 amendment is in effect, the Federal medical assist-
18 ance percentage applicable to such payments shall be
19 equal to 90 percent.

20 “(2) METHODOLOGY.—

21 “(A) IN GENERAL.—The State shall speci-
22 fy in the State plan amendment the method-
23 ology the State will use for determining pay-
24 ment for the provision of health home services.
25 Such methodology for determining payment—

1 “(i) may be tiered to reflect, with re-
2 spect to each eligible individual with chron-
3 ic conditions provided such services by a
4 designated provider, a team of health care
5 professionals operating with such a pro-
6 vider, or a health team, as well as the se-
7 verity or number of each such individual’s
8 chronic conditions or the specific capabili-
9 ties of the provider, team of health care
10 professionals, or health team; and

11 “(ii) shall be established consistent
12 with section 1902(a)(30)(A).

13 “(B) ALTERNATE MODELS OF PAYMENT.—
14 The methodology for determining payment for
15 provision of health home services under this
16 section shall not be limited to a per-member
17 per-month basis and may provide (as proposed
18 by the State and subject to approval by the
19 Secretary) for alternate models of payment.

20 “(3) PLANNING GRANTS.—

21 “(A) IN GENERAL.—Beginning January 1,
22 2011, the Secretary may award planning grants
23 to States for purposes of developing a State
24 plan amendment under this section. A planning

1 grant awarded to a State under this paragraph
2 shall remain available until expended.

3 “(B) STATE CONTRIBUTION.—A State
4 awarded a planning grant shall contribute an
5 amount equal to the State percentage deter-
6 mined under section 1905(b) (without regard to
7 section 5001 of Public Law 111–5) for each fis-
8 cal year for which the grant is awarded.

9 “(C) LIMITATION.—The total amount of
10 payments made to States under this paragraph
11 shall not exceed \$25,000,000.

12 “(d) HOSPITAL REFERRALS.—A State shall include
13 in the State plan amendment a requirement for hospitals
14 that are participating providers under the State plan or
15 a waiver of such plan to establish procedures for referring
16 any eligible individuals with chronic conditions who seek
17 or need treatment in a hospital emergency department to
18 designated providers.

19 “(e) COORDINATION.—A State shall consult and co-
20 ordinate, as appropriate, with the Substance Abuse and
21 Mental Health Services Administration in addressing
22 issues regarding the prevention and treatment of mental
23 illness and substance abuse among eligible individuals with
24 chronic conditions.

1 “(f) MONITORING.—A State shall include in the State
2 plan amendment—

3 “(1) a methodology for tracking avoidable hos-
4 pital readmissions and calculating savings that re-
5 sult from improved chronic care coordination and
6 management under this section; and

7 “(2) a proposal for use of health information
8 technology in providing health home services under
9 this section and improving service delivery and co-
10 ordination across the care continuum (including the
11 use of wireless patient technology to improve coordi-
12 nation and management of care and patient adher-
13 ence to recommendations made by their provider).

14 “(g) REPORT ON QUALITY MEASURES.—As a condi-
15 tion for receiving payment for health home services pro-
16 vided to an eligible individual with chronic conditions, a
17 designated provider shall report to the State, in accord-
18 ance with such requirements as the Secretary shall specify,
19 on all applicable measures for determining the quality of
20 such services. When appropriate and feasible, a designated
21 provider shall use health information technology in pro-
22 viding the State with such information.

23 “(h) DEFINITIONS.—In this section:

24 “(1) ELIGIBLE INDIVIDUAL WITH CHRONIC
25 CONDITIONS.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the term ‘eligible individual with
3 chronic conditions’ means an individual who—

4 “(i) is eligible for medical assistance
5 under the State plan or under a waiver of
6 such plan; and

7 “(ii) has at least—

8 “(I) 2 chronic conditions;

9 “(II) 1 chronic condition and is
10 at risk of having a second chronic
11 condition; or

12 “(III) 1 serious and persistent
13 mental health condition.

14 “(B) RULE OF CONSTRUCTION.—Nothing
15 in this paragraph shall prevent the Secretary
16 from establishing higher levels as to the number
17 or severity of chronic or mental health condi-
18 tions for purposes of determining eligibility for
19 receipt of health home services under this sec-
20 tion.

21 “(2) CHRONIC CONDITION.—The term ‘chronic
22 condition’ has the meaning given that term by the
23 Secretary and shall include, but is not limited to, the
24 following:

25 “(A) A mental health condition.

1 “(B) Substance use disorder.

2 “(C) Asthma.

3 “(D) Diabetes.

4 “(E) Heart disease.

5 “(F) Being overweight, as evidenced by
6 having a Body Mass Index (BMI) over 25.

7 “(3) HEALTH HOME.—The term ‘health home’
8 means a designated provider (including a provider
9 that operates in coordination with a team of health
10 care professionals) or a health team selected by an
11 eligible individual with chronic conditions to provide
12 health home services.

13 “(4) HEALTH HOME SERVICES.—

14 “(A) IN GENERAL.—The term ‘health
15 home services’ means comprehensive and timely
16 high-quality services described in subparagraph
17 (B) that are provided by a designated provider,
18 a team of health care professionals operating
19 with such a provider, or a health team.

20 “(B) SERVICES DESCRIBED.—The services
21 described in this subparagraph are—

22 “(i) comprehensive care management;

23 “(ii) care coordination and health pro-
24 motion;

1 “(iii) comprehensive transitional care,
2 including appropriate follow-up, from inpa-
3 tient to other settings;

4 “(iv) patient and family support (in-
5 cluding authorized representatives);

6 “(v) referral to community and social
7 support services, if relevant; and

8 “(vi) use of health information tech-
9 nology to link services, as feasible and ap-
10 propriate.

11 “(5) DESIGNATED PROVIDER.—The term ‘des-
12 ignated provider’ means a physician, clinical practice
13 or clinical group practice, rural clinic, community
14 health center, community mental health center,
15 home health agency, or any other entity or provider
16 (including pediatricians, gynecologists, and obstetri-
17 cians) that is determined by the State and approved
18 by the Secretary to be qualified to be a health home
19 for eligible individuals with chronic conditions on the
20 basis of documentation evidencing that the physi-
21 cian, practice, or clinic—

22 “(A) has the systems and infrastructure in
23 place to provide health home services; and

1 “(B) satisfies the qualification standards
2 established by the Secretary under subsection
3 (b).

4 “(6) TEAM OF HEALTH CARE PROFES-
5 SIONALS.—The term ‘team of health care profes-
6 sionals’ means a team of health professionals (as de-
7 scribed in the State plan amendment) that may—

8 “(A) include physicians and other profes-
9 sionals, such as a nurse care coordinator, nutri-
10 tionist, social worker, behavioral health profes-
11 sional, or any professionals deemed appropriate
12 by the State; and

13 “(B) be free standing, virtual, or based at
14 a hospital, community health center, community
15 mental health center, rural clinic, clinical prac-
16 tice or clinical group practice, academic health
17 center, or any entity deemed appropriate by the
18 State and approved by the Secretary.

19 “(7) HEALTH TEAM.—The term ‘health team’
20 has the meaning given such term for purposes of
21 section 3502 of the Patient Protection and Afford-
22 able Care Act.”.

23 (b) EVALUATION.—

24 (1) INDEPENDENT EVALUATION.—

1 (A) IN GENERAL.—The Secretary shall
2 enter into a contract with an independent entity
3 or organization to conduct an evaluation and
4 assessment of the States that have elected the
5 option to provide coordinated care through a
6 health home for Medicaid beneficiaries with
7 chronic conditions under section 1945 of the
8 Social Security Act (as added by subsection (a))
9 for the purpose of determining the effect of
10 such option on reducing hospital admissions,
11 emergency room visits, and admissions to
12 skilled nursing facilities.

13 (B) EVALUATION REPORT.—Not later than
14 January 1, 2017, the Secretary shall report to
15 Congress on the evaluation and assessment con-
16 ducted under subparagraph (A).

17 (2) SURVEY AND INTERIM REPORT.—

18 (A) IN GENERAL.—Not later than January
19 1, 2014, the Secretary of Health and Human
20 Services shall survey States that have elected
21 the option under section 1945 of the Social Se-
22 curity Act (as added by subsection (a)) and re-
23 port to Congress on the nature, extent, and use
24 of such option, particularly as it pertains to—

25 (i) hospital admission rates;

- 1 (ii) chronic disease management;
- 2 (iii) coordination of care for individ-
- 3 uals with chronic conditions;
- 4 (iv) assessment of program implemen-
- 5 tation;
- 6 (v) processes and lessons learned (as
- 7 described in subparagraph (B));
- 8 (vi) assessment of quality improve-
- 9 ments and clinical outcomes under such
- 10 option; and
- 11 (vii) estimates of cost savings.

12 (B) IMPLEMENTATION REPORTING.—A

13 State that has elected the option under section

14 1945 of the Social Security Act (as added by

15 subsection (a)) shall report to the Secretary, as

16 necessary, on processes that have been devel-

17 oped and lessons learned regarding provision of

18 coordinated care through a health home for

19 Medicaid beneficiaries with chronic conditions

20 under such option.

21 **SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTE-**

22 **GRATED CARE AROUND A HOSPITALIZATION.**

23 (a) AUTHORITY TO CONDUCT PROJECT.—

24 (1) IN GENERAL.—The Secretary of Health and

25 Human Services (in this section referred to as the

1 “Secretary”) shall establish a demonstration project
2 under title XIX of the Social Security Act to evalu-
3 ate the use of bundled payments for the provision of
4 integrated care for a Medicaid beneficiary—

5 (A) with respect to an episode of care that
6 includes a hospitalization; and

7 (B) for concurrent physicians services pro-
8 vided during a hospitalization.

9 (2) DURATION.—The demonstration project
10 shall begin on January 1, 2012, and shall end on
11 December 31, 2016.

12 (b) REQUIREMENTS.—The demonstration project
13 shall be conducted in accordance with the following:

14 (1) The demonstration project shall be con-
15 ducted in up to 8 States, determined by the Sec-
16 retary based on consideration of the potential to
17 lower costs under the Medicaid program while im-
18 proving care for Medicaid beneficiaries. A State se-
19 lected to participate in the demonstration project
20 may target the demonstration project to particular
21 categories of beneficiaries, beneficiaries with par-
22 ticular diagnoses, or particular geographic regions of
23 the State, but the Secretary shall insure that, as a
24 whole, the demonstration project is, to the greatest
25 extent possible, representative of the demographic

1 and geographic composition of Medicaid beneficiaries
2 nationally.

3 (2) The demonstration project shall focus on
4 conditions where there is evidence of an opportunity
5 for providers of services and suppliers to improve the
6 quality of care furnished to Medicaid beneficiaries
7 while reducing total expenditures under the State
8 Medicaid programs selected to participate, as deter-
9 mined by the Secretary.

10 (3) A State selected to participate in the dem-
11 onstration project shall specify the 1 or more epi-
12 sodes of care the State proposes to address in the
13 project, the services to be included in the bundled
14 payments, and the rationale for the selection of such
15 episodes of care and services. The Secretary may
16 modify the episodes of care as well as the services
17 to be included in the bundled payments prior to or
18 after approving the project. The Secretary may also
19 vary such factors among the different States partici-
20 pating in the demonstration project.

21 (4) The Secretary shall ensure that payments
22 made under the demonstration project are adjusted
23 for severity of illness and other characteristics of
24 Medicaid beneficiaries within a category or having a
25 diagnosis targeted as part of the demonstration

1 project. States shall ensure that Medicaid bene-
2 ficiaries are not liable for any additional cost sharing
3 than if their care had not been subject to payment
4 under the demonstration project.

5 (5) Hospitals participating in the demonstration
6 project shall have or establish robust discharge plan-
7 ning programs to ensure that Medicaid beneficiaries
8 requiring post-acute care are appropriately placed in,
9 or have ready access to, post-acute care settings.

10 (6) The Secretary and each State selected to
11 participate in the demonstration project shall ensure
12 that the demonstration project does not result in the
13 Medicaid beneficiaries whose care is subject to pay-
14 ment under the demonstration project being pro-
15 vided with less items and services for which medical
16 assistance is provided under the State Medicaid pro-
17 gram than the items and services for which medical
18 assistance would have been provided to such bene-
19 ficiaries under the State Medicaid program in the
20 absence of the demonstration project.

21 (c) WAIVER OF PROVISIONS.—Notwithstanding sec-
22 tion 1115(a) of the Social Security Act (42 U.S.C.
23 1315(a)), the Secretary may waive such provisions of titles
24 XIX, XVIII, and XI of that Act as may be necessary to
25 accomplish the goals of the demonstration, ensure bene-

1 ficiary access to acute and post-acute care, and maintain
2 quality of care.

3 (d) EVALUATION AND REPORT.—

4 (1) DATA.—Each State selected to participate
5 in the demonstration project under this section shall
6 provide to the Secretary, in such form and manner
7 as the Secretary shall specify, relevant data nec-
8 essary to monitor outcomes, costs, and quality, and
9 evaluate the rationales for selection of the episodes
10 of care and services specified by States under sub-
11 section (b)(3).

12 (2) REPORT.—Not later than 1 year after the
13 conclusion of the demonstration project, the Sec-
14 retary shall submit a report to Congress on the re-
15 sults of the demonstration project.

16 **SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEM-**
17 **ONSTRATION PROJECT.**

18 (a) IN GENERAL.—The Secretary of Health and
19 Human Services (referred to in this section as the “Sec-
20 retary”) shall, in coordination with the Center for Medi-
21 care and Medicaid Innovation (as established under sec-
22 tion 1115A of the Social Security Act, as added by section
23 3021 of this Act), establish the Medicaid Global Payment
24 System Demonstration Project under which a partici-
25 pating State shall adjust the payments made to an eligible

1 safety net hospital system or network from a fee-for-serv-
2 ice payment structure to a global capitated payment
3 model.

4 (b) DURATION AND SCOPE.—The demonstration
5 project conducted under this section shall operate during
6 a period of fiscal years 2010 through 2012. The Secretary
7 shall select not more than 5 States to participate in the
8 demonstration project.

9 (c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR
10 NETWORK.—For purposes of this section, the term “eligi-
11 ble safety net hospital system or network” means a large,
12 safety net hospital system or network (as defined by the
13 Secretary) that operates within a State selected by the
14 Secretary under subsection (b).

15 (d) EVALUATION.—

16 (1) TESTING.—The Innovation Center shall test
17 and evaluate the demonstration project conducted
18 under this section to examine any changes in health
19 care quality outcomes and spending by the eligible
20 safety net hospital systems or networks.

21 (2) BUDGET NEUTRALITY.—During the testing
22 period under paragraph (1), any budget neutrality
23 requirements under section 1115A(b)(3) of the So-
24 cial Security Act (as so added) shall not be applica-
25 ble.

1 (3) MODIFICATION.—During the testing period
2 under paragraph (1), the Secretary may, in the Sec-
3 retary’s discretion, modify or terminate the dem-
4 onstration project conducted under this section.

5 (e) REPORT.—Not later than 12 months after the
6 date of completion of the demonstration project under this
7 section, the Secretary shall submit to Congress a report
8 containing the results of the evaluation and testing con-
9 ducted under subsection (d), together with recommenda-
10 tions for such legislation and administrative action as the
11 Secretary determines appropriate.

12 (f) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated such sums as are nec-
14 essary to carry out this section.

15 **SEC. 2706. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION**
16 **DEMONSTRATION PROJECT.**

17 (a) AUTHORITY TO CONDUCT DEMONSTRATION.—

18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services (referred to in this section as the
20 “Secretary”) shall establish the Pediatric Account-
21 able Care Organization Demonstration Project to
22 authorize a participating State to allow pediatric
23 medical providers that meet specified requirements
24 to be recognized as an accountable care organization
25 for purposes of receiving incentive payments (as de-

1 scribed under subsection (d)), in the same manner
2 as an accountable care organization is recognized
3 and provided with incentive payments under section
4 1899 of the Social Security Act (as added by section
5 3022).

6 (2) DURATION.—The demonstration project
7 shall begin on January 1, 2012, and shall end on
8 December 31, 2016.

9 (b) APPLICATION.—A State that desires to partici-
10 pate in the demonstration project under this section shall
11 submit to the Secretary an application at such time, in
12 such manner, and containing such information as the Sec-
13 retary may require.

14 (c) REQUIREMENTS.—

15 (1) PERFORMANCE GUIDELINES.—The Sec-
16 retary, in consultation with the States and pediatric
17 providers, shall establish guidelines to ensure that
18 the quality of care delivered to individuals by a pro-
19 vider recognized as an accountable care organization
20 under this section is not less than the quality of care
21 that would have otherwise been provided to such in-
22 dividuals.

23 (2) SAVINGS REQUIREMENT.—A participating
24 State, in consultation with the Secretary, shall es-
25 tablish an annual minimal level of savings in expend-

1 itures for items and services covered under the Med-
2 icaid program under title XIX of the Social Security
3 Act and the CHIP program under title XXI of such
4 Act that must be reached by an accountable care or-
5 ganization in order for such organization to receive
6 an incentive payment under subsection (d).

7 (3) MINIMUM PARTICIPATION PERIOD.—A pro-
8 vider desiring to be recognized as an accountable
9 care organization under the demonstration project
10 shall enter into an agreement with the State to par-
11 ticipate in the project for not less than a 3-year pe-
12 riod.

13 (d) INCENTIVE PAYMENT.—An accountable care or-
14 ganization that meets the performance guidelines estab-
15 lished by the Secretary under subsection (c)(1) and
16 achieves savings greater than the annual minimal savings
17 level established by the State under subsection (c)(2) shall
18 receive an incentive payment for such year equal to a por-
19 tion (as determined appropriate by the Secretary) of the
20 amount of such excess savings. The Secretary may estab-
21 lish an annual cap on incentive payments for an account-
22 able care organization.

23 (e) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated such sums as are nec-
25 essary to carry out this section.

1 **SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEM-**
2 **ONSTRATION PROJECT.**

3 (a) **AUTHORITY TO CONDUCT DEMONSTRATION**
4 **PROJECT.**—The Secretary of Health and Human Services
5 (in this section referred to as the “Secretary”) shall estab-
6 lish a demonstration project under which an eligible State
7 (as described in subsection (c)) shall provide payment
8 under the State Medicaid plan under title XIX of the So-
9 cial Security Act to an institution for mental diseases that
10 is not publicly owned or operated and that is subject to
11 the requirements of section 1867 of the Social Security
12 Act (42 U.S.C. 1395dd) for the provision of medical as-
13 sistance available under such plan to individuals who—

14 (1) have attained age 21, but have not attained
15 age 65;

16 (2) are eligible for medical assistance under
17 such plan; and

18 (3) require such medical assistance to stabilize
19 an emergency medical condition.

20 (b) **STABILIZATION REVIEW.**—A State shall specify
21 in its application described in subsection (c)(1) establish
22 a mechanism for how it will ensure that institutions par-
23 ticipating in the demonstration will determine whether or
24 not such individuals have been stabilized (as defined in
25 subsection (h)(5)) . This mechanism shall commence be-
26 fore the third day of the inpatient stay. States partici-

1 participating in the demonstration project may manage the pro-
2 vision of services for the stabilization of medical emer-
3 gency conditions through utilization review, authorization,
4 or management practices, or the application of medical ne-
5 cessity and appropriateness criteria applicable to behav-
6 ioral health.

7 (c) ELIGIBLE STATE DEFINED.—

8 (1) IN GENERAL.—An eligible State is a State
9 that has made an application and has been selected
10 pursuant to paragraphs (2) and (3).

11 (2) APPLICATION.—A State seeking to partici-
12 pate in the demonstration project under this section
13 shall submit to the Secretary, at such time and in
14 such format as the Secretary requires, an applica-
15 tion that includes such information, provisions, and
16 assurances, as the Secretary may require.

17 (3) SELECTION.—A State shall be determined
18 eligible for the demonstration by the Secretary on a
19 competitive basis among States with applications
20 meeting the requirements of paragraph (1). In se-
21 lecting State applications for the demonstration
22 project, the Secretary shall seek to achieve an appro-
23 priate national balance in the geographic distribu-
24 tion of such projects.

1 (d) LENGTH OF DEMONSTRATION PROJECT.—The
2 demonstration project established under this section shall
3 be conducted for a period of 3 consecutive years.

4 (e) LIMITATIONS ON FEDERAL FUNDING.—

5 (1) APPROPRIATION.—

6 (A) IN GENERAL.—Out of any funds in the
7 Treasury not otherwise appropriated, there is
8 appropriated to carry out this section,
9 \$75,000,000 for fiscal year 2011.

10 (B) BUDGET AUTHORITY.—Subparagraph

11 (A) constitutes budget authority in advance of
12 appropriations Act and represents the obliga-
13 tion of the Federal Government to provide for
14 the payment of the amounts appropriated under
15 that subparagraph.

16 (2) 5-YEAR AVAILABILITY.—Funds appro-
17 priated under paragraph (1) shall remain available
18 for obligation through December 31, 2015.

19 (3) LIMITATION ON PAYMENTS.—In no case
20 may—

21 (A) the aggregate amount of payments
22 made by the Secretary to eligible States under
23 this section exceed \$75,000,000; or

24 (B) payments be provided by the Secretary
25 under this section after December 31, 2015.

1 (4) FUNDS ALLOCATED TO STATES.—Funds
2 shall be allocated to eligible States on the basis of
3 criteria, including a State’s application and the
4 availability of funds, as determined by the Secretary.

5 (5) PAYMENTS TO STATES.—The Secretary
6 shall pay to each eligible State, from its allocation
7 under paragraph (4), an amount each quarter equal
8 to the Federal medical assistance percentage of ex-
9 penditures in the quarter for medical assistance de-
10 scribed in subsection (a). As a condition of receiving
11 payment, a State shall collect and report informa-
12 tion, as determined necessary by the Secretary, for
13 the purposes of providing Federal oversight and con-
14 ducting an evaluation under subsection (f)(1).

15 (f) EVALUATION AND REPORT TO CONGRESS.—

16 (1) EVALUATION.—The Secretary shall conduct
17 an evaluation of the demonstration project in order
18 to determine the impact on the functioning of the
19 health and mental health service system and on indi-
20 viduals enrolled in the Medicaid program and shall
21 include the following:

22 (A) An assessment of access to inpatient
23 mental health services under the Medicaid pro-
24 gram; average lengths of inpatient stays; and
25 emergency room visits.

1 (B) An assessment of discharge planning
2 by participating hospitals.

3 (C) An assessment of the impact of the
4 demonstration project on the costs of the full
5 range of mental health services (including inpa-
6 tient, emergency and ambulatory care).

7 (D) An analysis of the percentage of con-
8 sumers with Medicaid coverage who are admit-
9 ted to inpatient facilities as a result of the dem-
10 onstration project as compared to those admit-
11 ted to these same facilities through other
12 means.

13 (E) A recommendation regarding whether
14 the demonstration project should be continued
15 after December 31, 2013, and expanded on a
16 national basis.

17 (2) REPORT.—Not later than December 31,
18 2013, the Secretary shall submit to Congress and
19 make available to the public a report on the findings
20 of the evaluation under paragraph (1).

21 (g) WAIVER AUTHORITY.—

22 (1) IN GENERAL.—The Secretary shall waive
23 the limitation of subdivision (B) following paragraph
24 (28) of section 1905(a) of the Social Security Act
25 (42 U.S.C. 1396d(a)) (relating to limitations on pay-

1 ments for care or services for individuals under 65
2 years of age who are patients in an institution for
3 mental diseases) for purposes of carrying out the
4 demonstration project under this section.

5 (2) LIMITED OTHER WAIVER AUTHORITY.—The
6 Secretary may waive other requirements of titles XI
7 and XIX of the Social Security Act (including the
8 requirements of sections 1902(a)(1) (relating to
9 statewideness) and 1902(1)(10)(B) (relating to com-
10 parability)) only to extent necessary to carry out the
11 demonstration project under this section.

12 (h) DEFINITIONS.—In this section:

13 (1) EMERGENCY MEDICAL CONDITION.—The
14 term “emergency medical condition” means, with re-
15 spect to an individual, an individual who expresses
16 suicidal or homicidal thoughts or gestures, if deter-
17 mined dangerous to self or others.

18 (2) FEDERAL MEDICAL ASSISTANCE PERCENT-
19 AGE.—The term “Federal medical assistance per-
20 centage” has the meaning given that term with re-
21 spect to a State under section 1905(b) of the Social
22 Security Act (42 U.S.C. 1396d(b)).

23 (3) INSTITUTION FOR MENTAL DISEASES.—The
24 term “institution for mental diseases” has the mean-

1 ing given to that term in section 1905(i) of the So-
2 cial Security Act (42 U.S.C. 1396d(i)).

3 (4) MEDICAL ASSISTANCE.—The term “medical
4 assistance” has the meaning given that term in sec-
5 tion 1905(a) of the Social Security Act (42 U.S.C.
6 1396d(a)).

7 (5) STABILIZED.—The term “stabilized”
8 means, with respect to an individual, that the emer-
9 gency medical condition no longer exists with respect
10 to the individual and the individual is no longer dan-
11 gerous to self or others.

12 (6) STATE.—The term “State” has the mean-
13 ing given that term for purposes of title XIX of the
14 Social Security Act (42 U.S.C. 1396 et seq.).

15 **Subtitle J—Improvements to the**
16 **Medicaid and CHIP Payment**
17 **and Access Commission**
18 **(MACPAC)**

19 **SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING**
20 **ALL MEDICAID BENEFICIARIES.**

21 (a) IN GENERAL.—Section 1900 of the Social Secu-
22 rity Act (42 U.S.C. 1396) is amended—

23 (1) in subsection (b)—

24 (A) in paragraph (1)—

- 1 (i) in the paragraph heading, by in-
2 serting “FOR ALL STATES” before “AND
3 ANNUAL”; and
- 4 (ii) in subparagraph (A), by striking
5 “children’s”;
- 6 (iii) in subparagraph (B), by inserting
7 “, the Secretary, and States” after “Con-
8 gress”;
- 9 (iv) in subparagraph (C), by striking
10 “March 1” and inserting “March 15”; and
- 11 (v) in subparagraph (D), by striking
12 “June 1” and inserting “June 15”;
- 13 (B) in paragraph (2)—
- 14 (i) in subparagraph (A)—
- 15 (I) in clause (i)—
- 16 (aa) by inserting “the effi-
17 cient provision of” after “expend-
18 itures for”; and
- 19 (bb) by striking “hospital,
20 skilled nursing facility, physician,
21 Federally-qualified health center,
22 rural health center, and other
23 fees” and inserting “payments to
24 medical, dental, and health pro-
25 fessionals, hospitals, residential

1 and long-term care providers,
2 providers of home and commu-
3 nity based services, Federally-
4 qualified health centers and rural
5 health clinics, managed care enti-
6 ties, and providers of other cov-
7 ered items and services”; and

8 (II) in clause (iii), by inserting
9 “(including how such factors and
10 methodologies enable such bene-
11 ficiaries to obtain the services for
12 which they are eligible, affect provider
13 supply, and affect providers that serve
14 a disproportionate share of low-income
15 and other vulnerable populations)”
16 after “beneficiaries”;

17 (ii) by redesignating subparagraphs
18 (B) and (C) as subparagraphs (F) and
19 (H), respectively;

20 (iii) by inserting after subparagraph
21 (A), the following:

22 “(B) ELIGIBILITY POLICIES.—Medicaid
23 and CHIP eligibility policies, including a deter-
24 mination of the degree to which Federal and

1 State policies provide health care coverage to
2 needy populations.

3 “(C) ENROLLMENT AND RETENTION PROC-
4 ESSES.—Medicaid and CHIP enrollment and
5 retention processes, including a determination
6 of the degree to which Federal and State poli-
7 cies encourage the enrollment of individuals
8 who are eligible for such programs and screen
9 out individuals who are ineligible, while mini-
10 mizing the share of program expenses devoted
11 to such processes.

12 “(D) COVERAGE POLICIES.—Medicaid and
13 CHIP benefit and coverage policies, including a
14 determination of the degree to which Federal
15 and State policies provide access to the services
16 enrollees require to improve and maintain their
17 health and functional status.

18 “(E) QUALITY OF CARE.—Medicaid and
19 CHIP policies as they relate to the quality of
20 care provided under those programs, including
21 a determination of the degree to which Federal
22 and State policies achieve their stated goals and
23 interact with similar goals established by other
24 purchasers of health care services.”;

1 (iv) by inserting after subparagraph
2 (F) (as redesignated by clause (ii) of this
3 subparagraph), the following:

4 “(G) INTERACTIONS WITH MEDICARE AND
5 MEDICAID.—Consistent with paragraph (11),
6 the interaction of policies under Medicaid and
7 the Medicare program under title XVIII, in-
8 cluding with respect to how such interactions
9 affect access to services, payments, and dual el-
10 igible individuals.” and

11 (v) in subparagraph (H) (as so redesi-
12 gnated), by inserting “and preventive,
13 acute, and long-term services and sup-
14 ports” after “barriers”;

15 (C) by redesignating paragraphs (3)
16 through (9) as paragraphs (4) through (10), re-
17 spectively;

18 (D) by inserting after paragraph (2), the
19 following new paragraph:

20 “(3) RECOMMENDATIONS AND REPORTS OF
21 STATE-SPECIFIC DATA.—MACPAC shall—

22 “(A) review national and State-specific
23 Medicaid and CHIP data; and

1 “(B) submit reports and recommendations
2 to Congress, the Secretary, and States based on
3 such reviews.”;

4 (E) in paragraph (4), as redesignated by
5 subparagraph (C), by striking “or any other
6 problems” and all that follows through the pe-
7 riod and inserting “, as well as other factors
8 that adversely affect, or have the potential to
9 adversely affect, access to care by, or the health
10 care status of, Medicaid and CHIP bene-
11 ficiaries. MACPAC shall include in the annual
12 report required under paragraph (1)(D) a de-
13 scription of all such areas or problems identi-
14 fied with respect to the period addressed in the
15 report.”;

16 (F) in paragraph (5), as so redesign-
17 ated,—

18 (i) in the paragraph heading, by in-
19 serting “AND REGULATIONS” after “RE-
20 PORTS”; and

21 (ii) by striking “If” and inserting the
22 following:

23 “(A) CERTAIN SECRETARIAL REPORTS.—
24 If”; and

1 (iii) in the second sentence, by insert-
2 ing “and the Secretary” after “appropriate
3 committees of Congress”; and

4 (iv) by adding at the end the fol-
5 lowing:

6 “(B) REGULATIONS.—MACPAC shall re-
7 view Medicaid and CHIP regulations and may
8 comment through submission of a report to the
9 appropriate committees of Congress and the
10 Secretary, on any such regulations that affect
11 access, quality, or efficiency of health care.”;

12 (G) in paragraph (10), as so redesignated,
13 by inserting “, and shall submit with any rec-
14 ommendations, a report on the Federal and
15 State-specific budget consequences of the rec-
16 ommendations” before the period; and

17 (H) by adding at the end the following:

18 “(11) CONSULTATION AND COORDINATION
19 WITH MEDPAC.—

20 “(A) IN GENERAL.—MACPAC shall con-
21 sult with the Medicare Payment Advisory Com-
22 mission (in this paragraph referred to as
23 ‘MedPAC’) established under section 1805 in
24 carrying out its duties under this section, as ap-
25 propriate and particularly with respect to the

1 issues specified in paragraph (2) as they relate
2 to those Medicaid beneficiaries who are dually
3 eligible for Medicaid and the Medicare program
4 under title XVIII, adult Medicaid beneficiaries
5 (who are not dually eligible for Medicare), and
6 beneficiaries under Medicare. Responsibility for
7 analysis of and recommendations to change
8 Medicare policy regarding Medicare bene-
9 ficiaries, including Medicare beneficiaries who
10 are dually eligible for Medicare and Medicaid,
11 shall rest with MedPAC.

12 “(B) INFORMATION SHARING.—MACPAC
13 and MedPAC shall have access to deliberations
14 and records of the other such entity, respec-
15 tively, upon the request of the other such enti-
16 ty.

17 “(12) CONSULTATION WITH STATES.—
18 MACPAC shall regularly consult with States in car-
19 rying out its duties under this section, including
20 with respect to developing processes for carrying out
21 such duties, and shall ensure that input from States
22 is taken into account and represented in MACPAC’s
23 recommendations and reports.

24 “(13) COORDINATE AND CONSULT WITH THE
25 FEDERAL COORDINATED HEALTH CARE OFFICE.—

1 MACPAC shall coordinate and consult with the Fed-
2 eral Coordinated Health Care Office established
3 under section 2081 of the Patient Protection and
4 Affordable Care Act before making any rec-
5 ommendations regarding dual eligible individuals.

6 “(14) PROGRAMMATIC OVERSIGHT VESTED IN
7 THE SECRETARY.—MACPAC’s authority to make
8 recommendations in accordance with this section
9 shall not affect, or be considered to duplicate, the
10 Secretary’s authority to carry out Federal respon-
11 sibilities with respect to Medicaid and CHIP.”;

12 (2) in subsection (c)(2)—

13 (A) by striking subparagraphs (A) and (B)
14 and inserting the following:

15 “(A) IN GENERAL.—The membership of
16 MACPAC shall include individuals who have
17 had direct experience as enrollees or parents or
18 caregivers of enrollees in Medicaid or CHIP and
19 individuals with national recognition for their
20 expertise in Federal safety net health programs,
21 health finance and economics, actuarial science,
22 health plans and integrated delivery systems,
23 reimbursement for health care, health informa-
24 tion technology, and other providers of health
25 services, public health, and other related fields,

1 who provide a mix of different professions,
2 broad geographic representation, and a balance
3 between urban and rural representation.

4 “(B) INCLUSION.—The membership of
5 MACPAC shall include (but not be limited to)
6 physicians, dentists, and other health profes-
7 sionals, employers, third-party payers, and indi-
8 viduals with expertise in the delivery of health
9 services. Such membership shall also include
10 representatives of children, pregnant women,
11 the elderly, individuals with disabilities, care-
12 givers, and dual eligible individuals, current or
13 former representatives of State agencies respon-
14 sible for administering Medicaid, and current or
15 former representatives of State agencies respon-
16 sible for administering CHIP.”.

17 (3) in subsection (d)(2), by inserting “and
18 State” after “Federal”;

19 (4) in subsection (e)(1), in the first sentence, by
20 inserting “and, as a condition for receiving payments
21 under sections 1903(a) and 2105(a), from any State
22 agency responsible for administering Medicaid or
23 CHIP,” after “United States”; and

24 (5) in subsection (f)—

1 (A) in the subsection heading, by striking
2 “AUTHORIZATION OF APPROPRIATIONS” and
3 inserting “FUNDING”;

4 (B) in paragraph (1), by inserting “(other
5 than for fiscal year 2010)” before “in the same
6 manner”; and

7 (C) by adding at the end the following:

8 “(3) FUNDING FOR FISCAL YEAR 2010.—

9 “(A) IN GENERAL.—Out of any funds in
10 the Treasury not otherwise appropriated, there
11 is appropriated to MACPAC to carry out the
12 provisions of this section for fiscal year 2010,
13 \$9,000,000.

14 “(B) TRANSFER OF FUNDS.—Notwith-
15 standing section 2104(a)(13), from the
16 amounts appropriated in such section for fiscal
17 year 2010, \$2,000,000 is hereby transferred
18 and made available in such fiscal year to
19 MACPAC to carry out the provisions of this
20 section.

21 “(4) AVAILABILITY.—Amounts made available
22 under paragraphs (2) and (3) to MACPAC to carry
23 out the provisions of this section shall remain avail-
24 able until expended.”.

1 (b) CONFORMING MEDPAC AMENDMENTS.—Section
2 1805(b) of the Social Security Act (42 U.S.C. 1395b–
3 6(b)), is amended—

4 (1) in paragraph (1)(C), by striking “March 1
5 of each year (beginning with 1998)” and inserting
6 “March 15”;

7 (2) in paragraph (1)(D), by inserting “, and
8 (beginning with 2012) containing an examination of
9 the topics described in paragraph (9), to the extent
10 feasible” before the period; and

11 (3) by adding at the end the following:

12 “(9) REVIEW AND ANNUAL REPORT ON MED-
13 ICAID AND COMMERCIAL TRENDS.—The Commission
14 shall review and report on aggregate trends in
15 spending, utilization, and financial performance
16 under the Medicaid program under title XIX and
17 the private market for health care services with re-
18 spect to providers for which, on an aggregate na-
19 tional basis, a significant portion of revenue or serv-
20 ices is associated with the Medicaid program. Where
21 appropriate, the Commission shall conduct such re-
22 view in consultation with the Medicaid and CHIP
23 Payment and Access Commission established under
24 section 1900 (in this section referred to as
25 ‘MACPAC’).

1 “(10) COORDINATE AND CONSULT WITH THE
2 FEDERAL COORDINATED HEALTH CARE OFFICE.—
3 The Commission shall coordinate and consult with
4 the Federal Coordinated Health Care Office estab-
5 lished under section 2081 of the Patient Protection
6 and Affordable Care Act before making any rec-
7 ommendations regarding dual eligible individuals.

8 “(11) INTERACTION OF MEDICAID AND MEDI-
9 CARE.—The Commission shall consult with
10 MACPAC in carrying out its duties under this sec-
11 tion, as appropriate. Responsibility for analysis of
12 and recommendations to change Medicare policy re-
13 garding Medicare beneficiaries, including Medicare
14 beneficiaries who are dually eligible for Medicare and
15 Medicaid, shall rest with the Commission. Responsi-
16 bility for analysis of and recommendations to change
17 Medicaid policy regarding Medicaid beneficiaries, in-
18 cluding Medicaid beneficiaries who are dually eligible
19 for Medicare and Medicaid, shall rest with
20 MACPAC.”.

21 **Subtitle K—Protections for Amer-**
22 **ican Indians and Alaska Natives**

23 **SEC. 2901. SPECIAL RULES RELATING TO INDIANS.**

24 (a) NO COST-SHARING FOR INDIANS WITH INCOME
25 AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN

1 COVERAGE THROUGH A STATE EXCHANGE.—For provi-
2 sions prohibiting cost sharing for Indians enrolled in any
3 qualified health plan in the individual market through an
4 Exchange, see section 1402(d) of the Patient Protection
5 and Affordable Care Act.

6 (b) PAYER OF LAST RESORT.—Health programs op-
7 erated by the Indian Health Service, Indian tribes, tribal
8 organizations, and Urban Indian organizations (as those
9 terms are defined in section 4 of the Indian Health Care
10 Improvement Act (25 U.S.C. 1603)) shall be the payer
11 of last resort for services provided by such Service, tribes,
12 or organizations to individuals eligible for services through
13 such programs, notwithstanding any Federal, State, or
14 local law to the contrary.

15 (c) FACILITATING ENROLLMENT OF INDIANS UNDER
16 THE EXPRESS LANE OPTION.—Section
17 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C.
18 1396a(e)(13)(F)(ii)) is amended—

19 (1) in the clause heading, by inserting “AND IN-
20 DIAN TRIBES AND TRIBAL ORGANIZATIONS” after
21 “AGENCIES”; and

22 (2) by adding at the end the following:

23 “(IV) The Indian Health Service,
24 an Indian Tribe, Tribal Organization,

1 or Urban Indian Organization (as de-
2 fined in section 1139(c)).”.

3 (d) TECHNICAL CORRECTIONS.—Section 1139(c) of
4 the Social Security Act (42 U.S.C. 1320b–9(c)) is amend-
5 ed by striking “In this section” and inserting “For pur-
6 poses of this section, title XIX, and title XXI”.

7 **SEC. 2902. ELIMINATION OF SUNSET FOR REIMBURSEMENT**
8 **FOR ALL MEDICARE PART B SERVICES FUR-**
9 **NISHED BY CERTAIN INDIAN HOSPITALS AND**
10 **CLINICS.**

11 (a) REIMBURSEMENT FOR ALL MEDICARE PART B
12 SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS
13 AND CLINICS.—Section 1880(e)(1)(A) of the Social Secu-
14 rity Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by strik-
15 ing “during the 5-year period beginning on” and inserting
16 “on or after”.

17 (b) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to items or services furnished on
19 or after January 1, 2010.

1 **Subtitle L—Maternal and Child**
2 **Health Services**

3 **SEC. 2951. MATERNAL, INFANT, AND EARLY CHILDHOOD**
4 **HOME VISITING PROGRAMS.**

5 Title V of the Social Security Act (42 U.S.C. 701
6 et seq.) is amended by adding at the end the following
7 new section:

8 **“SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD**
9 **HOME VISITING PROGRAMS.**

10 “(a) **PURPOSES.**—The purposes of this section are—

11 “(1) to strengthen and improve the programs
12 and activities carried out under this title;

13 “(2) to improve coordination of services for at
14 risk communities; and

15 “(3) to identify and provide comprehensive
16 services to improve outcomes for families who reside
17 in at risk communities.

18 “(b) **REQUIREMENT FOR ALL STATES TO ASSESS**
19 **STATEWIDE NEEDS AND IDENTIFY AT RISK COMMU-**
20 **NITIES.**—

21 “(1) **IN GENERAL.**—Not later than 6 months
22 after the date of enactment of this section, each
23 State shall, as a condition of receiving payments
24 from an allotment for the State under section 502
25 for fiscal year 2011, conduct a statewide needs as-

1 assessment (which shall be separate from the statewide
2 needs assessment required under section 505(a))
3 that identifies—

4 “(A) communities with concentrations of—

5 “(i) premature birth, low-birth weight
6 infants, and infant mortality, including in-
7 fant death due to neglect, or other indica-
8 tors of at-risk prenatal, maternal, newborn,
9 or child health;

10 “(ii) poverty;

11 “(iii) crime;

12 “(iv) domestic violence;

13 “(v) high rates of high-school drop-
14 outs;

15 “(vi) substance abuse;

16 “(vii) unemployment; or

17 “(viii) child maltreatment;

18 “(B) the quality and capacity of existing
19 programs or initiatives for early childhood home
20 visitation in the State including—

21 “(i) the number and types of individ-
22 uals and families who are receiving services
23 under such programs or initiatives;

24 “(ii) the gaps in early childhood home
25 visitation in the State; and

1 “(iii) the extent to which such pro-
2 grams or initiatives are meeting the needs
3 of eligible families described in subsection
4 (k)(2); and

5 “(C) the State’s capacity for providing
6 substance abuse treatment and counseling serv-
7 ices to individuals and families in need of such
8 treatment or services.

9 “(2) COORDINATION WITH OTHER ASSESS-
10 MENTS.—In conducting the statewide needs assess-
11 ment required under paragraph (1), the State shall
12 coordinate with, and take into account, other appro-
13 priate needs assessments conducted by the State, as
14 determined by the Secretary, including the needs as-
15 sessment required under section 505(a) (both the
16 most recently completed assessment and any such
17 assessment in progress), the communitywide stra-
18 tegic planning and needs assessments conducted in
19 accordance with section 640(g)(1)(C) of the Head
20 Start Act, and the inventory of current unmet needs
21 and current community-based and prevention-fo-
22 cused programs and activities to prevent child abuse
23 and neglect, and other family resource services oper-
24 ating in the State required under section 205(3) of
25 the Child Abuse Prevention and Treatment Act.

1 “(3) SUBMISSION TO THE SECRETARY.—Each
2 State shall submit to the Secretary, in such form
3 and manner as the Secretary shall require—

4 “(A) the results of the statewide needs as-
5 sessment required under paragraph (1); and

6 “(B) a description of how the State in-
7 tends to address needs identified by the assess-
8 ment, particularly with respect to communities
9 identified under paragraph (1)(A), which may
10 include applying for a grant to conduct an early
11 childhood home visitation program in accord-
12 ance with the requirements of this section.

13 “(c) GRANTS FOR EARLY CHILDHOOD HOME VISITA-
14 TION PROGRAMS.—

15 “(1) AUTHORITY TO MAKE GRANTS.—In addi-
16 tion to any other payments made under this title to
17 a State, the Secretary shall make grants to eligible
18 entities to enable the entities to deliver services
19 under early childhood home visitation programs that
20 satisfy the requirements of subsection (d) to eligible
21 families in order to promote improvements in mater-
22 nal and prenatal health, infant health, child health
23 and development, parenting related to child develop-
24 ment outcomes, school readiness, and the socio-

1 economic status of such families, and reductions in
2 child abuse, neglect, and injuries.

3 “(2) AUTHORITY TO USE INITIAL GRANT FUNDS
4 FOR PLANNING OR IMPLEMENTATION.—An eligible
5 entity that receives a grant under paragraph (1)
6 may use a portion of the funds made available to the
7 entity during the first 6 months of the period for
8 which the grant is made for planning or implementa-
9 tion activities to assist with the establishment of
10 early childhood home visitation programs that sat-
11 isfy the requirements of subsection (d).

12 “(3) GRANT DURATION.—The Secretary shall
13 determine the period of years for which a grant is
14 made to an eligible entity under paragraph (1).

15 “(4) TECHNICAL ASSISTANCE.—The Secretary
16 shall provide an eligible entity that receives a grant
17 under paragraph (1) with technical assistance in ad-
18 ministering programs or activities conducted in
19 whole or in part with grant funds.

20 “(d) REQUIREMENTS.—The requirements of this sub-
21 section for an early childhood home visitation program
22 conducted with a grant made under this section are as
23 follows:

24 “(1) QUANTIFIABLE, MEASURABLE IMPROVE-
25 MENT IN BENCHMARK AREAS.—

1 “(A) IN GENERAL.—The eligible entity es-
2 tablishes, subject to the approval of the Sec-
3 retary, quantifiable, measurable 3- and 5-year
4 benchmarks for demonstrating that the pro-
5 gram results in improvements for the eligible
6 families participating in the program in each of
7 the following areas:

8 “(i) Improved maternal and newborn
9 health.

10 “(ii) Prevention of child injuries, child
11 abuse, neglect, or maltreatment, and re-
12 duction of emergency department visits.

13 “(iii) Improvement in school readiness
14 and achievement.

15 “(iv) Reduction in crime or domestic
16 violence.

17 “(v) Improvements in family economic
18 self-sufficiency.

19 “(vi) Improvements in the coordina-
20 tion and referrals for other community re-
21 sources and supports.

22 “(B) DEMONSTRATION OF IMPROVEMENTS
23 AFTER 3 YEARS.—

24 “(i) REPORT TO THE SECRETARY.—

25 Not later than 30 days after the end of the

1 3rd year in which the eligible entity con-
2 ducts the program, the entity submits to
3 the Secretary a report demonstrating im-
4 provement in at least 4 of the areas speci-
5 fied in subparagraph (A).

6 “(ii) CORRECTIVE ACTION PLAN.—If
7 the report submitted by the eligible entity
8 under clause (i) fails to demonstrate im-
9 provement in at least 4 of the areas speci-
10 fied in subparagraph (A), the entity shall
11 develop and implement a plan to improve
12 outcomes in each of the areas specified in
13 subparagraph (A), subject to approval by
14 the Secretary. The plan shall include provi-
15 sions for the Secretary to monitor imple-
16 mentation of the plan and conduct contin-
17 ued oversight of the program, including
18 through submission by the entity of reg-
19 ular reports to the Secretary.

20 “(iii) TECHNICAL ASSISTANCE.—

21 “(I) IN GENERAL.—The Sec-
22 retary shall provide an eligible entity
23 required to develop and implement an
24 improvement plan under clause (ii)
25 with technical assistance to develop

1 and implement the plan. The Sec-
2 retary may provide the technical as-
3 sistance directly or through grants,
4 contracts, or cooperative agreements.

5 “(II) ADVISORY PANEL.—The
6 Secretary shall establish an advisory
7 panel for purposes of obtaining rec-
8 ommendations regarding the technical
9 assistance provided to entities in ac-
10 cordance with subclause (I).

11 “(iv) NO IMPROVEMENT OR FAILURE
12 TO SUBMIT REPORT.—If the Secretary de-
13 termines after a period of time specified by
14 the Secretary that an eligible entity imple-
15 menting an improvement plan under clause
16 (ii) has failed to demonstrate any improve-
17 ment in the areas specified in subpara-
18 graph (A), or if the Secretary determines
19 that an eligible entity has failed to submit
20 the report required under clause (i), the
21 Secretary shall terminate the entity’s grant
22 and may include any unexpended grant
23 funds in grants made to nonprofit organi-
24 zations under subsection (h)(2)(B).

1 “(C) FINAL REPORT.—Not later than De-
2 cember 31, 2015, the eligible entity shall sub-
3 mit a report to the Secretary demonstrating im-
4 provements (if any) in each of the areas speci-
5 fied in subparagraph (A).

6 “(2) IMPROVEMENTS IN OUTCOMES FOR INDI-
7 VIDUAL FAMILIES.—

8 “(A) IN GENERAL.—The program is de-
9 signed, with respect to an eligible family partici-
10 pating in the program, to result in the partici-
11 pant outcomes described in subparagraph (B)
12 that the eligible entity identifies on the basis of
13 an individualized assessment of the family, are
14 relevant for that family.

15 “(B) PARTICIPANT OUTCOMES.—The par-
16 ticipant outcomes described in this subpara-
17 graph are the following:

18 “(i) Improvements in prenatal, mater-
19 nal, and newborn health, including im-
20 proved pregnancy outcomes

21 “(ii) Improvements in child health
22 and development, including the prevention
23 of child injuries and maltreatment and im-
24 provements in cognitive, language, social-

1 emotional, and physical developmental indi-
2 cators.

3 “(iii) Improvements in parenting
4 skills.

5 “(iv) Improvements in school readi-
6 ness and child academic achievement.

7 “(v) Reductions in crime or domestic
8 violence.

9 “(vi) Improvements in family eco-
10 nomic self-sufficiency.

11 “(vii) Improvements in the coordina-
12 tion of referrals for, and the provision of,
13 other community resources and supports
14 for eligible families, consistent with State
15 child welfare agency training.

16 “(3) CORE COMPONENTS.—The program in-
17 cludes the following core components:

18 “(A) SERVICE DELIVERY MODEL OR MOD-
19 ELS.—

20 “(i) IN GENERAL.—Subject to clause
21 (ii), the program is conducted using 1 or
22 more of the service delivery models de-
23 scribed in item (aa) or (bb) of subclause
24 (I) or in subclause (II) selected by the eli-
25 gible entity:

1 “(I) The model conforms to a
2 clear consistent home visitation model
3 that has been in existence for at least
4 3 years and is research-based, ground-
5 ed in relevant empirically-based
6 knowledge, linked to program deter-
7 mined outcomes, associated with a na-
8 tional organization or institution of
9 higher education that has comprehen-
10 sive home visitation program stand-
11 ards that ensure high quality service
12 delivery and continuous program qual-
13 ity improvement, and has dem-
14 onstrated significant, (and in the case
15 of the service delivery model described
16 in item (aa), sustained) positive out-
17 comes, as described in the benchmark
18 areas specified in paragraph (1)(A)
19 and the participant outcomes de-
20 scribed in paragraph (2)(B), when
21 evaluated using well-designed and rig-
22 orous—

23 “(aa) randomized controlled
24 research designs, and the evalua-

1 tion results have been published
2 in a peer-reviewed journal; or

3 “(bb) quasi-experimental re-
4 search designs.

5 “(II) The model conforms to a
6 promising and new approach to
7 achieving the benchmark areas speci-
8 fied in paragraph (1)(A) and the par-
9 ticipant outcomes described in para-
10 graph (2)(B), has been developed or
11 identified by a national organization
12 or institution of higher education, and
13 will be evaluated through well-de-
14 signed and rigorous process.

15 “(ii) MAJORITY OF GRANT FUNDS
16 USED FOR EVIDENCE-BASED MODELS.—An
17 eligible entity shall use not more than 25
18 percent of the amount of the grant paid to
19 the entity for a fiscal year for purposes of
20 conducting a program using the service de-
21 livery model described in clause (i)(II).

22 “(iii) CRITERIA FOR EVIDENCE OF EF-
23 FECTIVENESS OF MODELS.—The Secretary
24 shall establish criteria for evidence of effec-
25 tiveness of the service delivery models and

1 shall ensure that the process for estab-
2 lishing the criteria is transparent and pro-
3 vides the opportunity for public comment.

4 “(B) ADDITIONAL REQUIREMENTS.—

5 “(i) The program adheres to a clear,
6 consistent model that satisfies the require-
7 ments of being grounded in empirically-
8 based knowledge related to home visiting
9 and linked to the benchmark areas speci-
10 fied in paragraph (1)(A) and the partici-
11 pant outcomes described in paragraph
12 (2)(B) related to the purposes of the pro-
13 gram.

14 “(ii) The program employs well-
15 trained and competent staff, as dem-
16 onstrated by education or training, such as
17 nurses, social workers, educators, child de-
18 velopment specialists, or other well-trained
19 and competent staff, and provides ongoing
20 and specific training on the model being
21 delivered.

22 “(iii) The program maintains high
23 quality supervision to establish home vis-
24 itor competencies.

1 “(iv) The program demonstrates
2 strong organizational capacity to imple-
3 ment the activities involved.

4 “(v) The program establishes appro-
5 priate linkages and referral networks to
6 other community resources and supports
7 for eligible families.

8 “(vi) The program monitors the fidel-
9 ity of program implementation to ensure
10 that services are delivered pursuant to the
11 specified model.

12 “(4) PRIORITY FOR SERVING HIGH-RISK POPU-
13 LATIONS.—The eligible entity gives priority to pro-
14 viding services under the program to the following:

15 “(A) Eligible families who reside in com-
16 munities in need of such services, as identified
17 in the statewide needs assessment required
18 under subsection (b)(1)(A).

19 “(B) Low-income eligible families.

20 “(C) Eligible families who are pregnant
21 women who have not attained age 21.

22 “(D) Eligible families that have a history
23 of child abuse or neglect or have had inter-
24 actions with child welfare services.

1 “(E) Eligible families that have a history
2 of substance abuse or need substance abuse
3 treatment.

4 “(F) Eligible families that have users of
5 tobacco products in the home.

6 “(G) Eligible families that are or have chil-
7 dren with low student achievement.

8 “(H) Eligible families with children with
9 developmental delays or disabilities.

10 “(I) Eligible families who, or that include
11 individuals who, are serving or formerly served
12 in the Armed Forces, including such families
13 that have members of the Armed Forces who
14 have had multiple deployments outside of the
15 United States.

16 “(e) APPLICATION REQUIREMENTS.—An eligible en-
17 tity desiring a grant under this section shall submit an
18 application to the Secretary for approval, in such manner
19 as the Secretary may require, that includes the following:

20 “(1) A description of the populations to be
21 served by the entity, including specific information
22 regarding how the entity will serve high risk popu-
23 lations described in subsection (d)(4).

24 “(2) An assurance that the entity will give pri-
25 ority to serving low-income eligible families and eligi-

1 ble families who reside in at risk communities identi-
2 fied in the statewide needs assessment required
3 under subsection (b)(1)(A).

4 “(3) The service delivery model or models de-
5 scribed in subsection (d)(3)(A) that the entity will
6 use under the program and the basis for the selec-
7 tion of the model or models.

8 “(4) A statement identifying how the selection
9 of the populations to be served and the service deliv-
10 ery model or models that the entity will use under
11 the program for such populations is consistent with
12 the results of the statewide needs assessment con-
13 ducted under subsection (b).

14 “(5) The quantifiable, measurable benchmarks
15 established by the State to demonstrate that the
16 program contributes to improvements in the areas
17 specified in subsection (d)(1)(A).

18 “(6) An assurance that the entity will obtain
19 and submit documentation or other appropriate evi-
20 dence from the organization or entity that developed
21 the service delivery model or models used under the
22 program to verify that the program is implemented
23 and services are delivered according to the model
24 specifications.

1 “(7) Assurances that the entity will establish
2 procedures to ensure that—

3 “(A) the participation of each eligible fam-
4 ily in the program is voluntary; and

5 “(B) services are provided to an eligible
6 family in accordance with the individual assess-
7 ment for that family.

8 “(8) Assurances that the entity will—

9 “(A) submit annual reports to the Sec-
10 retary regarding the program and activities car-
11 ried out under the program that include such
12 information and data as the Secretary shall re-
13 quire; and

14 “(B) participate in, and cooperate with,
15 data and information collection necessary for
16 the evaluation required under subsection (g)(2)
17 and other research and evaluation activities car-
18 ried out under subsection (h)(3).

19 “(9) A description of other State programs that
20 include home visitation services, including, if appli-
21 cable to the State, other programs carried out under
22 this title with funds made available from allotments
23 under section 502(c), programs funded under title
24 IV, title II of the Child Abuse Prevention and Treat-
25 ment Act (relating to community-based grants for

1 the prevention of child abuse and neglect), and sec-
2 tion 645A of the Head Start Act (relating to Early
3 Head Start programs).

4 “(10) Other information as required by the Sec-
5 retary.

6 “(f) MAINTENANCE OF EFFORT.—Funds provided to
7 an eligible entity receiving a grant under this section shall
8 supplement, and not supplant, funds from other sources
9 for early childhood home visitation programs or initiatives.

10 “(g) EVALUATION.—

11 “(1) INDEPENDENT, EXPERT ADVISORY
12 PANEL.—The Secretary, in accordance with sub-
13 section (h)(1)(A), shall appoint an independent advi-
14 sory panel consisting of experts in program evalua-
15 tion and research, education, and early childhood de-
16 velopment—

17 “(A) to review, and make recommendations
18 on, the design and plan for the evaluation re-
19 quired under paragraph (2) within 1 year after
20 the date of enactment of this section;

21 “(B) to maintain and advise the Secretary
22 regarding the progress of the evaluation; and

23 “(C) to comment, if the panel so desires,
24 on the report submitted under paragraph (3).

1 “(2) AUTHORITY TO CONDUCT EVALUATION.—
2 On the basis of the recommendations of the advisory
3 panel under paragraph (1), the Secretary shall, by
4 grant, contract, or interagency agreement, conduct
5 an evaluation of the statewide needs assessments
6 submitted under subsection (b) and the grants made
7 under subsections (c) and (h)(3)(B). The evaluation
8 shall include—

9 “(A) an analysis, on a State-by-State
10 basis, of the results of such assessments, in-
11 cluding indicators of maternal and prenatal
12 health and infant health and mortality, and
13 State actions in response to the assessments;
14 and

15 “(B) an assessment of—

16 “(i) the effect of early childhood home
17 visitation programs on child and parent
18 outcomes, including with respect to each of
19 the benchmark areas specified in sub-
20 section (d)(1)(A) and the participant out-
21 comes described in subsection (d)(2)(B);

22 “(ii) the effectiveness of such pro-
23 grams on different populations, including
24 the extent to which the ability of programs

1 to improve participant outcomes varies
2 across programs and populations; and

3 “(iii) the potential for the activities
4 conducted under such programs, if scaled
5 broadly, to improve health care practices,
6 eliminate health disparities, and improve
7 health care system quality, efficiencies, and
8 reduce costs.

9 “(3) REPORT.—Not later than March 31, 2015,
10 the Secretary shall submit a report to Congress on
11 the results of the evaluation conducted under para-
12 graph (2) and shall make the report publicly avail-
13 able.

14 “(h) OTHER PROVISIONS.—

15 “(1) INTRA-AGENCY COLLABORATION.—The
16 Secretary shall ensure that the Maternal and Child
17 Health Bureau and the Administration for Children
18 and Families collaborate with respect to carrying out
19 this section, including with respect to—

20 “(A) reviewing and analyzing the statewide
21 needs assessments required under subsection
22 (b), the awarding and oversight of grants
23 awarded under this section, the establishment
24 of the advisory panels required under sub-
25 sections (d)(1)(B)(iii)(II) and (g)(1), and the

1 evaluation and report required under subsection
2 (g); and

3 “(B) consulting with other Federal agen-
4 cies with responsibility for administering or
5 evaluating programs that serve eligible families
6 to coordinate and collaborate with respect to re-
7 search related to such programs and families,
8 including the Office of the Assistant Secretary
9 for Planning and Evaluation of the Department
10 of Health and Human Services, the Centers for
11 Disease Control and Prevention, the National
12 Institute of Child Health and Human Develop-
13 ment of the National Institutes of Health, the
14 Office of Juvenile Justice and Delinquency Pre-
15 vention of the Department of Justice, and the
16 Institute of Education Sciences of the Depart-
17 ment of Education.

18 “(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE
19 NOT STATES.—

20 “(A) INDIAN TRIBES, TRIBAL ORGANIZA-
21 TIONS, OR URBAN INDIAN ORGANIZATIONS.—
22 The Secretary shall specify requirements for eli-
23 gible entities that are Indian Tribes (or a con-
24 sortium of Indian Tribes), Tribal Organiza-
25 tions, or Urban Indian Organizations to apply

1 for and conduct an early childhood home visita-
2 tion program with a grant under this section.
3 Such requirements shall, to the greatest extent
4 practicable, be consistent with the requirements
5 applicable to eligible entities that are States
6 and shall require an Indian Tribe (or consor-
7 tium), Tribal Organization, or Urban Indian
8 Organization to—

9 “(i) conduct a needs assessment simi-
10 lar to the assessment required for all
11 States under subsection (b); and

12 “(ii) establish quantifiable, measur-
13 able 3- and 5-year benchmarks consistent
14 with subsection (d)(1)(A).

15 “(B) NONPROFIT ORGANIZATIONS.—If, as
16 of the beginning of fiscal year 2012, a State
17 has not applied or been approved for a grant
18 under this section, the Secretary may use
19 amounts appropriated under paragraph (1) of
20 subsection (j) that are available for expenditure
21 under paragraph (3) of that subsection to make
22 a grant to an eligible entity that is a nonprofit
23 organization described in subsection (k)(1)(B)
24 to conduct an early childhood home visitation
25 program in the State. The Secretary shall speci-

1 fy the requirements for such an organization to
2 apply for and conduct the program which shall,
3 to the greatest extent practicable, be consistent
4 with the requirements applicable to eligible enti-
5 ties that are States and shall require the orga-
6 nization to—

7 “(i) carry out the program based on
8 the needs assessment conducted by the
9 State under subsection (b); and

10 “(ii) establish quantifiable, measur-
11 able 3- and 5-year benchmarks consistent
12 with subsection (d)(1)(A).

13 “(3) RESEARCH AND OTHER EVALUATION AC-
14 TIVITIES.—

15 “(A) IN GENERAL.—The Secretary shall
16 carry out a continuous program of research and
17 evaluation activities in order to increase knowl-
18 edge about the implementation and effective-
19 ness of home visiting programs, using random
20 assignment designs to the maximum extent fea-
21 sible. The Secretary may carry out such activi-
22 ties directly, or through grants, cooperative
23 agreements, or contracts.

24 “(B) REQUIREMENTS.—The Secretary
25 shall ensure that—

1 “(i) evaluation of a specific program
2 or project is conducted by persons or indi-
3 viduals not directly involved in the oper-
4 ation of such program or project; and

5 “(ii) the conduct of research and eval-
6 uation activities includes consultation with
7 independent researchers, State officials,
8 and developers and providers of home vis-
9 iting programs on topics including research
10 design and administrative data matching.

11 “(4) REPORT AND RECOMMENDATION.—Not
12 later than December 31, 2015, the Secretary shall
13 submit a report to Congress regarding the programs
14 conducted with grants under this section. The report
15 required under this paragraph shall include—

16 “(A) information regarding the extent to
17 which eligible entities receiving grants under
18 this section demonstrated improvements in each
19 of the areas specified in subsection (d)(1)(A);

20 “(B) information regarding any technical
21 assistance provided under subsection
22 (d)(1)(B)(iii)(I), including the type of any such
23 assistance provided; and

1 “(C) recommendations for such legislative
2 or administrative action as the Secretary deter-
3 mines appropriate.

4 “(i) APPLICATION OF OTHER PROVISIONS OF
5 TITLE.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), the other provisions of this title shall not
8 apply to a grant made under this section.

9 “(2) EXCEPTIONS.—The following provisions of
10 this title shall apply to a grant made under this sec-
11 tion to the same extent and in the same manner as
12 such provisions apply to allotments made under sec-
13 tion 502(c):

14 “(A) Section 504(b)(6) (relating to prohi-
15 bition on payments to excluded individuals and
16 entities).

17 “(B) Section 504(c) (relating to the use of
18 funds for the purchase of technical assistance).

19 “(C) Section 504(d) (relating to a limita-
20 tion on administrative expenditures).

21 “(D) Section 506 (relating to reports and
22 audits), but only to the extent determined by
23 the Secretary to be appropriate for grants made
24 under this section.

1 “(E) Section 507 (relating to penalties for
2 false statements).

3 “(F) Section 508 (relating to non-
4 discrimination).

5 “(G) Section 509(a) (relating to the ad-
6 ministration of the grant program).

7 “(j) APPROPRIATIONS.—

8 “(1) IN GENERAL.—Out of any funds in the
9 Treasury not otherwise appropriated, there are ap-
10 propriated to the Secretary to carry out this sec-
11 tion—

12 “(A) \$100,000,000 for fiscal year 2010;

13 “(B) \$250,000,000 for fiscal year 2011;

14 “(C) \$350,000,000 for fiscal year 2012;

15 “(D) \$400,000,000 for fiscal year 2013;

16 and

17 “(E) \$400,000,000 for fiscal year 2014.

18 “(2) RESERVATIONS.—Of the amount appro-
19 priated under this subsection for a fiscal year, the
20 Secretary shall reserve—

21 “(A) 3 percent of such amount for pur-
22 poses of making grants to eligible entities that
23 are Indian Tribes (or a consortium of Indian
24 Tribes), Tribal Organizations, or Urban Indian
25 Organizations; and

1 “(B) 3 percent of such amount for pur-
2 poses of carrying out subsections (d)(1)(B)(iii),
3 (g), and (h)(3).

4 “(3) AVAILABILITY.—Funds made available to
5 an eligible entity under this section for a fiscal year
6 shall remain available for expenditure by the eligible
7 entity through the end of the second succeeding fis-
8 cal year after award. Any funds that are not ex-
9 pended by the eligible entity during the period in
10 which the funds are available under the preceding
11 sentence may be used for grants to nonprofit organi-
12 zations under subsection (h)(2)(B).

13 “(k) DEFINITIONS.—In this section:

14 “(1) ELIGIBLE ENTITY.—

15 “(A) IN GENERAL.—The term ‘eligible en-
16 tity’ means a State, an Indian Tribe, Tribal Or-
17 ganization, or Urban Indian Organization,
18 Puerto Rico, Guam, the Virgin Islands, the
19 Northern Mariana Islands, and American
20 Samoa.

21 “(B) NONPROFIT ORGANIZATIONS.—Only
22 for purposes of awarding grants under sub-
23 section (h)(2)(B), such term shall include a
24 nonprofit organization with an established
25 record of providing early childhood home visita-

1 tion programs or initiatives in a State or sev-
2 eral States.

3 “(2) ELIGIBLE FAMILY.—The term ‘eligible
4 family’ means—

5 “(A) a woman who is pregnant, and the fa-
6 ther of the child if the father is available; or

7 “(B) a parent or primary caregiver of a
8 child, including grandparents or other relatives
9 of the child, and foster parents, who are serving
10 as the child’s primary caregiver from birth to
11 kindergarten entry, and including a noncusto-
12 dial parent who has an ongoing relationship
13 with, and at times provides physical care for,
14 the child.

15 “(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—
16 The terms ‘Indian Tribe’ and ‘Tribal Organization’,
17 and ‘Urban Indian Organization’ have the meanings
18 given such terms in section 4 of the Indian Health
19 Care Improvement Act.”.

20 **SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR**
21 **POSTPARTUM DEPRESSION.**

22 (a) RESEARCH ON POSTPARTUM CONDITIONS.—

23 (1) EXPANSION AND INTENSIFICATION OF AC-
24 TIVITIES.—The Secretary of Health and Human
25 Services (in this subsection and subsection (c) re-

1 ferred to as the “Secretary”) is encouraged to con-
2 tinue activities on postpartum depression or
3 postpartum psychosis (in this subsection and sub-
4 section (c) referred to as “postpartum conditions”),
5 including research to expand the understanding of
6 the causes of, and treatments for, postpartum condi-
7 tions. Activities under this paragraph shall include
8 conducting and supporting the following:

9 (A) Basic research concerning the etiology
10 and causes of the conditions.

11 (B) Epidemiological studies to address the
12 frequency and natural history of the conditions
13 and the differences among racial and ethnic
14 groups with respect to the conditions.

15 (C) The development of improved screen-
16 ing and diagnostic techniques.

17 (D) Clinical research for the development
18 and evaluation of new treatments.

19 (E) Information and education programs
20 for health care professionals and the public,
21 which may include a coordinated national cam-
22 paign to increase the awareness and knowledge
23 of postpartum conditions. Activities under such
24 a national campaign may—

1 (i) include public service announce-
2 ments through television, radio, and other
3 means; and

4 (ii) focus on—

5 (I) raising awareness about
6 screening;

7 (II) educating new mothers and
8 their families about postpartum condi-
9 tions to promote earlier diagnosis and
10 treatment; and

11 (III) ensuring that such edu-
12 cation includes complete information
13 concerning postpartum conditions, in-
14 cluding its symptoms, methods of cop-
15 ing with the illness, and treatment re-
16 sources.

17 (2) SENSE OF CONGRESS REGARDING LONGITU-
18 DINAL STUDY OF RELATIVE MENTAL HEALTH CON-
19 SEQUENCES FOR WOMEN OF RESOLVING A PREG-
20 NANCY.—

21 (A) SENSE OF CONGRESS.—It is the sense
22 of Congress that the Director of the National
23 Institute of Mental Health may conduct a na-
24 tionally representative longitudinal study (dur-
25 ing the period of fiscal years 2010 through

1 2019) of the relative mental health con-
2 sequences for women of resolving a pregnancy
3 (intended and unintended) in various ways, in-
4 cluding carrying the pregnancy to term and
5 parenting the child, carrying the pregnancy to
6 term and placing the child for adoption, mis-
7 carriage, and having an abortion. This study
8 may assess the incidence, timing, magnitude,
9 and duration of the immediate and long-term
10 mental health consequences (positive or nega-
11 tive) of these pregnancy outcomes.

12 (B) REPORT.—Subject to the completion
13 of the study under subsection (a), beginning not
14 later than 5 years after the date of the enact-
15 ment of this Act, and periodically thereafter for
16 the duration of the study, such Director may
17 prepare and submit to the Congress reports on
18 the findings of the study.

19 (b) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS
20 WITH A POSTPARTUM CONDITION AND THEIR FAMI-
21 LIES.—Title V of the Social Security Act (42 U.S.C. 701
22 et seq.), as amended by section 2951, is amended by add-
23 ing at the end the following new section:

1 **“SEC. 512. SERVICES TO INDIVIDUALS WITH A**
2 **POSTPARTUM CONDITION AND THEIR FAMI-**
3 **LIES.**

4 “(a) IN GENERAL.—In addition to any other pay-
5 ments made under this title to a State, the Secretary may
6 make grants to eligible entities for projects for the estab-
7 lishment, operation, and coordination of effective and cost-
8 efficient systems for the delivery of essential services to
9 individuals with or at risk for postpartum conditions and
10 their families.

11 “(b) CERTAIN ACTIVITIES.—To the extent prac-
12 ticable and appropriate, the Secretary shall ensure that
13 projects funded under subsection (a) provide education
14 and services with respect to the diagnosis and manage-
15 ment of postpartum conditions for individuals with or at
16 risk for postpartum conditions and their families. The Sec-
17 retary may allow such projects to include the following:

18 “(1) Delivering or enhancing outpatient and
19 home-based health and support services, including
20 case management and comprehensive treatment
21 services.

22 “(2) Delivering or enhancing inpatient care
23 management services that ensure the well-being of
24 the mother and family and the future development
25 of the infant.

1 “(3) Improving the quality, availability, and or-
2 ganization of health care and support services (in-
3 cluding transportation services, attendant care,
4 homemaker services, day or respite care, and pro-
5 viding counseling on financial assistance and insur-
6 ance).

7 “(4) Providing education about postpartum
8 conditions to promote earlier diagnosis and treat-
9 ment. Such education may include—

10 “(A) providing complete information on
11 postpartum conditions, symptoms, methods of
12 coping with the illness, and treatment re-
13 sources; and

14 “(B) in the case of a grantee that is a
15 State, hospital, or birthing facility—

16 “(i) providing education to new moth-
17 ers and fathers, and other family members
18 as appropriate, concerning postpartum
19 conditions before new mothers leave the
20 health facility; and

21 “(ii) ensuring that training programs
22 regarding such education are carried out
23 at the health facility.

24 “(c) INTEGRATION WITH OTHER PROGRAMS.—To
25 the extent practicable and appropriate, the Secretary may

1 integrate the grant program under this section with other
2 grant programs carried out by the Secretary, including the
3 program under section 330 of the Public Health Service
4 Act.

5 “(d) REQUIREMENTS.—The Secretary shall establish
6 requirements for grants made under this section that in-
7 clude a limit on the amount of grants funds that may be
8 used for administration, accounting, reporting, or program
9 oversight functions and a requirement for each eligible en-
10 tity that receives a grant to submit, for each grant period,
11 a report to the Secretary that describes how grant funds
12 were used during such period.

13 “(e) TECHNICAL ASSISTANCE.—The Secretary may
14 provide technical assistance to entities seeking a grant
15 under this section in order to assist such entities in com-
16 plying with the requirements of this section.

17 “(f) APPLICATION OF OTHER PROVISIONS OF
18 TITLE.—

19 “(1) IN GENERAL.—Except as provided in para-
20 graph (2), the other provisions of this title shall not
21 apply to a grant made under this section.

22 “(2) EXCEPTIONS.—The following provisions of
23 this title shall apply to a grant made under this sec-
24 tion to the same extent and in the same manner as

1 such provisions apply to allotments made under sec-
2 tion 502(c):

3 “(A) Section 504(b)(6) (relating to prohi-
4 bition on payments to excluded individuals and
5 entities).

6 “(B) Section 504(c) (relating to the use of
7 funds for the purchase of technical assistance).

8 “(C) Section 504(d) (relating to a limita-
9 tion on administrative expenditures).

10 “(D) Section 506 (relating to reports and
11 audits), but only to the extent determined by
12 the Secretary to be appropriate for grants made
13 under this section.

14 “(E) Section 507 (relating to penalties for
15 false statements).

16 “(F) Section 508 (relating to non-
17 discrimination).

18 “(G) Section 509(a) (relating to the ad-
19 ministration of the grant program).

20 “(g) DEFINITIONS.—In this section:

21 “(1) The term ‘eligible entity’—

22 “(A) means a public or nonprofit private
23 entity; and

24 “(B) includes a State or local government,
25 public-private partnership, recipient of a grant

1 under section 330H of the Public Health Serv-
2 ice Act (relating to the Healthy Start Initia-
3 tive), public or nonprofit private hospital, com-
4 munity-based organization, hospice, ambulatory
5 care facility, community health center, migrant
6 health center, public housing primary care cen-
7 ter, or homeless health center.

8 “(2) The term ‘postpartum condition’ means
9 postpartum depression or postpartum psychosis.”.

10 (c) GENERAL PROVISIONS.—

11 (1) AUTHORIZATION OF APPROPRIATIONS.—To
12 carry out this section and the amendment made by
13 subsection (b), there are authorized to be appro-
14 priated, in addition to such other sums as may be
15 available for such purpose—

16 (A) \$3,000,000 for fiscal year 2010; and

17 (B) such sums as may be necessary for fis-
18 cal years 2011 and 2012.

19 (2) REPORT BY THE SECRETARY.—

20 (A) STUDY.—The Secretary shall conduct
21 a study on the benefits of screening for
22 postpartum conditions.

23 (B) REPORT.—Not later than 2 years after
24 the date of the enactment of this Act, the Sec-
25 retary shall complete the study required by sub-

1 paragraph (A) and submit a report to the Con-
2 gress on the results of such study.

3 **SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.**

4 Title V of the Social Security Act (42 U.S.C. 701
5 et seq.), as amended by sections 2951 and 2952(c), is
6 amended by adding at the end the following:

7 **“SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.**

8 “(a) ALLOTMENTS TO STATES.—

9 “(1) AMOUNT.—

10 “(A) IN GENERAL.—For the purpose de-
11 scribed in subsection (b), subject to the suc-
12 ceeding provisions of this section, for each of
13 fiscal years 2010 through 2014, the Secretary
14 shall allot to each State an amount equal to the
15 product of—

16 “(i) the amount appropriated under
17 subsection (f) for the fiscal year and avail-
18 able for allotments to States after the ap-
19 plication of subsection (c); and

20 “(ii) the State youth population per-
21 centage determined under paragraph (2).

22 “(B) MINIMUM ALLOTMENT.—

23 “(i) IN GENERAL.—Each State allot-
24 ment under this paragraph for a fiscal
25 year shall be at least \$250,000.

1 “(ii) PRO RATA ADJUSTMENTS.—The
2 Secretary shall adjust on a pro rata basis
3 the amount of the State allotments deter-
4 mined under this paragraph for a fiscal
5 year to the extent necessary to comply with
6 clause (i).

7 “(C) APPLICATION REQUIRED TO ACCESS
8 ALLOTMENTS.—

9 “(i) IN GENERAL.—A State shall not
10 be paid from its allotment for a fiscal year
11 unless the State submits an application to
12 the Secretary for the fiscal year and the
13 Secretary approves the application (or re-
14 quires changes to the application that the
15 State satisfies) and meets such additional
16 requirements as the Secretary may specify.

17 “(ii) REQUIREMENTS.—The State ap-
18 plication shall contain an assurance that
19 the State has complied with the require-
20 ments of this section in preparing and sub-
21 mitting the application and shall include
22 the following as well as such additional in-
23 formation as the Secretary may require:

24 “(I) Based on data from the
25 Centers for Disease Control and Pre-

1 vention National Center for Health
2 Statistics, the most recent pregnancy
3 rates for the State for youth ages 10
4 to 14 and youth ages 15 to 19 for
5 which data are available, the most re-
6 cent birth rates for such youth popu-
7 lations in the State for which data are
8 available, and trends in those rates
9 for the most recently preceding 5-year
10 period for which such data are avail-
11 able.

12 “(II) State-established goals for
13 reducing the pregnancy rates and
14 birth rates for such youth populations.

15 “(III) A description of the
16 State’s plan for using the State allot-
17 ments provided under this section to
18 achieve such goals, especially among
19 youth populations that are the most
20 high-risk or vulnerable for pregnancies
21 or otherwise have special cir-
22 cumstances, including youth in foster
23 care, homeless youth, youth with HIV/
24 AIDS, pregnant youth who are under
25 21 years of age, mothers who are

1 under 21 years of age, and youth re-
2 siding in areas with high birth rates
3 for youth.

4 “(2) STATE YOUTH POPULATION PERCENT-
5 AGE.—

6 “(A) IN GENERAL.—For purposes of para-
7 graph (1)(A)(ii), the State youth population
8 percentage is, with respect to a State, the pro-
9 portion (expressed as a percentage) of—

10 “(i) the number of individuals who
11 have attained age 10 but not attained age
12 20 in the State; to

13 “(ii) the number of such individuals in
14 all States.

15 “(B) DETERMINATION OF NUMBER OF
16 YOUTH.—The number of individuals described
17 in clauses (i) and (ii) of subparagraph (A) in a
18 State shall be determined on the basis of the
19 most recent Bureau of the Census data.

20 “(3) AVAILABILITY OF STATE ALLOTMENTS.—
21 Subject to paragraph (4)(A), amounts allotted to a
22 State pursuant to this subsection for a fiscal year
23 shall remain available for expenditure by the State
24 through the end of the second succeeding fiscal year.

1 “(4) AUTHORITY TO AWARD GRANTS FROM
2 STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND
3 ENTITIES IN NONPARTICIPATING STATES.—

4 “(A) GRANTS FROM UNEXPENDED ALLOT-
5 MENTS.—If a State does not submit an applica-
6 tion under this section for fiscal year 2010 or
7 2011, the State shall no longer be eligible to
8 submit an application to receive funds from the
9 amounts allotted for the State for each of fiscal
10 years 2010 through 2014 and such amounts
11 shall be used by the Secretary to award grants
12 under this paragraph for each of fiscal years
13 2012 through 2014. The Secretary also shall
14 use any amounts from the allotments of States
15 that submit applications under this section for
16 a fiscal year that remain unexpended as of the
17 end of the period in which the allotments are
18 available for expenditure under paragraph (3)
19 for awarding grants under this paragraph.

20 “(B) 3-YEAR GRANTS.—

21 “(i) IN GENERAL.—The Secretary
22 shall solicit applications to award 3-year
23 grants in each of fiscal years 2012, 2013,
24 and 2014 to local organizations and enti-
25 ties to conduct, consistent with subsection

1 (b), programs and activities in States that
2 do not submit an application for an allot-
3 ment under this section for fiscal year
4 2010 or 2011.

5 “(ii) FAITH-BASED ORGANIZATIONS
6 OR CONSORTIA.—The Secretary may solicit
7 and award grants under this paragraph to
8 faith-based organizations or consortia.

9 “(C) EVALUATION.—An organization or
10 entity awarded a grant under this paragraph
11 shall agree to participate in a rigorous Federal
12 evaluation.

13 “(5) MAINTENANCE OF EFFORT.—No payment
14 shall be made to a State from the allotment deter-
15 mined for the State under this subsection or to a
16 local organization or entity awarded a grant under
17 paragraph (4), if the expenditure of non-federal
18 funds by the State, organization, or entity for activi-
19 ties, programs, or initiatives for which amounts from
20 allotments and grants under this subsection may be
21 expended is less than the amount expended by the
22 State, organization, or entity for such programs or
23 initiatives for fiscal year 2009.

24 “(6) DATA COLLECTION AND REPORTING.—A
25 State or local organization or entity receiving funds

1 under this section shall cooperate with such require-
2 ments relating to the collection of data and informa-
3 tion and reporting on outcomes regarding the pro-
4 grams and activities carried out with such funds, as
5 the Secretary shall specify.

6 “(b) PURPOSE.—

7 “(1) IN GENERAL.—The purpose of an allot-
8 ment under subsection (a)(1) to a State is to enable
9 the State (or, in the case of grants made under sub-
10 section (a)(4)(B), to enable a local organization or
11 entity) to carry out personal responsibility education
12 programs consistent with this subsection.

13 “(2) PERSONAL RESPONSIBILITY EDUCATION
14 PROGRAMS.—

15 “(A) IN GENERAL.—In this section, the
16 term ‘personal responsibility education pro-
17 gram’ means a program that is designed to
18 educate adolescents on—

19 “(i) both abstinence and contraception
20 for the prevention of pregnancy and sexu-
21 ally transmitted infections, including HIV/
22 AIDS, consistent with the requirements of
23 subparagraph (B); and

1 “(ii) at least 3 of the adulthood prep-
2 aration subjects described in subparagraph
3 (C).

4 “(B) REQUIREMENTS.—The requirements
5 of this subparagraph are the following:

6 “(i) The program replicates evidence-
7 based effective programs or substantially
8 incorporates elements of effective programs
9 that have been proven on the basis of rig-
10 orous scientific research to change behav-
11 ior, which means delaying sexual activity,
12 increasing condom or contraceptive use for
13 sexually active youth, or reducing preg-
14 nancy among youth.

15 “(ii) The program is medically-accu-
16 rate and complete.

17 “(iii) The program includes activities
18 to educate youth who are sexually active
19 regarding responsible sexual behavior with
20 respect to both abstinence and the use of
21 contraception.

22 “(iv) The program places substantial
23 emphasis on both abstinence and contra-
24 ception for the prevention of pregnancy

1 among youth and sexually transmitted in-
2 fections.

3 “(v) The program provides age-appro-
4 priate information and activities.

5 “(vi) The information and activities
6 carried out under the program are pro-
7 vided in the cultural context that is most
8 appropriate for individuals in the par-
9 ticular population group to which they are
10 directed.

11 “(C) ADULTHOOD PREPARATION SUB-
12 JECTS.—The adulthood preparation subjects
13 described in this subparagraph are the fol-
14 lowing:

15 “(i) Healthy relationships, such as
16 positive self-esteem and relationship dy-
17 namics, friendships, dating, romantic in-
18 volvement, marriage, and family inter-
19 actions.

20 “(ii) Adolescent development, such as
21 the development of healthy attitudes and
22 values about adolescent growth and devel-
23 opment, body image, racial and ethnic di-
24 versity, and other related subjects.

25 “(iii) Financial literacy.

1 “(iv) Parent-child communication.

2 “(v) Educational and career success,
3 such as developing skills for employment
4 preparation, job seeking, independent liv-
5 ing, financial self-sufficiency, and work-
6 place productivity.

7 “(vi) Healthy life skills, such as goal-
8 setting, decision making, negotiation, com-
9 munication and interpersonal skills, and
10 stress management.

11 “(c) RESERVATIONS OF FUNDS.—

12 “(1) GRANTS TO IMPLEMENT INNOVATIVE
13 STRATEGIES.—From the amount appropriated under
14 subsection (f) for the fiscal year, the Secretary shall
15 reserve \$10,000,000 of such amount for purposes of
16 awarding grants to entities to implement innovative
17 youth pregnancy prevention strategies and target
18 services to high-risk, vulnerable, and culturally
19 under-represented youth populations, including
20 youth in foster care, homeless youth, youth with
21 HIV/AIDS, pregnant women who are under 21 years
22 of age and their partners, mothers who are under 21
23 years of age and their partners, and youth residing
24 in areas with high birth rates for youth. An entity
25 awarded a grant under this paragraph shall agree to

1 participate in a rigorous Federal evaluation of the
2 activities carried out with grant funds.

3 “(2) OTHER RESERVATIONS.—From the
4 amount appropriated under subsection (f) for the
5 fiscal year that remains after the application of
6 paragraph (1), the Secretary shall reserve the fol-
7 lowing amounts:

8 “(A) GRANTS FOR INDIAN TRIBES OR
9 TRIBAL ORGANIZATIONS.—The Secretary shall
10 reserve 5 percent of such remainder for pur-
11 poses of awarding grants to Indian tribes and
12 tribal organizations in such manner, and sub-
13 ject to such requirements, as the Secretary, in
14 consultation with Indian tribes and tribal orga-
15 nizations, determines appropriate.

16 “(B) SECRETARIAL RESPONSIBILITIES.—

17 “(i) RESERVATION OF FUNDS.—The
18 Secretary shall reserve 10 percent of such
19 remainder for expenditures by the Sec-
20 retary for the activities described in
21 clauses (ii) and (iii).

22 “(ii) PROGRAM SUPPORT.—The Sec-
23 retary shall provide, directly or through a
24 competitive grant process, research, train-
25 ing and technical assistance, including dis-

1 semination of research and information re-
2 garding effective and promising practices,
3 providing consultation and resources on a
4 broad array of teen pregnancy prevention
5 strategies, including abstinence and contra-
6 ception, and developing resources and ma-
7 terials to support the activities of recipi-
8 ents of grants and other State, tribal, and
9 community organizations working to re-
10 duce teen pregnancy. In carrying out such
11 functions, the Secretary shall collaborate
12 with a variety of entities that have exper-
13 tise in the prevention of teen pregnancy,
14 HIV and sexually transmitted infections,
15 healthy relationships, financial literacy,
16 and other topics addressed through the
17 personal responsibility education programs.

18 “(iii) EVALUATION.—The Secretary
19 shall evaluate the programs and activities
20 carried out with funds made available
21 through allotments or grants under this
22 section.

23 “(d) ADMINISTRATION.—

24 “(1) IN GENERAL.—The Secretary shall admin-
25 ister this section through the Assistant Secretary for

1 the Administration for Children and Families within
2 the Department of Health and Human Services.

3 “(2) APPLICATION OF OTHER PROVISIONS OF
4 TITLE.—

5 “(A) IN GENERAL.—Except as provided in
6 subparagraph (B), the other provisions of this
7 title shall not apply to allotments or grants
8 made under this section.

9 “(B) EXCEPTIONS.—The following provi-
10 sions of this title shall apply to allotments and
11 grants made under this section to the same ex-
12 tent and in the same manner as such provisions
13 apply to allotments made under section 502(c):

14 “(i) Section 504(b)(6) (relating to
15 prohibition on payments to excluded indi-
16 viduals and entities).

17 “(ii) Section 504(c) (relating to the
18 use of funds for the purchase of technical
19 assistance).

20 “(iii) Section 504(d) (relating to a
21 limitation on administrative expenditures).

22 “(iv) Section 506 (relating to reports
23 and audits), but only to the extent deter-
24 mined by the Secretary to be appropriate
25 for grants made under this section.

1 “(v) Section 507 (relating to penalties
2 for false statements).

3 “(vi) Section 508 (relating to non-
4 discrimination).

5 “(e) DEFINITIONS.—In this section:

6 “(1) AGE-APPROPRIATE.—The term ‘age-appro-
7 priate’, with respect to the information in pregnancy
8 prevention, means topics, messages, and teaching
9 methods suitable to particular ages or age groups of
10 children and adolescents, based on developing cog-
11 nitive, emotional, and behavioral capacity typical for
12 the age or age group.

13 “(2) MEDICALLY ACCURATE AND COMPLETE.—
14 The term ‘medically accurate and complete’ means
15 verified or supported by the weight of research con-
16 ducted in compliance with accepted scientific meth-
17 ods and—

18 “(A) published in peer-reviewed journals,
19 where applicable; or

20 “(B) comprising information that leading
21 professional organizations and agencies with
22 relevant expertise in the field recognize as accu-
23 rate, objective, and complete.

24 “(3) INDIAN TRIBES; TRIBAL ORGANIZA-
25 TIONS.—The terms ‘Indian tribe’ and ‘Tribal organi-

1 zation’ have the meanings given such terms in sec-
2 tion 4 of the Indian Health Care Improvement Act
3 (25 U.S.C. 1603)).

4 “(4) YOUTH.—The term ‘youth’ means an indi-
5 vidual who has attained age 10 but has not attained
6 age 20.

7 “(f) APPROPRIATION.—For the purpose of carrying
8 out this section, there is appropriated, out of any money
9 in the Treasury not otherwise appropriated, \$75,000,000
10 for each of fiscal years 2010 through 2014. Amounts ap-
11 propriated under this subsection shall remain available
12 until expended.”.

13 **SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE**
14 **EDUCATION.**

15 Section 510 of the Social Security Act (42 U.S.C.
16 710) is amended—

17 (1) in subsection (a), by striking “fiscal year
18 1998 and each subsequent fiscal year” and inserting
19 “each of fiscal years 2010 through 2014”; and

20 (2) in subsection (d)—

21 (A) in the first sentence, by striking “1998
22 through 2003” and inserting “2010 through
23 2014”; and

24 (B) in the second sentence, by inserting
25 “(except that such appropriation shall be made

1 on the date of enactment of the Patient Protec-
2 tion and Affordable Care Act in the case of fis-
3 cal year 2010)” before the period.

4 **SEC. 2955. INCLUSION OF INFORMATION ABOUT THE IM-**
5 **PORTANCE OF HAVING A HEALTH CARE**
6 **POWER OF ATTORNEY IN TRANSITION PLAN-**
7 **NING FOR CHILDREN AGING OUT OF FOSTER**
8 **CARE AND INDEPENDENT LIVING PROGRAMS.**

9 (a) **TRANSITION PLANNING.**—Section 475(5)(H) of
10 the Social Security Act (42 U.S.C. 675(5)(H)) is amended
11 by inserting “includes information about the importance
12 of designating another individual to make health care
13 treatment decisions on behalf of the child if the child be-
14 comes unable to participate in such decisions and the child
15 does not have, or does not want, a relative who would oth-
16 erwise be authorized under State law to make such deci-
17 sions, and provides the child with the option to execute
18 a health care power of attorney, health care proxy, or
19 other similar document recognized under State law,” after
20 “employment services,”.

21 (b) **INDEPENDENT LIVING EDUCATION.**—Section
22 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended
23 by adding at the end the following:

24 “(K) A certification by the chief executive
25 officer of the State that the State will ensure

1 that an adolescent participating in the program
2 under this section are provided with education
3 about the importance of designating another in-
4 dividual to make health care treatment deci-
5 sions on behalf of the adolescent if the adoles-
6 cent becomes unable to participate in such deci-
7 sions and the adolescent does not have, or does
8 not want, a relative who would otherwise be au-
9 thorized under State law to make such deci-
10 sions, whether a health care power of attorney,
11 health care proxy, or other similar document is
12 recognized under State law, and how to execute
13 such a document if the adolescent wants to do
14 so.”.

15 (c) HEALTH OVERSIGHT AND COORDINATION
16 PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C.
17 622(b)(15)(A)) is amended—

18 (1) in clause (v), by striking “and” at the end;

19 and

20 (2) by adding at the end the following:

21 “(vii) steps to ensure that the compo-
22 nents of the transition plan development
23 process required under section 475(5)(H)
24 that relate to the health care needs of chil-
25 dren aging out of foster care, including the

1 requirements to include options for health
2 insurance, information about a health care
3 power of attorney, health care proxy, or
4 other similar document recognized under
5 State law, and to provide the child with the
6 option to execute such a document, are
7 met; and”.

8 (d) EFFECTIVE DATE.—The amendments made by
9 this section take effect on October 1, 2010.

10 **TITLE III—IMPROVING THE**
11 **QUALITY AND EFFICIENCY OF**
12 **HEALTH CARE**

13 **Subtitle A—Transforming the**
14 **Health Care Delivery System**

15 **PART I—LINKING PAYMENT TO QUALITY**

16 **OUTCOMES UNDER THE MEDICARE PROGRAM**

17 **SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PRO-**
18 **GRAM.**

19 (a) PROGRAM.—

20 (1) IN GENERAL.—Section 1886 of the Social
21 Security Act (42 U.S.C. 1395ww), as amended by
22 section 4102(a) of the HITECH Act (Public Law
23 111–5), is amended by adding at the end the fol-
24 lowing new subsection:

1 “(o) HOSPITAL VALUE-BASED PURCHASING PRO-
2 GRAM.—

3 “(1) ESTABLISHMENT.—

4 “(A) IN GENERAL.—Subject to the suc-
5 ceeding provisions of this subsection, the Sec-
6 retary shall establish a hospital value-based
7 purchasing program (in this subsection referred
8 to as the ‘Program’) under which value-based
9 incentive payments are made in a fiscal year to
10 hospitals that meet the performance standards
11 under paragraph (3) for the performance period
12 for such fiscal year (as established under para-
13 graph (4)).

14 “(B) PROGRAM TO BEGIN IN FISCAL YEAR
15 2013.—The Program shall apply to payments
16 for discharges occurring on or after October 1,
17 2012.

18 “(C) APPLICABILITY OF PROGRAM TO HOS-
19 PITALS.—

20 “(i) IN GENERAL.—For purposes of
21 this subsection, subject to clause (ii), the
22 term ‘hospital’ means a subsection (d) hos-
23 pital (as defined in subsection (d)(1)(B)).

1 “(ii) EXCLUSIONS.—The term ‘hos-
2 pital’ shall not include, with respect to a
3 fiscal year, a hospital—

4 “(I) that is subject to the pay-
5 ment reduction under subsection
6 (b)(3)(B)(viii)(I) for such fiscal year;

7 “(II) for which, during the per-
8 formance period for such fiscal year,
9 the Secretary has cited deficiencies
10 that pose immediate jeopardy to the
11 health or safety of patients;

12 “(III) for which there are not a
13 minimum number (as determined by
14 the Secretary) of measures that apply
15 to the hospital for the performance
16 period for such fiscal year; or

17 “(IV) for which there are not a
18 minimum number (as determined by
19 the Secretary) of cases for the meas-
20 ures that apply to the hospital for the
21 performance period for such fiscal
22 year.

23 “(iii) INDEPENDENT ANALYSIS.—For
24 purposes of determining the minimum
25 numbers under subclauses (III) and (IV)

1 of clause (ii), the Secretary shall have con-
2 ducted an independent analysis of what
3 numbers are appropriate.

4 “(iv) EXEMPTION.—In the case of a
5 hospital that is paid under section
6 1814(b)(3), the Secretary may exempt
7 such hospital from the application of this
8 subsection if the State which is paid under
9 such section submits an annual report to
10 the Secretary describing how a similar pro-
11 gram in the State for a participating hos-
12 pital or hospitals achieves or surpasses the
13 measured results in terms of patient health
14 outcomes and cost savings established
15 under this subsection.

16 “(2) MEASURES.—

17 “(A) IN GENERAL.—The Secretary shall
18 select measures for purposes of the Program.
19 Such measures shall be selected from the meas-
20 ures specified under subsection (b)(3)(B)(viii).

21 “(B) REQUIREMENTS.—

22 “(i) FOR FISCAL YEAR 2013.—For
23 value-based incentive payments made with
24 respect to discharges occurring during fis-

1 cal year 2013, the Secretary shall ensure
2 the following:

3 “(I) CONDITIONS OR PROCE-
4 DURES.—Measures are selected under
5 subparagraph (A) that cover at least
6 the following 5 specific conditions or
7 procedures:

8 “(aa) Acute myocardial in-
9 farction (AMI).

10 “(bb) Heart failure.

11 “(cc) Pneumonia.

12 “(dd) Surgeries, as meas-
13 ured by the Surgical Care Im-
14 provement Project (formerly re-
15 ferred to as ‘Surgical Infection
16 Prevention’ for discharges occur-
17 ring before July 2006).

18 “(ee) Healthcare-associated
19 infections, as measured by the
20 prevention metrics and targets
21 established in the HHS Action
22 Plan to Prevent Healthcare-Asso-
23 ciated Infections (or any suc-
24 cessor plan) of the Department
25 of Health and Human Services.

1 “(II) HCAHPS.—Measures se-
2 lected under subparagraph (A) shall
3 be related to the Hospital Consumer
4 Assessment of Healthcare Providers
5 and Systems survey (HCAHPS).

6 “(ii) INCLUSION OF EFFICIENCY
7 MEASURES.—For value-based incentive
8 payments made with respect to discharges
9 occurring during fiscal year 2014 or a sub-
10 sequent fiscal year, the Secretary shall en-
11 sure that measures selected under subpara-
12 graph (A) include efficiency measures, in-
13 cluding measures of ‘Medicare spending
14 per beneficiary’. Such measures shall be
15 adjusted for factors such as age, sex, race,
16 severity of illness, and other factors that
17 the Secretary determines appropriate.

18 “(C) LIMITATIONS.—

19 “(i) TIME REQUIREMENT FOR PRIOR
20 REPORTING AND NOTICE.—The Secretary
21 may not select a measure under subpara-
22 graph (A) for use under the Program with
23 respect to a performance period for a fiscal
24 year (as established under paragraph (4))
25 unless such measure has been specified

1 under subsection (b)(3)(B)(viii) and in-
2 cluded on the Hospital Compare Internet
3 website for at least 1 year prior to the be-
4 ginning of such performance period.

5 “(ii) MEASURE NOT APPLICABLE UN-
6 LESS HOSPITAL FURNISHES SERVICES AP-
7 PROPRIATE TO THE MEASURE.—A measure
8 selected under subparagraph (A) shall not
9 apply to a hospital if such hospital does
10 not furnish services appropriate to such
11 measure.

12 “(D) REPLACING MEASURES.—Subclause
13 (VI) of subsection (b)(3)(B)(viii) shall apply to
14 measures selected under subparagraph (A) in
15 the same manner as such subclause applies to
16 measures selected under such subsection.

17 “(3) PERFORMANCE STANDARDS.—

18 “(A) ESTABLISHMENT.—The Secretary
19 shall establish performance standards with re-
20 spect to measures selected under paragraph (2)
21 for a performance period for a fiscal year (as
22 established under paragraph (4)).

23 “(B) ACHIEVEMENT AND IMPROVE-
24 MENT.—The performance standards established

1 under subparagraph (A) shall include levels of
2 achievement and improvement.

3 “(C) TIMING.—The Secretary shall estab-
4 lish and announce the performance standards
5 under subparagraph (A) not later than 60 days
6 prior to the beginning of the performance pe-
7 riod for the fiscal year involved.

8 “(D) CONSIDERATIONS IN ESTABLISHING
9 STANDARDS.—In establishing performance
10 standards with respect to measures under this
11 paragraph, the Secretary shall take into ac-
12 count appropriate factors, such as—

13 “(i) practical experience with the
14 measures involved, including whether a sig-
15 nificant proportion of hospitals failed to
16 meet the performance standard during pre-
17 vious performance periods;

18 “(ii) historical performance standards;

19 “(iii) improvement rates; and

20 “(iv) the opportunity for continued
21 improvement.

22 “(4) PERFORMANCE PERIOD.—For purposes of
23 the Program, the Secretary shall establish the per-
24 formance period for a fiscal year. Such performance

1 period shall begin and end prior to the beginning of
2 such fiscal year.

3 “(5) HOSPITAL PERFORMANCE SCORE.—

4 “(A) IN GENERAL.—Subject to subpara-
5 graph (B), the Secretary shall develop a meth-
6 odology for assessing the total performance of
7 each hospital based on performance standards
8 with respect to the measures selected under
9 paragraph (2) for a performance period (as es-
10 tablished under paragraph (4)). Using such
11 methodology, the Secretary shall provide for an
12 assessment (in this subsection referred to as the
13 ‘hospital performance score’) for each hospital
14 for each performance period.

15 “(B) APPLICATION.—

16 “(i) APPROPRIATE DISTRIBUTION.—

17 The Secretary shall ensure that the appli-
18 cation of the methodology developed under
19 subparagraph (A) results in an appropriate
20 distribution of value-based incentive pay-
21 ments under paragraph (6) among hos-
22 pitals achieving different levels of hospital
23 performance scores, with hospitals achiev-
24 ing the highest hospital performance scores

1 receiving the largest value-based incentive
2 payments.

3 “(ii) HIGHER OF ACHIEVEMENT OR
4 IMPROVEMENT.—The methodology devel-
5 oped under subparagraph (A) shall provide
6 that the hospital performance score is de-
7 termined using the higher of its achieve-
8 ment or improvement score for each meas-
9 ure.

10 “(iii) WEIGHTS.—The methodology
11 developed under subparagraph (A) shall
12 provide for the assignment of weights for
13 categories of measures as the Secretary de-
14 termines appropriate.

15 “(iv) NO MINIMUM PERFORMANCE
16 STANDARD.—The Secretary shall not set a
17 minimum performance standard in deter-
18 mining the hospital performance score for
19 any hospital.

20 “(v) REFLECTION OF MEASURES AP-
21 PPLICABLE TO THE HOSPITAL.—The hos-
22 pital performance score for a hospital shall
23 reflect the measures that apply to the hos-
24 pital.

1 “(6) CALCULATION OF VALUE-BASED INCEN-
2 TIVE PAYMENTS.—

3 “(A) IN GENERAL.—In the case of a hos-
4 pital that the Secretary determines meets (or
5 exceeds) the performance standards under para-
6 graph (3) for the performance period for a fis-
7 cal year (as established under paragraph (4)),
8 the Secretary shall increase the base operating
9 DRG payment amount (as defined in paragraph
10 (7)(D)), as determined after application of
11 paragraph (7)(B)(i), for a hospital for each dis-
12 charge occurring in such fiscal year by the
13 value-based incentive payment amount.

14 “(B) VALUE-BASED INCENTIVE PAYMENT
15 AMOUNT.—The value-based incentive payment
16 amount for each discharge of a hospital in a fis-
17 cal year shall be equal to the product of—

18 “(i) the base operating DRG payment
19 amount (as defined in paragraph (7)(D))
20 for the discharge for the hospital for such
21 fiscal year; and

22 “(ii) the value-based incentive pay-
23 ment percentage specified under subpara-
24 graph (C) for the hospital for such fiscal
25 year.

1 “(C) VALUE-BASED INCENTIVE PAYMENT
2 PERCENTAGE.—

3 “(i) IN GENERAL.—The Secretary
4 shall specify a value-based incentive pay-
5 ment percentage for a hospital for a fiscal
6 year.

7 “(ii) REQUIREMENTS.—In specifying
8 the value-based incentive payment percent-
9 age for each hospital for a fiscal year
10 under clause (i), the Secretary shall ensure
11 that—

12 “(I) such percentage is based on
13 the hospital performance score of the
14 hospital under paragraph (5); and

15 “(II) the total amount of value-
16 based incentive payments under this
17 paragraph to all hospitals in such fis-
18 cal year is equal to the total amount
19 available for value-based incentive
20 payments for such fiscal year under
21 paragraph (7)(A), as estimated by the
22 Secretary.

23 “(7) FUNDING FOR VALUE-BASED INCENTIVE
24 PAYMENTS.—

1 “(A) AMOUNT.—The total amount avail-
2 able for value-based incentive payments under
3 paragraph (6) for all hospitals for a fiscal year
4 shall be equal to the total amount of reduced
5 payments for all hospitals under subparagraph
6 (B) for such fiscal year, as estimated by the
7 Secretary.

8 “(B) ADJUSTMENT TO PAYMENTS.—

9 “(i) IN GENERAL.—The Secretary
10 shall reduce the base operating DRG pay-
11 ment amount (as defined in subparagraph
12 (D)) for a hospital for each discharge in a
13 fiscal year (beginning with fiscal year
14 2013) by an amount equal to the applica-
15 ble percent (as defined in subparagraph
16 (C)) of the base operating DRG payment
17 amount for the discharge for the hospital
18 for such fiscal year. The Secretary shall
19 make such reductions for all hospitals in
20 the fiscal year involved, regardless of
21 whether or not the hospital has been deter-
22 mined by the Secretary to have earned a
23 value-based incentive payment under para-
24 graph (6) for such fiscal year.

1 “(ii) NO EFFECT ON OTHER PAY-
2 MENTS.—Payments described in items (aa)
3 and (bb) of subparagraph (D)(i)(II) for a
4 hospital shall be determined as if this sub-
5 section had not been enacted.

6 “(C) APPLICABLE PERCENT DEFINED.—
7 For purposes of subparagraph (B), the term
8 ‘applicable percent’ means—

9 “(i) with respect to fiscal year 2013,
10 1.0 percent;

11 “(ii) with respect to fiscal year 2014,
12 1.25 percent;

13 “(iii) with respect to fiscal year 2015,
14 1.5 percent;

15 “(iv) with respect to fiscal year 2016,
16 1.75 percent; and

17 “(v) with respect to fiscal year 2017
18 and succeeding fiscal years, 2 percent.

19 “(D) BASE OPERATING DRG PAYMENT
20 AMOUNT DEFINED.—

21 “(i) IN GENERAL.—Except as pro-
22 vided in clause (ii), in this subsection, the
23 term ‘base operating DRG payment
24 amount’ means, with respect to a hospital
25 for a fiscal year—

1 “(I) the payment amount that
2 would otherwise be made under sub-
3 section (d) (determined without re-
4 gard to subsection (q)) for a discharge
5 if this subsection did not apply; re-
6 duced by

7 “(II) any portion of such pay-
8 ment amount that is attributable to—

9 “(aa) payments under para-
10 graphs (5)(A), (5)(B), (5)(F),
11 and (12) of subsection (d); and

12 “(bb) such other payments
13 under subsection (d) determined
14 appropriate by the Secretary.

15 “(ii) SPECIAL RULES FOR CERTAIN
16 HOSPITALS.—

17 “(I) SOLE COMMUNITY HOS-
18 PITALS AND MEDICARE-DEPENDENT,
19 SMALL RURAL HOSPITALS.—In the
20 case of a medicare-dependent, small
21 rural hospital (with respect to dis-
22 charges occurring during fiscal year
23 2012 and 2013) or a sole community
24 hospital, in applying subparagraph
25 (A)(i), the payment amount that

1 would otherwise be made under sub-
2 section (d) shall be determined with-
3 out regard to subparagraphs (I) and
4 (L) of subsection (b)(3) and subpara-
5 graphs (D) and (G) of subsection
6 (d)(5).

7 “(II) HOSPITALS PAID UNDER
8 SECTION 1814.—In the case of a hos-
9 pital that is paid under section
10 1814(b)(3), the term ‘base operating
11 DRG payment amount’ means the
12 payment amount under such section.

13 “(8) ANNOUNCEMENT OF NET RESULT OF AD-
14 JUSTMENTS.—Under the Program, the Secretary
15 shall, not later than 60 days prior to the fiscal year
16 involved, inform each hospital of the adjustments to
17 payments to the hospital for discharges occurring in
18 such fiscal year under paragraphs (6) and (7)(B)(i).

19 “(9) NO EFFECT IN SUBSEQUENT FISCAL
20 YEARS.—The value-based incentive payment under
21 paragraph (6) and the payment reduction under
22 paragraph (7)(B)(i) shall each apply only with re-
23 spect to the fiscal year involved, and the Secretary
24 shall not take into account such value-based incen-
25 tive payment or payment reduction in making pay-

1 ments to a hospital under this section in a subse-
2 quent fiscal year.

3 “(10) PUBLIC REPORTING.—

4 “(A) HOSPITAL SPECIFIC INFORMATION.—

5 “(i) IN GENERAL.—The Secretary
6 shall make information available to the
7 public regarding the performance of indi-
8 vidual hospitals under the Program, in-
9 cluding—

10 “(I) the performance of the hos-
11 pital with respect to each measure
12 that applies to the hospital;

13 “(II) the performance of the hos-
14 pital with respect to each condition or
15 procedure; and

16 “(III) the hospital performance
17 score assessing the total performance
18 of the hospital.

19 “(ii) OPPORTUNITY TO REVIEW AND
20 SUBMIT CORRECTIONS.—The Secretary
21 shall ensure that a hospital has the oppor-
22 tunity to review, and submit corrections
23 for, the information to be made public with
24 respect to the hospital under clause (i)

1 prior to such information being made pub-
2 lie.

3 “(iii) WEBSITE.—Such information
4 shall be posted on the Hospital Compare
5 Internet website in an easily understand-
6 able format.

7 “(B) AGGREGATE INFORMATION.—The
8 Secretary shall periodically post on the Hospital
9 Compare Internet website aggregate informa-
10 tion on the Program, including—

11 “(i) the number of hospitals receiving
12 value-based incentive payments under
13 paragraph (6) and the range and total
14 amount of such value-based incentive pay-
15 ments; and

16 “(ii) the number of hospitals receiving
17 less than the maximum value-based incen-
18 tive payment available to the hospital for
19 the fiscal year involved and the range and
20 amount of such payments.

21 “(11) IMPLEMENTATION.—

22 “(A) APPEALS.—The Secretary shall es-
23 tablish a process by which hospitals may appeal
24 the calculation of a hospital’s performance as-
25 sessment with respect to the performance

1 standards established under paragraph (3)(A)
2 and the hospital performance score under para-
3 graph (5). The Secretary shall ensure that such
4 process provides for resolution of such appeals
5 in a timely manner.

6 “(B) LIMITATION ON REVIEW.—Except as
7 provided in subparagraph (A), there shall be no
8 administrative or judicial review under section
9 1869, section 1878, or otherwise of the fol-
10 lowing:

11 “(i) The methodology used to deter-
12 mine the amount of the value-based incen-
13 tive payment under paragraph (6) and the
14 determination of such amount.

15 “(ii) The determination of the amount
16 of funding available for such value-based
17 incentive payments under paragraph
18 (7)(A) and the payment reduction under
19 paragraph (7)(B)(i).

20 “(iii) The establishment of the per-
21 formance standards under paragraph (3)
22 and the performance period under para-
23 graph (4).

1 “(iv) The measures specified under
2 subsection (b)(3)(B)(viii) and the measures
3 selected under paragraph (2).

4 “(v) The methodology developed under
5 paragraph (5) that is used to calculate
6 hospital performance scores and the cal-
7 culation of such scores.

8 “(vi) The validation methodology
9 specified in subsection (b)(3)(B)(viii)(XI).

10 “(C) CONSULTATION WITH SMALL HOS-
11 PITALS.—The Secretary shall consult with small
12 rural and urban hospitals on the application of
13 the Program to such hospitals.

14 “(12) PROMULGATION OF REGULATIONS.—The
15 Secretary shall promulgate regulations to carry out
16 the Program, including the selection of measures
17 under paragraph (2), the methodology developed
18 under paragraph (5) that is used to calculate hos-
19 pital performance scores, and the methodology used
20 to determine the amount of value-based incentive
21 payments under paragraph (6).”.

22 (2) AMENDMENTS FOR REPORTING OF HOS-
23 PITAL QUALITY INFORMATION.—Section
24 1886(b)(3)(B)(viii) of the Social Security Act (42
25 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

1 (A) in subclause (II), by adding at the end
2 the following sentence: “The Secretary may re-
3 quire hospitals to submit data on measures that
4 are not used for the determination of value-
5 based incentive payments under subsection
6 (o).”;

7 (B) in subclause (V), by striking “begin-
8 ning with fiscal year 2008” and inserting “for
9 fiscal years 2008 through 2012”;

10 (C) in subclause (VII), in the first sen-
11 tence, by striking “data submitted” and insert-
12 ing “information regarding measures sub-
13 mitted”; and

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

16 “(VIII) Effective for payments beginning with fiscal
17 year 2013, with respect to quality measures for outcomes
18 of care, the Secretary shall provide for such risk adjust-
19 ment as the Secretary determines to be appropriate to
20 maintain incentives for hospitals to treat patients with se-
21 vere illnesses or conditions.

22 “(IX)(aa) Subject to item (bb), effective for payments
23 beginning with fiscal year 2013, each measure specified
24 by the Secretary under this clause shall be endorsed by
25 the entity with a contract under section 1890(a).

1 “(bb) In the case of a specified area or medical topic
2 determined appropriate by the Secretary for which a fea-
3 sible and practical measure has not been endorsed by the
4 entity with a contract under section 1890(a), the Sec-
5 retary may specify a measure that is not so endorsed as
6 long as due consideration is given to measures that have
7 been endorsed or adopted by a consensus organization
8 identified by the Secretary.

9 “(X) To the extent practicable, the Secretary shall,
10 with input from consensus organizations and other stake-
11 holders, take steps to ensure that the measures specified
12 by the Secretary under this clause are coordinated and
13 aligned with quality measures applicable to—

14 “(aa) physicians under section 1848(k); and

15 “(bb) other providers of services and suppliers
16 under this title.

17 “(XI) The Secretary shall establish a process to vali-
18 date measures specified under this clause as appropriate.
19 Such process shall include the auditing of a number of
20 randomly selected hospitals sufficient to ensure validity of
21 the reporting program under this clause as a whole and
22 shall provide a hospital with an opportunity to appeal the
23 validation of measures reported by such hospital.”.

24 (3) WEBSITE IMPROVEMENTS.—Section
25 1886(b)(3)(B) of the Social Security Act (42 U.S.C.

1 1395ww(b)(3)(B)), as amended by section 4102(b)
2 of the HITECH Act (Public Law 111–5), is amend-
3 ed by adding at the end the following new clause:

4 “(x)(I) The Secretary shall develop standard Internet
5 website reports tailored to meet the needs of various stake-
6 holders such as hospitals, patients, researchers, and pol-
7 icymakers. The Secretary shall seek input from such
8 stakeholders in determining the type of information that
9 is useful and the formats that best facilitate the use of
10 the information.

11 “(II) The Secretary shall modify the Hospital Com-
12 pare Internet website to make the use and navigation of
13 that website readily available to individuals accessing it.”.

14 (4) GAO STUDY AND REPORT.—

15 (A) STUDY.—The Comptroller General of
16 the United States shall conduct a study on the
17 performance of the hospital value-based pur-
18 chasing program established under section
19 1886(o) of the Social Security Act, as added by
20 paragraph (1). Such study shall include an
21 analysis of the impact of such program on—

22 (i) the quality of care furnished to
23 Medicare beneficiaries, including diverse
24 Medicare beneficiary populations (such as

1 diverse in terms of race, ethnicity, and so-
2 cioeconomic status);

3 (ii) expenditures under the Medicare
4 program, including any reduced expendi-
5 tures under Part A of title XVIII of such
6 Act that are attributable to the improve-
7 ment in the delivery of inpatient hospital
8 services by reason of such hospital value-
9 based purchasing program;

10 (iii) the quality performance among
11 safety net hospitals and any barriers such
12 hospitals face in meeting the performance
13 standards applicable under such hospital
14 value-based purchasing program; and

15 (iv) the quality performance among
16 small rural and small urban hospitals and
17 any barriers such hospitals face in meeting
18 the performance standards applicable
19 under such hospital value-based purchasing
20 program.

21 (B) REPORTS.—

22 (i) INTERIM REPORT.—Not later than
23 October 1, 2015, the Comptroller General
24 of the United States shall submit to Con-
25 gress an interim report containing the re-

1 sults of the study conducted under sub-
2 paragraph (A), together with recommenda-
3 tions for such legislation and administra-
4 tive action as the Comptroller General de-
5 termines appropriate.

6 (ii) FINAL REPORT.—Not later than
7 July 1, 2017, the Comptroller General of
8 the United States shall submit to Congress
9 a report containing the results of the study
10 conducted under subparagraph (A), to-
11 gether with recommendations for such leg-
12 islation and administrative action as the
13 Comptroller General determines appro-
14 priate.

15 (5) HHS STUDY AND REPORT.—

16 (A) STUDY.—The Secretary of Health and
17 Human Services shall conduct a study on the
18 performance of the hospital value-based pur-
19 chasing program established under section
20 1886(o) of the Social Security Act, as added by
21 paragraph (1). Such study shall include an
22 analysis—

23 (i) of ways to improve the hospital
24 value-based purchasing program and ways
25 to address any unintended consequences

1 that may occur as a result of such pro-
2 gram;

3 (ii) of whether the hospital value-
4 based purchasing program resulted in
5 lower spending under the Medicare pro-
6 gram under title XVIII of such Act or
7 other financial savings to hospitals;

8 (iii) the appropriateness of the Medi-
9 care program sharing in any savings gen-
10 erated through the hospital value-based
11 purchasing program; and

12 (iv) any other area determined appro-
13 priate by the Secretary.

14 (B) REPORT.—Not later than January 1,
15 2016, the Secretary of Health and Human
16 Services shall submit to Congress a report con-
17 taining the results of the study conducted under
18 subparagraph (A), together with recommenda-
19 tions for such legislation and administrative ac-
20 tion as the Secretary determines appropriate.

21 (b) VALUE-BASED PURCHASING DEMONSTRATION
22 PROGRAMS.—

23 (1) VALUE-BASED PURCHASING DEMONSTRA-
24 TION PROGRAM FOR INPATIENT CRITICAL ACCESS
25 HOSPITALS.—

1 (A) ESTABLISHMENT.—

2 (i) IN GENERAL.—Not later than 2
3 years after the date of enactment of this
4 Act, the Secretary of Health and Human
5 Services (in this subsection referred to as
6 the “Secretary”) shall establish a dem-
7 onstration program under which the Sec-
8 retary establishes a value-based purchasing
9 program under the Medicare program
10 under title XVIII of the Social Security
11 Act for critical access hospitals (as defined
12 in paragraph (1) of section 1861(mm) of
13 such Act (42 U.S.C. 1395x(mm))) with re-
14 spect to inpatient critical access hospital
15 services (as defined in paragraph (2) of
16 such section) in order to test innovative
17 methods of measuring and rewarding qual-
18 ity and efficient health care furnished by
19 such hospitals.

20 (ii) DURATION.—The demonstration
21 program under this paragraph shall be
22 conducted for a 3-year period.

23 (iii) SITES.—The Secretary shall con-
24 duct the demonstration program under this
25 paragraph at an appropriate number (as

1 determined by the Secretary) of critical ac-
2 cess hospitals. The Secretary shall ensure
3 that such hospitals are representative of
4 the spectrum of such hospitals that partici-
5 pate in the Medicare program.

6 (B) WAIVER AUTHORITY.—The Secretary
7 may waive such requirements of titles XI and
8 XVIII of the Social Security Act as may be nec-
9 essary to carry out the demonstration program
10 under this paragraph.

11 (C) BUDGET NEUTRALITY REQUIRE-
12 MENT.—In conducting the demonstration pro-
13 gram under this section, the Secretary shall en-
14 sure that the aggregate payments made by the
15 Secretary do not exceed the amount which the
16 Secretary would have paid if the demonstration
17 program under this section was not imple-
18 mented.

19 (D) REPORT.—Not later than 18 months
20 after the completion of the demonstration pro-
21 gram under this paragraph, the Secretary shall
22 submit to Congress a report on the demonstra-
23 tion program together with—

24 (i) recommendations on the establish-
25 ment of a permanent value-based pur-

1 chasing program under the Medicare pro-
2 gram for critical access hospitals with re-
3 spect to inpatient critical access hospital
4 services; and

5 (ii) recommendations for such other
6 legislation and administrative action as the
7 Secretary determines appropriate.

8 (2) VALUE-BASED PURCHASING DEMONSTRA-
9 TION PROGRAM FOR HOSPITALS EXCLUDED FROM
10 HOSPITAL VALUE-BASED PURCHASING PROGRAM AS
11 A RESULT OF INSUFFICIENT NUMBERS OF MEAS-
12 URES AND CASES.—

13 (A) ESTABLISHMENT.—

14 (i) IN GENERAL.—Not later than 2
15 years after the date of enactment of this
16 Act, the Secretary shall establish a dem-
17 onstration program under which the Sec-
18 retary establishes a value-based purchasing
19 program under the Medicare program
20 under title XVIII of the Social Security
21 Act for applicable hospitals (as defined in
22 clause (ii)) with respect to inpatient hos-
23 pital services (as defined in section
24 1861(b) of the Social Security Act (42
25 U.S.C. 1395x(b))) in order to test innova-

1 tive methods of measuring and rewarding
2 quality and efficient health care furnished
3 by such hospitals.

4 (ii) APPLICABLE HOSPITAL DE-
5 FINED.—For purposes of this paragraph,
6 the term “applicable hospital” means a
7 hospital described in subclause (III) or
8 (IV) of section 1886(o)(1)(C)(ii) of the So-
9 cial Security Act, as added by subsection
10 (a)(1).

11 (iii) DURATION.—The demonstration
12 program under this paragraph shall be
13 conducted for a 3-year period.

14 (iv) SITES.—The Secretary shall con-
15 duct the demonstration program under this
16 paragraph at an appropriate number (as
17 determined by the Secretary) of applicable
18 hospitals. The Secretary shall ensure that
19 such hospitals are representative of the
20 spectrum of such hospitals that participate
21 in the Medicare program.

22 (B) WAIVER AUTHORITY.—The Secretary
23 may waive such requirements of titles XI and
24 XVIII of the Social Security Act as may be nec-

1 essary to carry out the demonstration program
2 under this paragraph.

3 (C) BUDGET NEUTRALITY REQUIRE-
4 MENT.—In conducting the demonstration pro-
5 gram under this section, the Secretary shall en-
6 sure that the aggregate payments made by the
7 Secretary do not exceed the amount which the
8 Secretary would have paid if the demonstration
9 program under this section was not imple-
10 mented.

11 (D) REPORT.—Not later than 18 months
12 after the completion of the demonstration pro-
13 gram under this paragraph, the Secretary shall
14 submit to Congress a report on the demonstra-
15 tion program together with—

16 (i) recommendations on the establish-
17 ment of a permanent value-based pur-
18 chasing program under the Medicare pro-
19 gram for applicable hospitals with respect
20 to inpatient hospital services; and

21 (ii) recommendations for such other
22 legislation and administrative action as the
23 Secretary determines appropriate.

1 **SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY**
2 **REPORTING SYSTEM.**

3 (a) EXTENSION.—Section 1848(m) of the Social Se-
4 curity Act (42 U.S.C. 1395w-4(m)) is amended—

5 (1) in paragraph (1)—

6 (A) in subparagraph (A), in the matter
7 preceding clause (i), by striking “2010” and in-
8 serting “2014”; and

9 (B) in subparagraph (B)—

10 (i) in clause (i), by striking “and” at
11 the end;

12 (ii) in clause (ii), by striking the pe-
13 riod at the end and inserting a semicolon;
14 and

15 (iii) by adding at the end the fol-
16 lowing new clauses:

17 “(iii) for 2011, 1.0 percent; and

18 “(iv) for 2012, 2013, and 2014, 0.5
19 percent.”;

20 (2) in paragraph (3)—

21 (A) in subparagraph (A), in the matter
22 preceding clause (i), by inserting “(or, for pur-
23 poses of subsection (a)(8), for the quality re-
24 porting period for the year)” after “reporting
25 period”; and

1 (B) in subparagraph (C)(i), by inserting “,
2 or, for purposes of subsection (a)(8), for a qual-
3 ity reporting period for the year” after “(a)(5),
4 for a reporting period for a year”;

5 (3) in paragraph (5)(E)(iv), by striking “sub-
6 section (a)(5)(A)” and inserting “paragraphs (5)(A)
7 and (8)(A) of subsection (a)”;

8 (4) in paragraph (6)(C)—

9 (A) in clause (i)(II), by striking “, 2009,
10 2010, and 2011” and inserting “and subse-
11 quent years”;

12 (B) in clause (iii)—

13 (i) by inserting “(a)(8)” after
14 “(a)(5)”;

15 (ii) by striking “under subparagraph
16 (D)(iii) of such subsection” and inserting
17 “under subsection (a)(5)(D)(iii) or the
18 quality reporting period under subsection
19 (a)(8)(D)(iii), respectively”.

20 (b) INCENTIVE PAYMENT ADJUSTMENT FOR QUAL-
21 ITY REPORTING.—Section 1848(a) of the Social Security
22 Act (42 U.S.C. 1395w–4(a)) is amended by adding at the
23 end the following new paragraph:

24 “(8) INCENTIVES FOR QUALITY REPORTING.—

25 “(A) ADJUSTMENT.—

1 “(i) IN GENERAL.—With respect to
2 covered professional services furnished by
3 an eligible professional during 2015 or any
4 subsequent year, if the eligible professional
5 does not satisfactorily submit data on qual-
6 ity measures for covered professional serv-
7 ices for the quality reporting period for the
8 year (as determined under subsection
9 (m)(3)(A)), the fee schedule amount for
10 such services furnished by such profes-
11 sional during the year (including the fee
12 schedule amount for purposes of deter-
13 mining a payment based on such amount)
14 shall be equal to the applicable percent of
15 the fee schedule amount that would other-
16 wise apply to such services under this sub-
17 section (determined after application of
18 paragraphs (3), (5), and (7), but without
19 regard to this paragraph).

20 “(ii) APPLICABLE PERCENT.—For
21 purposes of clause (i), the term ‘applicable
22 percent’ means—

23 “(I) for 2015, 98.5 percent; and

24 “(II) for 2016 and each subse-
25 quent year, 98 percent.

1 “(B) APPLICATION.—

2 “(i) PHYSICIAN REPORTING SYSTEM
3 RULES.—Paragraphs (5), (6), and (8) of
4 subsection (k) shall apply for purposes of
5 this paragraph in the same manner as they
6 apply for purposes of such subsection.

7 “(ii) INCENTIVE PAYMENT VALIDA-
8 TION RULES.—Clauses (ii) and (iii) of sub-
9 section (m)(5)(D) shall apply for purposes
10 of this paragraph in a similar manner as
11 they apply for purposes of such subsection.

12 “(C) DEFINITIONS.—For purposes of this
13 paragraph:

14 “(i) ELIGIBLE PROFESSIONAL; COV-
15 ERED PROFESSIONAL SERVICES.—The
16 terms ‘eligible professional’ and ‘covered
17 professional services’ have the meanings
18 given such terms in subsection (k)(3).

19 “(ii) PHYSICIAN REPORTING SYS-
20 TEM.—The term ‘physician reporting sys-
21 tem’ means the system established under
22 subsection (k).

23 “(iii) QUALITY REPORTING PERIOD.—
24 The term ‘quality reporting period’ means,

1 with respect to a year, a period specified
2 by the Secretary.”.

3 (c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

4 (1) IN GENERAL.—Section 1848(k)(4) of the
5 Social Security Act (42 U.S.C. 1395w–4(k)(4)) is
6 amended by inserting “or through a Maintenance of
7 Certification program operated by a specialty body
8 of the American Board of Medical Specialties that
9 meets the criteria for such a registry” after “Data-
10 base)”.

11 (2) EFFECTIVE DATE.—The amendment made
12 by paragraph (1) shall apply for years after 2010.

13 (d) INTEGRATION OF PHYSICIAN QUALITY REPORT-
14 ING AND EHR REPORTING.—Section 1848(m) of the So-
15 cial Security Act (42 U.S.C. 1395w–4(m)) is amended by
16 adding at the end the following new paragraph:

17 “(7) INTEGRATION OF PHYSICIAN QUALITY RE-
18 PORTING AND EHR REPORTING.—Not later than
19 January 1, 2012, the Secretary shall develop a plan
20 to integrate reporting on quality measures under
21 this subsection with reporting requirements under
22 subsection (o) relating to the meaningful use of elec-
23 tronic health records. Such integration shall consist
24 of the following:

1 “(A) The selection of measures, the report-
2 ing of which would both demonstrate—

3 “(i) meaningful use of an electronic
4 health record for purposes of subsection
5 (o); and

6 “(ii) quality of care furnished to an
7 individual.

8 “(B) Such other activities as specified by
9 the Secretary.”.

10 (e) FEEDBACK.—Section 1848(m)(5) of the Social
11 Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by
12 adding at the end the following new subparagraph:

13 “(H) FEEDBACK.—The Secretary shall
14 provide timely feedback to eligible professionals
15 on the performance of the eligible professional
16 with respect to satisfactorily submitting data on
17 quality measures under this subsection.”.

18 (f) APPEALS.—Such section is further amended—

19 (1) in subparagraph (E), by striking “There
20 shall” and inserting “Except as provided in subpara-
21 graph (I), there shall”; and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(I) INFORMAL APPEALS PROCESS.—The
25 Secretary shall, by not later than January 1,

1 2011, establish and have in place an informal
2 process for eligible professionals to seek a re-
3 view of the determination that an eligible pro-
4 fessional did not satisfactorily submit data on
5 quality measures under this subsection.”.

6 **SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK**
7 **PROGRAM.**

8 (a) IN GENERAL.—Section 1848(n) of the Social Se-
9 curity Act (42 U.S.C. 1395w-4(n)) is amended—

10 (1) in paragraph (1)—

11 (A) in subparagraph (A)—

12 (i) by striking “GENERAL.—The Sec-
13 retary” and inserting “GENERAL.—

14 “(i) ESTABLISHMENT.—The Sec-
15 retary”;

16 (ii) in clause (i), as added by clause
17 (i), by striking “the ‘Program’” and all
18 that follows through the period at the end
19 of the second sentence and inserting “the
20 ‘Program’.”; and

21 (iii) by adding at the end the fol-
22 lowing new clauses:

23 “(ii) REPORTS ON RESOURCES.—The
24 Secretary shall use claims data under this
25 title (and may use other data) to provide

1 confidential reports to physicians (and, as
2 determined appropriate by the Secretary,
3 to groups of physicians) that measure the
4 resources involved in furnishing care to in-
5 dividuals under this title.

6 “(iii) INCLUSION OF CERTAIN INFOR-
7 MATION.—If determined appropriate by
8 the Secretary, the Secretary may include
9 information on the quality of care fur-
10 nished to individuals under this title by the
11 physician (or group of physicians) in such
12 reports.”; and

13 (B) in subparagraph (B), by striking “sub-
14 paragraph (A)” and inserting “subparagraph
15 (A)(ii)”;

16 (2) in paragraph (4)—

17 (A) in the heading, by inserting “INITIAL”
18 after “FOCUS”; and

19 (B) in the matter preceding subparagraph
20 (A), by inserting “initial” after “focus the”;

21 (3) in paragraph (6), by adding at the end the
22 following new sentence: “For adjustments for re-
23 ports on utilization under paragraph (9), see sub-
24 paragraph (D) of such paragraph.”; and

1 (4) by adding at the end the following new
2 paragraphs:

3 “(9) REPORTS ON UTILIZATION.—

4 “(A) DEVELOPMENT OF EPISODE GROUP-
5 ER.—

6 “(i) IN GENERAL.—The Secretary
7 shall develop an episode grouper that com-
8 bines separate but clinically related items
9 and services into an episode of care for an
10 individual, as appropriate.

11 “(ii) TIMELINE FOR DEVELOP-
12 MENT.—The episode grouper described in
13 subparagraph (A) shall be developed by not
14 later than January 1, 2012.

15 “(iii) PUBLIC AVAILABILITY.—The
16 Secretary shall make the details of the epi-
17 sode grouper described in subparagraph
18 (A) available to the public.

19 “(iv) ENDORSEMENT.—The Secretary
20 shall seek endorsement of the episode
21 grouper described in subparagraph (A) by
22 the entity with a contract under section
23 1890(a).

24 “(B) REPORTS ON UTILIZATION.—Effec-
25 tive beginning with 2012, the Secretary shall

1 provide reports to physicians that compare, as
2 determined appropriate by the Secretary, pat-
3 terns of resource use of the individual physician
4 to such patterns of other physicians.

5 “(C) ANALYSIS OF DATA.—The Secretary
6 shall, for purposes of preparing reports under
7 this paragraph, establish methodologies as ap-
8 propriate, such as to—

9 “(i) attribute episodes of care, in
10 whole or in part, to physicians;

11 “(ii) identify appropriate physicians
12 for purposes of comparison under subpara-
13 graph (B); and

14 “(iii) aggregate episodes of care at-
15 tributed to a physician under clause (i)
16 into a composite measure per individual.

17 “(D) DATA ADJUSTMENT.—In preparing
18 reports under this paragraph, the Secretary
19 shall make appropriate adjustments, including
20 adjustments—

21 “(i) to account for differences in so-
22 cioeconomic and demographic characteris-
23 ties, ethnicity, and health status of individ-
24 uals (such as to recognize that less healthy

1 individuals may require more intensive
2 interventions); and

3 “(ii) to eliminate the effect of geo-
4 graphic adjustments in payment rates (as
5 described in subsection (e)).

6 “(E) PUBLIC AVAILABILITY OF METHOD-
7 OLOGY.—The Secretary shall make available to
8 the public—

9 “(i) the methodologies established
10 under subparagraph (C);

11 “(ii) information regarding any ad-
12 justments made to data under subpara-
13 graph (D); and

14 “(iii) aggregate reports with respect
15 to physicians.

16 “(F) DEFINITION OF PHYSICIAN.—In this
17 paragraph:

18 “(i) IN GENERAL.—The term ‘physi-
19 cian’ has the meaning given that term in
20 section 1861(r)(1).

21 “(ii) TREATMENT OF GROUPS.—Such
22 term includes, as the Secretary determines
23 appropriate, a group of physicians.

24 “(G) LIMITATIONS ON REVIEW.—There
25 shall be no administrative or judicial review

1 under section 1869, section 1878, or otherwise
2 of the establishment of the methodology under
3 subparagraph (C), including the determination
4 of an episode of care under such methodology.

5 “(10) COORDINATION WITH OTHER VALUE-
6 BASED PURCHASING REFORMS.—The Secretary shall
7 coordinate the Program with the value-based pay-
8 ment modifier established under subsection (p) and,
9 as the Secretary determines appropriate, other simi-
10 lar provisions of this title.”.

11 (b) CONFORMING AMENDMENT.—Section 1890(b) of
12 the Social Security Act (42 U.S.C. 1395aaa(b)) is amend-
13 ed by adding at the end the following new paragraph:

14 “(6) REVIEW AND ENDORSEMENT OF EPISODE
15 GROUPER UNDER THE PHYSICIAN FEEDBACK PRO-
16 GRAM.—The entity shall provide for the review and,
17 as appropriate, the endorsement of the episode
18 grouper developed by the Secretary under section
19 1848(n)(9)(A). Such review shall be conducted on an
20 expedited basis.”.

21 **SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE**
22 **HOSPITALS, INPATIENT REHABILITATION**
23 **HOSPITALS, AND HOSPICE PROGRAMS.**

24 (a) LONG-TERM CARE HOSPITALS.—Section
25 1886(m) of the Social Security Act (42 U.S.C.

1 1395ww(m)), as amended by section 3401(c), is amended
2 by adding at the end the following new paragraph:

3 “(5) QUALITY REPORTING.—

4 “(A) REDUCTION IN UPDATE FOR FAILURE
5 TO REPORT.—

6 “(i) IN GENERAL.—Under the system
7 described in paragraph (1), for rate year
8 2014 and each subsequent rate year, in the
9 case of a long-term care hospital that does
10 not submit data to the Secretary in accord-
11 ance with subparagraph (C) with respect
12 to such a rate year, any annual update to
13 a standard Federal rate for discharges for
14 the hospital during the rate year, and after
15 application of paragraph (3), shall be re-
16 duced by 2 percentage points.

17 “(ii) SPECIAL RULE.—The application
18 of this subparagraph may result in such
19 annual update being less than 0.0 for a
20 rate year, and may result in payment rates
21 under the system described in paragraph
22 (1) for a rate year being less than such
23 payment rates for the preceding rate year.

24 “(B) NONCUMULATIVE APPLICATION.—

25 Any reduction under subparagraph (A) shall

1 apply only with respect to the rate year involved
2 and the Secretary shall not take into account
3 such reduction in computing the payment
4 amount under the system described in para-
5 graph (1) for a subsequent rate year.

6 “(C) SUBMISSION OF QUALITY DATA.—For
7 rate year 2014 and each subsequent rate year,
8 each long-term care hospital shall submit to the
9 Secretary data on quality measures specified
10 under subparagraph (D). Such data shall be
11 submitted in a form and manner, and at a time,
12 specified by the Secretary for purposes of this
13 subparagraph.

14 “(D) QUALITY MEASURES.—

15 “(i) IN GENERAL.—Subject to clause
16 (ii), any measure specified by the Secretary
17 under this subparagraph must have been
18 endorsed by the entity with a contract
19 under section 1890(a).

20 “(ii) EXCEPTION.—In the case of a
21 specified area or medical topic determined
22 appropriate by the Secretary for which a
23 feasible and practical measure has not
24 been endorsed by the entity with a contract
25 under section 1890(a), the Secretary may

1 specify a measure that is not so endorsed
2 as long as due consideration is given to
3 measures that have been endorsed or
4 adopted by a consensus organization iden-
5 tified by the Secretary.

6 “(iii) TIME FRAME.—Not later than
7 October 1, 2012, the Secretary shall pub-
8 lish the measures selected under this sub-
9 paragraph that will be applicable with re-
10 spect to rate year 2014.

11 “(E) PUBLIC AVAILABILITY OF DATA SUB-
12 MITTED.—The Secretary shall establish proce-
13 dures for making data submitted under sub-
14 paragraph (C) available to the public. Such pro-
15 cedures shall ensure that a long-term care hos-
16 pital has the opportunity to review the data
17 that is to be made public with respect to the
18 hospital prior to such data being made public.
19 The Secretary shall report quality measures
20 that relate to services furnished in inpatient
21 settings in long-term care hospitals on the
22 Internet website of the Centers for Medicare &
23 Medicaid Services.”.

1 (b) INPATIENT REHABILITATION HOSPITALS.—Sec-
2 tion 1886(j) of the Social Security Act (42 U.S.C.
3 1395ww(j)) is amended—

4 (1) by redesignating paragraph (7) as para-
5 graph (8); and

6 (2) by inserting after paragraph (6) the fol-
7 lowing new paragraph:

8 “(7) QUALITY REPORTING.—

9 “(A) REDUCTION IN UPDATE FOR FAILURE
10 TO REPORT.—

11 “(i) IN GENERAL.—For purposes of
12 fiscal year 2014 and each subsequent fiscal
13 year, in the case of a rehabilitation facility
14 that does not submit data to the Secretary
15 in accordance with subparagraph (C) with
16 respect to such a fiscal year, after deter-
17 mining the increase factor described in
18 paragraph (3)(C), and after application of
19 paragraph (3)(D), the Secretary shall re-
20 duce such increase factor for payments for
21 discharges occurring during such fiscal
22 year by 2 percentage points.

23 “(ii) SPECIAL RULE.—The application
24 of this subparagraph may result in the in-
25 crease factor described in paragraph (3)(C)

1 being less than 0.0 for a fiscal year, and
2 may result in payment rates under this
3 subsection for a fiscal year being less than
4 such payment rates for the preceding fiscal
5 year.

6 “(B) NONCUMULATIVE APPLICATION.—
7 Any reduction under subparagraph (A) shall
8 apply only with respect to the fiscal year in-
9 volved and the Secretary shall not take into ac-
10 count such reduction in computing the payment
11 amount under this subsection for a subsequent
12 fiscal year.

13 “(C) SUBMISSION OF QUALITY DATA.—For
14 fiscal year 2014 and each subsequent rate year,
15 each rehabilitation facility shall submit to the
16 Secretary data on quality measures specified
17 under subparagraph (D). Such data shall be
18 submitted in a form and manner, and at a time,
19 specified by the Secretary for purposes of this
20 subparagraph.

21 “(D) QUALITY MEASURES.—

22 “(i) IN GENERAL.—Subject to clause
23 (ii), any measure specified by the Secretary
24 under this subparagraph must have been

1 endorsed by the entity with a contract
2 under section 1890(a).

3 “(ii) EXCEPTION.—In the case of a
4 specified area or medical topic determined
5 appropriate by the Secretary for which a
6 feasible and practical measure has not
7 been endorsed by the entity with a contract
8 under section 1890(a), the Secretary may
9 specify a measure that is not so endorsed
10 as long as due consideration is given to
11 measures that have been endorsed or
12 adopted by a consensus organization iden-
13 tified by the Secretary.

14 “(iii) TIME FRAME.—Not later than
15 October 1, 2012, the Secretary shall pub-
16 lish the measures selected under this sub-
17 paragraph that will be applicable with re-
18 spect to fiscal year 2014.

19 “(E) PUBLIC AVAILABILITY OF DATA SUB-
20 MITTED.—The Secretary shall establish proce-
21 dures for making data submitted under sub-
22 paragraph (C) available to the public. Such pro-
23 cedures shall ensure that a rehabilitation facil-
24 ity has the opportunity to review the data that
25 is to be made public with respect to the facility

1 prior to such data being made public. The Sec-
2 retary shall report quality measures that relate
3 to services furnished in inpatient settings in re-
4 habilitation facilities on the Internet website of
5 the Centers for Medicare & Medicaid Services.”.

6 (c) HOSPICE PROGRAMS.—Section 1814(i) of the So-
7 cial Security Act (42 U.S.C. 1395f(i)) is amended—

8 (1) by redesignating paragraph (5) as para-
9 graph (6); and

10 (2) by inserting after paragraph (4) the fol-
11 lowing new paragraph:

12 “(5) QUALITY REPORTING.—

13 “(A) REDUCTION IN UPDATE FOR FAILURE
14 TO REPORT.—

15 “(i) IN GENERAL.—For purposes of
16 fiscal year 2014 and each subsequent fiscal
17 year, in the case of a hospice program that
18 does not submit data to the Secretary in
19 accordance with subparagraph (C) with re-
20 spect to such a fiscal year, after deter-
21 mining the market basket percentage in-
22 crease under paragraph (1)(C)(ii)(VII) or
23 paragraph (1)(C)(iii), as applicable, and
24 after application of paragraph (1)(C)(iv),
25 with respect to the fiscal year, the Sec-

1 retary shall reduce such market basket
2 percentage increase by 2 percentage points.

3 “(ii) SPECIAL RULE.—The application
4 of this subparagraph may result in the
5 market basket percentage increase under
6 paragraph (1)(C)(ii)(VII) or paragraph
7 (1)(C)(iii), as applicable, being less than
8 0.0 for a fiscal year, and may result in
9 payment rates under this subsection for a
10 fiscal year being less than such payment
11 rates for the preceding fiscal year.

12 “(B) NONCUMULATIVE APPLICATION.—
13 Any reduction under subparagraph (A) shall
14 apply only with respect to the fiscal year in-
15 volved and the Secretary shall not take into ac-
16 count such reduction in computing the payment
17 amount under this subsection for a subsequent
18 fiscal year.

19 “(C) SUBMISSION OF QUALITY DATA.—For
20 fiscal year 2014 and each subsequent fiscal
21 year, each hospice program shall submit to the
22 Secretary data on quality measures specified
23 under subparagraph (D). Such data shall be
24 submitted in a form and manner, and at a time,

1 specified by the Secretary for purposes of this
2 subparagraph.

3 “(D) QUALITY MEASURES.—

4 “(i) IN GENERAL.—Subject to clause
5 (ii), any measure specified by the Secretary
6 under this subparagraph must have been
7 endorsed by the entity with a contract
8 under section 1890(a).

9 “(ii) EXCEPTION.—In the case of a
10 specified area or medical topic determined
11 appropriate by the Secretary for which a
12 feasible and practical measure has not
13 been endorsed by the entity with a contract
14 under section 1890(a), the Secretary may
15 specify a measure that is not so endorsed
16 as long as due consideration is given to
17 measures that have been endorsed or
18 adopted by a consensus organization iden-
19 tified by the Secretary.

20 “(iii) TIME FRAME.—Not later than
21 October 1, 2012, the Secretary shall pub-
22 lish the measures selected under this sub-
23 paragraph that will be applicable with re-
24 spect to fiscal year 2014.

1 “(E) PUBLIC AVAILABILITY OF DATA SUB-
2 MITTED.—The Secretary shall establish proce-
3 dures for making data submitted under sub-
4 paragraph (C) available to the public. Such pro-
5 cedures shall ensure that a hospice program has
6 the opportunity to review the data that is to be
7 made public with respect to the hospice pro-
8 gram prior to such data being made public. The
9 Secretary shall report quality measures that re-
10 late to hospice care provided by hospice pro-
11 grams on the Internet website of the Centers
12 for Medicare & Medicaid Services.”.

13 **SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER**
14 **HOSPITALS.**

15 Section 1866 of the Social Security Act (42 U.S.C.
16 1395cc) is amended—

17 (1) in subsection (a)(1)—

18 (A) in subparagraph (U), by striking
19 “and” at the end;

20 (B) in subparagraph (V), by striking the
21 period at the end and inserting “, and”; and

22 (C) by adding at the end the following new
23 subparagraph:

24 “(W) in the case of a hospital described in
25 section 1886(d)(1)(B)(v), to report quality data

1 to the Secretary in accordance with subsection
2 (k).”; and

3 (2) by adding at the end the following new sub-
4 section:

5 “(k) QUALITY REPORTING BY CANCER HOS-
6 PITALS.—

7 “(1) IN GENERAL.—For purposes of fiscal year
8 2014 and each subsequent fiscal year, a hospital de-
9 scribed in section 1886(d)(1)(B)(v) shall submit
10 data to the Secretary in accordance with paragraph
11 (2) with respect to such a fiscal year.

12 “(2) SUBMISSION OF QUALITY DATA.—For fis-
13 cal year 2014 and each subsequent fiscal year, each
14 hospital described in such section shall submit to the
15 Secretary data on quality measures specified under
16 paragraph (3). Such data shall be submitted in a
17 form and manner, and at a time, specified by the
18 Secretary for purposes of this subparagraph.

19 “(3) QUALITY MEASURES.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), any measure specified by the Sec-
22 retary under this paragraph must have been en-
23 dorsed by the entity with a contract under sec-
24 tion 1890(a).

1 “(B) EXCEPTION.—In the case of a speci-
2 fied area or medical topic determined appro-
3 priate by the Secretary for which a feasible and
4 practical measure has not been endorsed by the
5 entity with a contract under section 1890(a),
6 the Secretary may specify a measure that is not
7 so endorsed as long as due consideration is
8 given to measures that have been endorsed or
9 adopted by a consensus organization identified
10 by the Secretary.

11 “(C) TIME FRAME.—Not later than Octo-
12 ber 1, 2012, the Secretary shall publish the
13 measures selected under this paragraph that
14 will be applicable with respect to fiscal year
15 2014.

16 “(4) PUBLIC AVAILABILITY OF DATA SUB-
17 MITTED.—The Secretary shall establish procedures
18 for making data submitted under paragraph (4)
19 available to the public. Such procedures shall ensure
20 that a hospital described in section 1886(d)(1)(B)(v)
21 has the opportunity to review the data that is to be
22 made public with respect to the hospital prior to
23 such data being made public. The Secretary shall re-
24 port quality measures of process, structure, outcome,
25 patients’ perspective on care, efficiency, and costs of

1 care that relate to services furnished in such hos-
2 pitals on the Internet website of the Centers for
3 Medicare & Medicaid Services.”.

4 **SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PRO-**
5 **GRAM FOR SKILLED NURSING FACILITIES**
6 **AND HOME HEALTH AGENCIES.**

7 (a) SKILLED NURSING FACILITIES.—

8 (1) IN GENERAL.—The Secretary of Health and
9 Human Services (in this section referred to as the
10 “Secretary”) shall develop a plan to implement a
11 value-based purchasing program for payments under
12 the Medicare program under title XVIII of the So-
13 cial Security Act for skilled nursing facilities (as de-
14 fined in section 1819(a) of such Act (42 U.S.C.
15 1395i-3(a))).

16 (2) DETAILS.—In developing the plan under
17 paragraph (1), the Secretary shall consider the fol-
18 lowing issues:

19 (A) The ongoing development, selection,
20 and modification process for measures (includ-
21 ing under section 1890 of the Social Security
22 Act (42 U.S.C. 1395aaa) and section 1890A
23 such Act, as added by section 3014), to the ex-
24 tent feasible and practicable, of all dimensions

1 of quality and efficiency in skilled nursing fa-
2 cilities.

3 (i) IN GENERAL.—Subject to clause
4 (ii), any measure specified by the Secretary
5 under subparagraph (A)(iii) must have
6 been endorsed by the entity with a contract
7 under section 1890(a).

8 (ii) EXCEPTION.—In the case of a
9 specified area or medical topic determined
10 appropriate by the Secretary for which a
11 feasible and practical measure has not
12 been endorsed by the entity with a contract
13 under section 1890(a), the Secretary may
14 specify a measure that is not so endorsed
15 as long as due consideration is given to
16 measures that have been endorsed or
17 adopted by a consensus organization iden-
18 tified by the Secretary.

19 (B) The reporting, collection, and valida-
20 tion of quality data.

21 (C) The structure of value-based payment
22 adjustments, including the determination of
23 thresholds or improvements in quality that
24 would substantiate a payment adjustment, the

1 size of such payments, and the sources of fund-
2 ing for the value-based bonus payments.

3 (D) Methods for the public disclosure of
4 information on the performance of skilled nurs-
5 ing facilities.

6 (E) Any other issues determined appro-
7 priate by the Secretary.

8 (3) CONSULTATION.—In developing the plan
9 under paragraph (1), the Secretary shall—

10 (A) consult with relevant affected parties;
11 and

12 (B) consider experience with such dem-
13 onstrations that the Secretary determines are
14 relevant to the value-based purchasing program
15 described in paragraph (1).

16 (4) REPORT TO CONGRESS.—Not later than Oc-
17 tober 1, 2011, the Secretary shall submit to Con-
18 gress a report containing the plan developed under
19 paragraph (1).

20 (b) HOME HEALTH AGENCIES.—

21 (1) IN GENERAL.—The Secretary of Health and
22 Human Services (in this section referred to as the
23 “Secretary”) shall develop a plan to implement a
24 value-based purchasing program for payments under
25 the Medicare program under title XVIII of the So-

1 cial Security Act for home health agencies (as de-
2 fined in section 1861(o) of such Act (42 U.S.C.
3 1395x(o))).

4 (2) DETAILS.—In developing the plan under
5 paragraph (1), the Secretary shall consider the fol-
6 lowing issues:

7 (A) The ongoing development, selection,
8 and modification process for measures (includ-
9 ing under section 1890 of the Social Security
10 Act (42 U.S.C. 1395aaa) and section 1890A
11 such Act, as added by section 3014), to the ex-
12 tent feasible and practicable, of all dimensions
13 of quality and efficiency in home health agen-
14 cies.

15 (B) The reporting, collection, and valida-
16 tion of quality data.

17 (C) The structure of value-based payment
18 adjustments, including the determination of
19 thresholds or improvements in quality that
20 would substantiate a payment adjustment, the
21 size of such payments, and the sources of fund-
22 ing for the value-based bonus payments.

23 (D) Methods for the public disclosure of
24 information on the performance of home health
25 agencies.

1 (E) Any other issues determined appro-
2 priate by the Secretary.

3 (3) CONSULTATION.—In developing the plan
4 under paragraph (1), the Secretary shall—

5 (A) consult with relevant affected parties;
6 and

7 (B) consider experience with such dem-
8 onstrations that the Secretary determines are
9 relevant to the value-based purchasing program
10 described in paragraph (1).

11 (4) REPORT TO CONGRESS.—Not later than Oc-
12 tober 1, 2011, the Secretary shall submit to Con-
13 gress a report containing the plan developed under
14 paragraph (1).

15 **SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE**
16 **PHYSICIAN FEE SCHEDULE.**

17 Section 1848 of the Social Security Act (42 U.S.C.
18 1395w-4) is amended—

19 (1) in subsection (b)(1), by inserting “subject
20 to subsection (p),” after “1998,”; and

21 (2) by adding at the end the following new sub-
22 section:

23 “(p) ESTABLISHMENT OF VALUE-BASED PAYMENT
24 MODIFIER.—

1 “(1) IN GENERAL.—The Secretary shall estab-
2 lish a payment modifier that provides for differential
3 payment to a physician or a group of physicians
4 under the fee schedule established under subsection
5 (b) based upon the quality of care furnished com-
6 pared to cost (as determined under paragraphs (2)
7 and (3), respectively) during a performance period.
8 Such payment modifier shall be separate from the
9 geographic adjustment factors established under
10 subsection (e).

11 “(2) QUALITY.—

12 “(A) IN GENERAL.—For purposes of para-
13 graph (1), quality of care shall be evaluated, to
14 the extent practicable, based on a composite of
15 measures of the quality of care furnished (as
16 established by the Secretary under subpara-
17 graph (B)).

18 “(B) MEASURES.—

19 “(i) The Secretary shall establish ap-
20 propriate measures of the quality of care
21 furnished by a physician or group of physi-
22 cians to individuals enrolled under this
23 part, such as measures that reflect health
24 outcomes. Such measures shall be risk ad-

1 justed as determined appropriate by the
2 Secretary.

3 “(ii) The Secretary shall seek endorse-
4 ment of the measures established under
5 this subparagraph by the entity with a
6 contract under section 1890(a).

7 “(3) COSTS.—For purposes of paragraph (1),
8 costs shall be evaluated, to the extent practicable,
9 based on a composite of appropriate measures of
10 costs established by the Secretary (such as the com-
11 posite measure under the methodology established
12 under subsection (n)(9)(C)(iii)) that eliminate the
13 effect of geographic adjustments in payment rates
14 (as described in subsection (e)), and take into ac-
15 count risk factors (such as socioeconomic and demo-
16 graphic characteristics, ethnicity, and health status
17 of individuals (such as to recognize that less healthy
18 individuals may require more intensive interventions)
19 and other factors determined appropriate by the
20 Secretary.

21 “(4) IMPLEMENTATION.—

22 “(A) PUBLICATION OF MEASURES, DATES
23 OF IMPLEMENTATION, PERFORMANCE PE-
24 RIOD.—Not later than January 1, 2012, the
25 Secretary shall publish the following:

1 “(i) The measures of quality of care
2 and costs established under paragraphs (2)
3 and (3), respectively.

4 “(ii) The dates for implementation of
5 the payment modifier (as determined under
6 subparagraph (B)).

7 “(iii) The initial performance period
8 (as specified under subparagraph (B)(ii)).

9 “(B) DEADLINES FOR IMPLEMENTA-
10 TION.—

11 “(i) INITIAL IMPLEMENTATION.—Sub-
12 ject to the preceding provisions of this sub-
13 paragraph, the Secretary shall begin imple-
14 menting the payment modifier established
15 under this subsection through the rule-
16 making process during 2013 for the physi-
17 cian fee schedule established under sub-
18 section (b).

19 “(ii) INITIAL PERFORMANCE PE-
20 RIOD.—

21 “(I) IN GENERAL.—The Sec-
22 retary shall specify an initial perform-
23 ance period for application of the pay-
24 ment modifier established under this
25 subsection with respect to 2015.

1 “(II) PROVISION OF INFORMA-
2 TION DURING INITIAL PERFORMANCE
3 PERIOD.—During the initial perform-
4 ance period, the Secretary shall, to
5 the extent practicable, provide infor-
6 mation to physicians and groups of
7 physicians about the quality of care
8 furnished by the physician or group of
9 physicians to individuals enrolled
10 under this part compared to cost (as
11 determined under paragraphs (2) and
12 (3), respectively) with respect to the
13 performance period.

14 “(iii) APPLICATION.—The Secretary
15 shall apply the payment modifier estab-
16 lished under this subsection for items and
17 services furnished—

18 “(I) beginning on January 1,
19 2015, with respect to specific physi-
20 cians and groups of physicians the
21 Secretary determines appropriate; and

22 “(II) beginning not later than
23 January 1, 2017, with respect to all
24 physicians and groups of physicians.

1 “(C) BUDGET NEUTRALITY.—The pay-
2 ment modifier established under this subsection
3 shall be implemented in a budget neutral man-
4 ner.

5 “(5) SYSTEMS-BASED CARE.—The Secretary
6 shall, as appropriate, apply the payment modifier es-
7 tablished under this subsection in a manner that
8 promotes systems-based care.

9 “(6) CONSIDERATION OF SPECIAL CIR-
10 CUMSTANCES OF CERTAIN PROVIDERS.—In applying
11 the payment modifier under this subsection, the Sec-
12 retary shall, as appropriate, take into account the
13 special circumstances of physicians or groups of phy-
14 sicians in rural areas and other underserved commu-
15 nities.

16 “(7) APPLICATION.—For purposes of the initial
17 application of the payment modifier established
18 under this subsection during the period beginning on
19 January 1, 2015, and ending on December 31,
20 2016, the term ‘physician’ has the meaning given
21 such term in section 1861(r). On or after January
22 1, 2017, the Secretary may apply this subsection to
23 eligible professionals (as defined in subsection
24 (k)(3)(B)) as the Secretary determines appropriate.

1 “(8) DEFINITIONS.—For purposes of this sub-
2 section:

3 “(A) COSTS.—The term ‘costs’ means ex-
4 penditures per individual as determined appro-
5 priate by the Secretary. In making the deter-
6 mination under the preceding sentence, the Sec-
7 retary may take into account the amount of
8 growth in expenditures per individual for a phy-
9 sician compared to the amount of such growth
10 for other physicians.

11 “(B) PERFORMANCE PERIOD.—The term
12 ‘performance period’ means a period specified
13 by the Secretary.

14 “(9) COORDINATION WITH OTHER VALUE-
15 BASED PURCHASING REFORMS.—The Secretary shall
16 coordinate the value-based payment modifier estab-
17 lished under this subsection with the Physician
18 Feedback Program under subsection (n) and, as the
19 Secretary determines appropriate, other similar pro-
20 visions of this title.

21 “(10) LIMITATIONS ON REVIEW.—There shall
22 be no administrative or judicial review under section
23 1869, section 1878, or otherwise of—

24 “(A) the establishment of the value-based
25 payment modifier under this subsection;

1 “(B) the evaluation of quality of care
2 under paragraph (2), including the establish-
3 ment of appropriate measures of the quality of
4 care under paragraph (2)(B);

5 “(C) the evaluation of costs under para-
6 graph (3), including the establishment of appro-
7 priate measures of costs under such paragraph;

8 “(D) the dates for implementation of the
9 value-based payment modifier;

10 “(E) the specification of the initial per-
11 formance period and any other performance pe-
12 riod under paragraphs (4)(B)(ii) and (8)(B),
13 respectively;

14 “(F) the application of the value-based
15 payment modifier under paragraph (7); and

16 “(G) the determination of costs under
17 paragraph (8)(A).”.

18 **SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS AC-**
19 **QUIRED IN HOSPITALS.**

20 (a) IN GENERAL.—Section 1886 of the Social Secu-
21 rity Act (42 U.S.C. 1395ww), as amended by section
22 3001, is amended by adding at the end the following new
23 subsection:

24 “(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR
25 HOSPITAL ACQUIRED CONDITIONS.—

1 “(1) IN GENERAL.—In order to provide an in-
2 centive for applicable hospitals to reduce hospital ac-
3 quired conditions under this title, with respect to
4 discharges from an applicable hospital occurring
5 during fiscal year 2015 or a subsequent fiscal year,
6 the amount of payment under this section or section
7 1814(b)(3), as applicable, for such discharges during
8 the fiscal year shall be equal to 99 percent of the
9 amount of payment that would otherwise apply to
10 such discharges under this section or section
11 1814(b)(3) (determined after the application of sub-
12 sections (o) and (q) and section 1814(l)(4) but with-
13 out regard to this subsection).

14 “(2) APPLICABLE HOSPITALS.—

15 “(A) IN GENERAL.—For purposes of this
16 subsection, the term ‘applicable hospital’ means
17 a subsection (d) hospital that meets the criteria
18 described in subparagraph (B).

19 “(B) CRITERIA DESCRIBED.—

20 “(i) IN GENERAL.—The criteria de-
21 scribed in this subparagraph, with respect
22 to a subsection (d) hospital, is that the
23 subsection (d) hospital is in the top quar-
24 tile of all subsection (d) hospitals, relative
25 to the national average, of hospital ac-

1 required conditions during the applicable pe-
2 riod, as determined by the Secretary.

3 “(ii) RISK ADJUSTMENT.—In carrying
4 out clause (i), the Secretary shall establish
5 and apply an appropriate risk adjustment
6 methodology.

7 “(C) EXEMPTION.—In the case of a hos-
8 pital that is paid under section 1814(b)(3), the
9 Secretary may exempt such hospital from the
10 application of this subsection if the State which
11 is paid under such section submits an annual
12 report to the Secretary describing how a similar
13 program in the State for a participating hos-
14 pital or hospitals achieves or surpasses the
15 measured results in terms of patient health out-
16 comes and cost savings established under this
17 subsection.

18 “(3) HOSPITAL ACQUIRED CONDITIONS.—For
19 purposes of this subsection, the term ‘hospital ac-
20 quired condition’ means a condition identified for
21 purposes of subsection (d)(4)(D)(iv) and any other
22 condition determined appropriate by the Secretary
23 that an individual acquires during a stay in an ap-
24 plicable hospital, as determined by the Secretary.

1 “(4) APPLICABLE PERIOD.—In this subsection,
2 the term ‘applicable period’ means, with respect to
3 a fiscal year, a period specified by the Secretary.

4 “(5) REPORTING TO HOSPITALS.—Prior to fis-
5 cal year 2015 and each subsequent fiscal year, the
6 Secretary shall provide confidential reports to appli-
7 cable hospitals with respect to hospital acquired con-
8 ditions of the applicable hospital during the applica-
9 ble period.

10 “(6) REPORTING HOSPITAL SPECIFIC INFORMA-
11 TION.—

12 “(A) IN GENERAL.—The Secretary shall
13 make information available to the public re-
14 garding hospital acquired conditions of each ap-
15 plicable hospital.

16 “(B) OPPORTUNITY TO REVIEW AND SUB-
17 MIT CORRECTIONS.—The Secretary shall ensure
18 that an applicable hospital has the opportunity
19 to review, and submit corrections for, the infor-
20 mation to be made public with respect to the
21 hospital under subparagraph (A) prior to such
22 information being made public.

23 “(C) WEBSITE.—Such information shall be
24 posted on the Hospital Compare Internet
25 website in an easily understandable format.

1 “(7) LIMITATIONS ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869, section 1878, or otherwise of the following:

4 “(A) The criteria described in paragraph
5 (2)(A).

6 “(B) The specification of hospital acquired
7 conditions under paragraph (3).

8 “(C) The specification of the applicable pe-
9 riod under paragraph (4).

10 “(D) The provision of reports to applicable
11 hospitals under paragraph (5) and the informa-
12 tion made available to the public under para-
13 graph (6).”.

14 (b) STUDY AND REPORT ON EXPANSION OF
15 HEALTHCARE ACQUIRED CONDITIONS POLICY TO OTHER
16 PROVIDERS.—

17 (1) STUDY.—The Secretary of Health and
18 Human Services shall conduct a study on expanding
19 the healthcare acquired conditions policy under sub-
20 section (d)(4)(D) of section 1886 of the Social Secu-
21 rity Act (42 U.S.C. 1395ww) to payments made to
22 other facilities under the Medicare program under
23 title XVIII of the Social Security Act, including such
24 payments made to inpatient rehabilitation facilities,
25 long-term care hospitals (as described in sub-

1 section(d)(1)(B)(iv) of such section), hospital out-
2 patient departments, and other hospitals excluded
3 from the inpatient prospective payment system
4 under such section, skilled nursing facilities, ambula-
5 tory surgical centers, and health clinics. Such study
6 shall include an analysis of how such policies could
7 impact quality of patient care, patient safety, and
8 spending under the Medicare program.

9 (2) REPORT.—Not later than January 1, 2012,
10 the Secretary shall submit to Congress a report con-
11 taining the results of the study conducted under
12 paragraph (1), together with recommendations for
13 such legislation and administrative action as the
14 Secretary determines appropriate.

15 **PART II—NATIONAL STRATEGY TO IMPROVE**

16 **HEALTH CARE QUALITY**

17 **SEC. 3011. NATIONAL STRATEGY.**

18 Title III of the Public Health Service Act (42 U.S.C.
19 241 et seq.) is amended by adding at the end the fol-
20 lowing:

1 **“PART S—HEALTH CARE QUALITY PROGRAMS**

2 **“Subpart I—National Strategy for Quality**

3 **Improvement in Health Care**

4 **“SEC. 399HH. NATIONAL STRATEGY FOR QUALITY IM-**
5 **PROVEMENT IN HEALTH CARE.**

6 “(a) ESTABLISHMENT OF NATIONAL STRATEGY AND
7 PRIORITIES.—

8 “(1) NATIONAL STRATEGY.—The Secretary,
9 through a transparent collaborative process, shall es-
10 tablish a national strategy to improve the delivery of
11 health care services, patient health outcomes, and
12 population health.

13 “(2) IDENTIFICATION OF PRIORITIES.—

14 “(A) IN GENERAL.—The Secretary shall
15 identify national priorities for improvement in
16 developing the strategy under paragraph (1).

17 “(B) REQUIREMENTS.—The Secretary
18 shall ensure that priorities identified under sub-
19 paragraph (A) will—

20 “(i) have the greatest potential for im-
21 proving the health outcomes, efficiency,
22 and patient-centeredness of health care for
23 all populations, including children and vul-
24 nerable populations;

25 “(ii) identify areas in the delivery of
26 health care services that have the potential

1 for rapid improvement in the quality and
2 efficiency of patient care;

3 “(iii) address gaps in quality, effi-
4 ciency, comparative effectiveness informa-
5 tion, and health outcomes measures and
6 data aggregation techniques;

7 “(iv) improve Federal payment policy
8 to emphasize quality and efficiency;

9 “(v) enhance the use of health care
10 data to improve quality, efficiency, trans-
11 parency, and outcomes;

12 “(vi) address the health care provided
13 to patients with high-cost chronic diseases;

14 “(vii) improve research and dissemi-
15 nation of strategies and best practices to
16 improve patient safety and reduce medical
17 errors, preventable admissions and re-
18 admissions, and health care-associated in-
19 fections;

20 “(viii) reduce health disparities across
21 health disparity populations (as defined in
22 section 485E) and geographic areas; and

23 “(ix) address other areas as deter-
24 mined appropriate by the Secretary.

1 “(C) CONSIDERATIONS.—In identifying
2 priorities under subparagraph (A), the Sec-
3 retary shall take into consideration the rec-
4 ommendations submitted by the entity with a
5 contract under section 1890(a) of the Social Se-
6 curity Act and other stakeholders.

7 “(D) COORDINATION WITH STATE AGEN-
8 CIES.—The Secretary shall collaborate, coordi-
9 nate, and consult with State agencies respon-
10 sible for administering the Medicaid program
11 under title XIX of the Social Security Act and
12 the Children’s Health Insurance Program under
13 title XXI of such Act with respect to developing
14 and disseminating strategies, goals, models, and
15 timetables that are consistent with the national
16 priorities identified under subparagraph (A).

17 “(b) STRATEGIC PLAN.—

18 “(1) IN GENERAL.—The national strategy shall
19 include a comprehensive strategic plan to achieve the
20 priorities described in subsection (a).

21 “(2) REQUIREMENTS.—The strategic plan shall
22 include provisions for addressing, at a minimum, the
23 following:

24 “(A) Coordination among agencies within
25 the Department, which shall include steps to

1 minimize duplication of efforts and utilization
2 of common quality measures, where available.
3 Such common quality measures shall be meas-
4 ures identified by the Secretary under section
5 1139A or 1139B of the Social Security Act or
6 endorsed under section 1890 of such Act.

7 “(B) Agency-specific strategic plans to
8 achieve national priorities.

9 “(C) Establishment of annual benchmarks
10 for each relevant agency to achieve national pri-
11 orities.

12 “(D) A process for regular reporting by
13 the agencies to the Secretary on the implemen-
14 tation of the strategic plan.

15 “(E) Strategies to align public and private
16 payers with regard to quality and patient safety
17 efforts.

18 “(F) Incorporating quality improvement
19 and measurement in the strategic plan for
20 health information technology required by the
21 American Recovery and Reinvestment Act of
22 2009 (Public Law 111–5).

23 “(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—
24 The Secretary shall update the national strategy not less

1 than annually. Any such update shall include a review of
2 short- and long-term goals.

3 “(d) SUBMISSION AND AVAILABILITY OF NATIONAL
4 STRATEGY AND UPDATES.—

5 “(1) DEADLINE FOR INITIAL SUBMISSION OF
6 NATIONAL STRATEGY.—Not later than January 1,
7 2011, the Secretary shall submit to the relevant
8 committees of Congress the national strategy de-
9 scribed in subsection (a).

10 “(2) UPDATES.—

11 “(A) IN GENERAL.—The Secretary shall
12 submit to the relevant committees of Congress
13 an annual update to the strategy described in
14 paragraph (1).

15 “(B) INFORMATION SUBMITTED.—Each
16 update submitted under subparagraph (A) shall
17 include—

18 “(i) a review of the short- and long-
19 term goals of the national strategy and any
20 gaps in such strategy;

21 “(ii) an analysis of the progress, or
22 lack of progress, in meeting such goals and
23 any barriers to such progress;

24 “(iii) the information reported under
25 section 1139A of the Social Security Act,

1 consistent with the reporting requirements
2 of such section; and

3 “(iv) in the case of an update required
4 to be submitted on or after January 1,
5 2014, the information reported under sec-
6 tion 1139B(b)(4) of the Social Security
7 Act, consistent with the reporting require-
8 ments of such section.

9 “(C) SATISFACTION OF OTHER REPORTING
10 REQUIREMENTS.—Compliance with the require-
11 ments of clauses (iii) and (iv) of subparagraph
12 (B) shall satisfy the reporting requirements
13 under sections 1139A(a)(6) and 1139B(b)(4),
14 respectively, of the Social Security Act.

15 “(e) HEALTH CARE QUALITY INTERNET
16 WEBSITE.—Not later than January 1, 2011, the Sec-
17 retary shall create an Internet website to make public in-
18 formation regarding—

19 “(1) the national priorities for health care qual-
20 ity improvement established under subsection (a)(2);

21 “(2) the agency-specific strategic plans for
22 health care quality described in subsection (b)(2)(B);
23 and

24 “(3) other information, as the Secretary deter-
25 mines to be appropriate.”.

1 **SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH**
2 **CARE QUALITY.**

3 (a) **IN GENERAL.**—The President shall convene a
4 working group to be known as the Interagency Working
5 Group on Health Care Quality (referred to in this section
6 as the “Working Group”).

7 (b) **GOALS.**—The goals of the Working Group shall
8 be to achieve the following:

9 (1) Collaboration, cooperation, and consultation
10 between Federal departments and agencies with re-
11 spect to developing and disseminating strategies,
12 goals, models, and timetables that are consistent
13 with the national priorities identified under section
14 399HH(a)(2) of the Public Health Service Act (as
15 added by section 3011).

16 (2) Avoidance of inefficient duplication of qual-
17 ity improvement efforts and resources, where prac-
18 ticable, and a streamlined process for quality report-
19 ing and compliance requirements.

20 (3) Assess alignment of quality efforts in the
21 public sector with private sector initiatives.

22 (c) **COMPOSITION.**—

23 (1) **IN GENERAL.**—The Working Group shall be
24 composed of senior level representatives of—

25 (A) the Department of Health and Human
26 Services;

- 1 (B) the Centers for Medicare & Medicaid
2 Services;
- 3 (C) the National Institutes of Health;
- 4 (D) the Centers for Disease Control and
5 Prevention;
- 6 (E) the Food and Drug Administration;
- 7 (F) the Health Resources and Services Ad-
8 ministration;
- 9 (G) the Agency for Healthcare Research
10 and Quality;
- 11 (H) the Office of the National Coordinator
12 for Health Information Technology;
- 13 (I) the Substance Abuse and Mental
14 Health Services Administration;
- 15 (J) the Administration for Children and
16 Families;
- 17 (K) the Department of Commerce;
- 18 (L) the Office of Management and Budget;
- 19 (M) the United States Coast Guard;
- 20 (N) the Federal Bureau of Prisons;
- 21 (O) the National Highway Traffic Safety
22 Administration;
- 23 (P) the Federal Trade Commission;
- 24 (Q) the Social Security Administration;
- 25 (R) the Department of Labor;

1 (S) the United States Office of Personnel
2 Management;

3 (T) the Department of Defense;

4 (U) the Department of Education;

5 (V) the Department of Veterans Affairs;

6 (W) the Veterans Health Administration;

7 and

8 (X) any other Federal agencies and de-
9 partments with activities relating to improving
10 health care quality and safety, as determined by
11 the President.

12 (2) CHAIR AND VICE-CHAIR.—

13 (A) CHAIR.—The Working Group shall be
14 chaired by the Secretary of Health and Human
15 Services.

16 (B) VICE CHAIR.—Members of the Work-
17 ing Group, other than the Secretary of Health
18 and Human Services, shall serve as Vice Chair
19 of the Group on a rotating basis, as determined
20 by the Group.

21 (d) REPORT TO CONGRESS.—Not later than Decem-
22 ber 31, 2010, and annually thereafter, the Working Group
23 shall submit to the relevant Committees of Congress, and
24 make public on an Internet website, a report describing

1 the progress and recommendations of the Working Group
 2 in meeting the goals described in subsection (b).

3 **SEC. 3013. QUALITY MEASURE DEVELOPMENT.**

4 (a) PUBLIC HEALTH SERVICE ACT.—Title IX of the
 5 Public Health Service Act (42 U.S.C. 299 et seq.) is
 6 amended—

7 (1) by redesignating part D as part E;

8 (2) by redesignating sections 931 through 938
 9 as sections 941 through 948, respectively;

10 (3) in section 948(1), as so redesignated, by
 11 striking “931” and inserting “941”; and

12 (4) by inserting after section 926 the following:

13 **“PART D—HEALTH CARE QUALITY**

14 **IMPROVEMENT**

15 **“Subpart I—Quality Measure Development**

16 **“SEC. 931. QUALITY MEASURE DEVELOPMENT.**

17 “(a) QUALITY MEASURE.—In this subpart, the term
 18 ‘quality measure’ means a standard for measuring the per-
 19 formance and improvement of population health or of
 20 health plans, providers of services, and other clinicians in
 21 the delivery of health care services.

22 “(b) IDENTIFICATION OF QUALITY MEASURES.—

23 “(1) IDENTIFICATION.—The Secretary, in con-
 24 sultation with the Director of the Agency for
 25 Healthcare Research and Quality and the Adminis-

1 trator of the Centers for Medicare & Medicaid Serv-
2 ices, shall identify, not less often than triennially,
3 gaps where no quality measures exist and existing
4 quality measures that need improvement, updating,
5 or expansion, consistent with the national strategy
6 under section 399HH, to the extent available, for
7 use in Federal health programs. In identifying such
8 gaps and existing quality measures that need im-
9 provement, the Secretary shall take into consider-
10 ation—

11 “(A) the gaps identified by the entity with
12 a contract under section 1890(a) of the Social
13 Security Act and other stakeholders;

14 “(B) quality measures identified by the pe-
15 diatric quality measures program under section
16 1139A of the Social Security Act; and

17 “(C) quality measures identified through
18 the Medicaid Quality Measurement Program
19 under section 1139B of the Social Security Act.

20 “(2) PUBLICATION.—The Secretary shall make
21 available to the public on an Internet website a re-
22 port on any gaps identified under paragraph (1) and
23 the process used to make such identification.

24 “(c) GRANTS OR CONTRACTS FOR QUALITY MEAS-
25 URE DEVELOPMENT.—

1 “(1) IN GENERAL.—The Secretary shall award
2 grants, contracts, or intergovernmental agreements
3 to eligible entities for purposes of developing, im-
4 proving, updating, or expanding quality measures
5 identified under subsection (b).

6 “(2) PRIORITIZATION IN THE DEVELOPMENT
7 OF QUALITY MEASURES.—In awarding grants, con-
8 tracts, or agreements under this subsection, the Sec-
9 retary shall give priority to the development of qual-
10 ity measures that allow the assessment of—

11 “(A) health outcomes and functional status
12 of patients;

13 “(B) the management and coordination of
14 health care across episodes of care and care
15 transitions for patients across the continuum of
16 providers, health care settings, and health
17 plans;

18 “(C) the experience, quality, and use of in-
19 formation provided to and used by patients,
20 caregivers, and authorized representatives to in-
21 form decisionmaking about treatment options,
22 including the use of shared decisionmaking
23 tools and preference sensitive care (as defined
24 in section 936);

1 “(D) the meaningful use of health informa-
2 tion technology;

3 “(E) the safety, effectiveness, patient-
4 centeredness, appropriateness, and timeliness of
5 care;

6 “(F) the efficiency of care;

7 “(G) the equity of health services and
8 health disparities across health disparity popu-
9 lations (as defined in section 485E) and geo-
10 graphic areas;

11 “(H) patient experience and satisfaction;

12 “(I) the use of innovative strategies and
13 methodologies identified under section 933; and

14 “(J) other areas determined appropriate by
15 the Secretary.

16 “(3) ELIGIBLE ENTITIES.—To be eligible for a
17 grant or contract under this subsection, an entity
18 shall—

19 “(A) have demonstrated expertise and ca-
20 pacity in the development and evaluation of
21 quality measures;

22 “(B) have adopted procedures to include in
23 the quality measure development process—

1 “(i) the views of those providers or
2 payers whose performance will be assessed
3 by the measure; and

4 “(ii) the views of other parties who
5 also will use the quality measures (such as
6 patients, consumers, and health care pur-
7 chasers);

8 “(C) collaborate with the entity with a con-
9 tract under section 1890(a) of the Social Secu-
10 rity Act and other stakeholders, as practicable,
11 and the Secretary so that quality measures de-
12 veloped by the eligible entity will meet the re-
13 quirements to be considered for endorsement by
14 the entity with a contract under such section
15 1890(a);

16 “(D) have transparent policies regarding
17 governance and conflicts of interest; and

18 “(E) submit an application to the Sec-
19 retary at such time and in such manner, as the
20 Secretary may require.

21 “(4) USE OF FUNDS.—An entity that receives
22 a grant, contract, or agreement under this sub-
23 section shall use such award to develop quality
24 measures that meet the following requirements:

1 “(A) Such measures support measures re-
2 quired to be reported under the Social Security
3 Act, where applicable, and in support of gaps
4 and existing quality measures that need im-
5 provement, as described in subsection (b)(1)(A).

6 “(B) Such measures support measures de-
7 veloped under section 1139A of the Social Secu-
8 rity Act and the Medicaid Quality Measurement
9 Program under section 1139B of such Act,
10 where applicable.

11 “(C) To the extent practicable, data on
12 such quality measures is able to be collected
13 using health information technologies.

14 “(D) Each quality measure is free of
15 charge to users of such measure.

16 “(E) Each quality measure is publicly
17 available on an Internet website.

18 “(d) OTHER ACTIVITIES BY THE SECRETARY.—The
19 Secretary may use amounts available under this section
20 to update and test, where applicable, quality measures en-
21 dorsed by the entity with a contract under section 1890(a)
22 of the Social Security Act or adopted by the Secretary.

23 “(e) COORDINATION OF GRANTS.—The Secretary
24 shall ensure that grants or contracts awarded under this
25 section are coordinated with grants and contracts awarded

1 under sections 1139A(5) and 1139B(4)(A) of the Social
2 Security Act.”.

3 (b) SOCIAL SECURITY ACT.—Section 1890A of the
4 Social Security Act, as added by section 3014(b), is
5 amended by adding at the end the following new sub-
6 section:

7 “(e) DEVELOPMENT OF QUALITY MEASURES.—The
8 Administrator of the Center for Medicare & Medicaid
9 Services shall through contracts develop quality measures
10 (as determined appropriate by the Administrator) for use
11 under this Act. In developing such measures, the Adminis-
12 trator shall consult with the Director of the Agency for
13 Healthcare Research and Quality.”.

14 (c) FUNDING.—There are authorized to be appro-
15 priated to the Secretary of Health and Human Services
16 to carry out this section, \$75,000,000 for each of fiscal
17 years 2010 through 2014. Of the amounts appropriated
18 under the preceding sentence in a fiscal year, not less than
19 50 percent of such amounts shall be used pursuant to sub-
20 section (e) of section 1890A of the Social Security Act,
21 as added by subsection (b), with respect to programs
22 under such Act. Amounts appropriated under this sub-
23 section for a fiscal year shall remain available until ex-
24 pended.

1 **SEC. 3014. QUALITY MEASUREMENT.**

2 (a) NEW DUTIES FOR CONSENSUS-BASED ENTITY.—

3 (1) MULTI-STAKEHOLDER GROUP INPUT.—Sec-
4 tion 1890(b) of the Social Security Act (42 U.S.C.
5 1395aaa(b)), as amended by section 3003, is amend-
6 ed by adding at the end the following new para-
7 graphs:

8 “(7) CONVENING MULTI-STAKEHOLDER
9 GROUPS.—

10 “(A) IN GENERAL.—The entity shall con-
11 vene multi-stakeholder groups to provide input
12 on—

13 “(i) the selection of quality measures
14 described in subparagraph (B), from
15 among—

16 “(I) such measures that have
17 been endorsed by the entity; and

18 “(II) such measures that have
19 not been considered for endorsement
20 by such entity but are used or pro-
21 posed to be used by the Secretary for
22 the collection or reporting of quality
23 measures; and

24 “(ii) national priorities (as identified
25 under section 399HH of the Public Health
26 Service Act) for improvement in population

1 health and in the delivery of health care
2 services for consideration under the na-
3 tional strategy established under section
4 399HH of the Public Health Service Act.

5 “(B) QUALITY MEASURES.—

6 “(i) IN GENERAL.—Subject to clause
7 (ii), the quality measures described in this
8 subparagraph are quality measures—

9 “(I) for use pursuant to sections

10 1814(i)(5)(D), 1833(i)(7),

11 1833(t)(17), 1848(k)(2)(C),

12 1866(k)(3), 1881(h)(2)(A)(iii),

13 1886(b)(3)(B)(viii), 1886(j)(7)(D),

14 1886(m)(5)(D), 1886(o)(2), and

15 1895(b)(3)(B)(v);

16 “(II) for use in reporting per-

17 formance information to the public;

18 and

19 “(III) for use in health care pro-

20 grams other than for use under this

21 Act.

22 “(ii) EXCLUSION.—Data sets (such as

23 the outcome and assessment information

24 set for home health services and the min-

25 imum data set for skilled nursing facility

1 services) that are used for purposes of
2 classification systems used in establishing
3 payment rates under this title shall not be
4 quality measures described in this subpara-
5 graph.

6 “(C) REQUIREMENT FOR TRANSPARENCY
7 IN PROCESS.—

8 “(i) IN GENERAL.—In convening
9 multi-stakeholder groups under subpara-
10 graph (A) with respect to the selection of
11 quality measures, the entity shall provide
12 for an open and transparent process for
13 the activities conducted pursuant to such
14 convening.

15 “(ii) SELECTION OF ORGANIZATIONS
16 PARTICIPATING IN MULTI-STAKEHOLDER
17 GROUPS.—The process described in clause
18 (i) shall ensure that the selection of rep-
19 resentatives comprising such groups pro-
20 vides for public nominations for, and the
21 opportunity for public comment on, such
22 selection.

23 “(D) MULTI-STAKEHOLDER GROUP DE-
24 FINED.—In this paragraph, the term ‘multi-
25 stakeholder group’ means, with respect to a

1 quality measure, a voluntary collaborative of or-
2 ganizations representing a broad group of
3 stakeholders interested in or affected by the use
4 of such quality measure.

5 “(8) TRANSMISSION OF MULTI-STAKEHOLDER
6 INPUT.—Not later than February 1 of each year
7 (beginning with 2012), the entity shall transmit to
8 the Secretary the input of multi-stakeholder groups
9 provided under paragraph (7).”.

10 (2) ANNUAL REPORT.—Section 1890(b)(5)(A)
11 of the Social Security Act (42 U.S.C.
12 1395aaa(b)(5)(A)) is amended—

13 (A) in clause (ii), by striking “and” at the
14 end;

15 (B) in clause (iii), by striking the period at
16 the end and inserting a semicolon; and

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

19 “(iv) gaps in endorsed quality meas-
20 ures, which shall include measures that are
21 within priority areas identified by the Sec-
22 retary under the national strategy estab-
23 lished under section 399HH of the Public
24 Health Service Act, and where quality

1 measures are unavailable or inadequate to
 2 identify or address such gaps;

3 “(v) areas in which evidence is insuffi-
 4 cient to support endorsement of quality
 5 measures in priority areas identified by the
 6 Secretary under the national strategy es-
 7 tablished under section 399HH of the
 8 Public Health Service Act and where tar-
 9 geted research may address such gaps; and
 10 “(vi) the matters described in clauses
 11 (i) and (ii) of paragraph (7)(A).”.

12 (b) MULTI-STAKEHOLDER GROUP INPUT INTO SE-
 13 LECTION OF QUALITY MEASURES.—Title XVIII of the So-
 14 cial Security Act (42 U.S.C. 1395 et seq.) is amended by
 15 inserting after section 1890 the following:

16 “QUALITY MEASUREMENT

17 “SEC. 1890A. (a) MULTI-STAKEHOLDER GROUP
 18 INPUT INTO SELECTION OF QUALITY MEASURES.—The
 19 Secretary shall establish a pre-rulemaking process under
 20 which the following steps occur with respect to the selec-
 21 tion of quality measures described in section
 22 1890(b)(7)(B):

23 “(1) INPUT.—Pursuant to section 1890(b)(7),
 24 the entity with a contract under section 1890 shall
 25 convene multi-stakeholder groups to provide input to

1 the Secretary on the selection of quality measures
2 described in subparagraph (B) of such paragraph.

3 “(2) PUBLIC AVAILABILITY OF MEASURES CON-
4 sidered for selection.—Not later than Decem-
5 ber 1 of each year (beginning with 2011), the Sec-
6 retary shall make available to the public a list of
7 quality measures described in section 1890(b)(7)(B)
8 that the Secretary is considering under this title.

9 “(3) TRANSMISSION OF MULTI-STAKEHOLDER
10 INPUT.—Pursuant to section 1890(b)(8), not later
11 than February 1 of each year (beginning with
12 2012), the entity shall transmit to the Secretary the
13 input of multi-stakeholder groups described in para-
14 graph (1).

15 “(4) CONSIDERATION OF MULTI-STAKEHOLDER
16 INPUT.—The Secretary shall take into consideration
17 the input from multi-stakeholder groups described in
18 paragraph (1) in selecting quality measures de-
19 scribed in section 1890(b)(7)(B) that have been en-
20 dorsed by the entity with a contract under section
21 1890 and measures that have not been endorsed by
22 such entity.

23 “(5) RATIONALE FOR USE OF QUALITY MEAS-
24 URES.—The Secretary shall publish in the Federal
25 Register the rationale for the use of any quality

1 measure described in section 1890(b)(7)(B) that has
2 not been endorsed by the entity with a contract
3 under section 1890.

4 “(6) ASSESSMENT OF IMPACT.—Not later than
5 March 1, 2012, and at least once every three years
6 thereafter, the Secretary shall—

7 “(A) conduct an assessment of the quality
8 impact of the use of endorsed measures de-
9 scribed in section 1890(b)(7)(B); and

10 “(B) make such assessment available to
11 the public.

12 “(b) PROCESS FOR DISSEMINATION OF MEASURES
13 USED BY THE SECRETARY.—

14 “(1) IN GENERAL.—The Secretary shall estab-
15 lish a process for disseminating quality measures
16 used by the Secretary. Such process shall include the
17 following:

18 “(A) The incorporation of such measures,
19 where applicable, in workforce programs, train-
20 ing curricula, and any other means of dissemi-
21 nation determined appropriate by the Secretary.

22 “(B) The dissemination of such quality
23 measures through the national strategy devel-
24 oped under section 399HH of the Public Health
25 Service Act.

1 “(2) EXISTING METHODS.—To the extent prac-
2 ticable, the Secretary shall utilize and expand exist-
3 ing dissemination methods in disseminating quality
4 measures under the process established under para-
5 graph (1).

6 “(c) REVIEW OF QUALITY MEASURES USED BY THE
7 SECRETARY.—

8 “(1) IN GENERAL.—The Secretary shall—

9 “(A) periodically (but in no case less often
10 than once every 3 years) review quality meas-
11 ures described in section 1890(b)(7)(B); and

12 “(B) with respect to each such measure,
13 determine whether to—

14 “(i) maintain the use of such meas-
15 ure; or

16 “(ii) phase out such measure.

17 “(2) CONSIDERATIONS.—In conducting the re-
18 view under paragraph (1), the Secretary shall take
19 steps to—

20 “(A) seek to avoid duplication of measures
21 used; and

22 “(B) take into consideration current inno-
23 vative methodologies and strategies for quality
24 improvement practices in the delivery of health
25 care services that represent best practices for

1 such quality improvement and measures en-
2 dorsed by the entity with a contract under sec-
3 tion 1890 since the previous review by the Sec-
4 retary.

5 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
6 tion shall preclude a State from using the quality meas-
7 ures identified under sections 1139A and 1139B.”.

8 (e) FUNDING.—For purposes of carrying out the
9 amendments made by this section, the Secretary shall pro-
10 vide for the transfer, from the Federal Hospital Insurance
11 Trust Fund under section 1817 of the Social Security Act
12 (42 U.S.C. 1395i) and the Federal Supplementary Med-
13 ical Insurance Trust Fund under section 1841 of such Act
14 (42 U.S.C. 1395t), in such proportion as the Secretary
15 determines appropriate, of \$20,000,000, to the Centers for
16 Medicare & Medicaid Services Program Management Ac-
17 count for each of fiscal years 2010 through 2014.
18 Amounts transferred under the preceding sentence shall
19 remain available until expended.

20 **SEC. 3015. DATA COLLECTION; PUBLIC REPORTING.**

21 Title III of the Public Health Service Act (42 U.S.C.
22 241 et seq.), as amended by section 3011, is further
23 amended by adding at the end the following:

1 **“SEC. 399II. COLLECTION AND ANALYSIS OF DATA FOR**
2 **QUALITY AND RESOURCE USE MEASURES.**

3 “(a) IN GENERAL.—The Secretary shall collect and
4 aggregate consistent data on quality and resource use
5 measures from information systems used to support health
6 care delivery to implement the public reporting of perform-
7 ance information, as described in section 399JJ, and may
8 award grants or contracts for this purpose. The Secretary
9 shall ensure that such collection, aggregation, and analysis
10 systems span an increasingly broad range of patient popu-
11 lations, providers, and geographic areas over time.

12 “(b) GRANTS OR CONTRACTS FOR DATA COLLEC-
13 TION.—

14 “(1) IN GENERAL.—The Secretary may award
15 grants or contracts to eligible entities to support
16 new, or improve existing, efforts to collect and ag-
17 gregate quality and resource use measures described
18 under subsection (c).

19 “(2) ELIGIBLE ENTITIES.—To be eligible for a
20 grant or contract under this subsection, an entity
21 shall—

22 “(A) be—

23 “(i) a multi-stakeholder entity that co-
24 ordinates the development of methods and
25 implementation plans for the consistent re-

1 reporting of summary quality and cost infor-
2 mation;

3 “(ii) an entity capable of submitting
4 such summary data for a particular popu-
5 lation and providers, such as a disease reg-
6 istry, regional collaboration, health plan
7 collaboration, or other population-wide
8 source; or

9 “(iii) a Federal Indian Health Service
10 program or a health program operated by
11 an Indian tribe (as defined in section 4 of
12 the Indian Health Care Improvement Act);

13 “(B) promote the use of the systems that
14 provide data to improve and coordinate patient
15 care;

16 “(C) support the provision of timely, con-
17 sistent quality and resource use information to
18 health care providers, and other groups and or-
19 ganizations as appropriate, with an opportunity
20 for providers to correct inaccurate measures;
21 and

22 “(D) agree to report, as determined by the
23 Secretary, measures on quality and resource use
24 to the public in accordance with the public re-

1 porting process established under section
2 399JJ.

3 “(c) CONSISTENT DATA AGGREGATION.—The Sec-
4 retary may award grants or contracts under this section
5 only to entities that enable summary data that can be inte-
6 grated and compared across multiple sources. The Sec-
7 retary shall provide standards for the protection of the se-
8 curity and privacy of patient data.

9 “(d) MATCHING FUNDS.—The Secretary may not
10 award a grant or contract under this section to an entity
11 unless the entity agrees that it will make available (di-
12 rectly or through contributions from other public or pri-
13 vate entities) non-Federal contributions toward the activi-
14 ties to be carried out under the grant or contract in an
15 amount equal to \$1 for each \$5 of Federal funds provided
16 under the grant or contract. Such non-Federal matching
17 funds may be provided directly or through donations from
18 public or private entities and may be in cash or in-kind,
19 fairly evaluated, including plant, equipment, or services.

20 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
21 carry out this section, there are authorized to be appro-
22 priated such sums as may be necessary for fiscal years
23 2010 through 2014.

1 **“SEC. 399JJ. PUBLIC REPORTING OF PERFORMANCE IN-**
2 **FORMATION.**

3 “(a) DEVELOPMENT OF PERFORMANCE
4 WEBSITES.—The Secretary shall make available to the
5 public, through standardized Internet websites, perform-
6 ance information summarizing data on quality measures.
7 Such information shall be tailored to respond to the dif-
8 fering needs of hospitals and other institutional health
9 care providers, physicians and other clinicians, patients,
10 consumers, researchers, policymakers, States, and other
11 stakeholders, as the Secretary may specify.

12 “(b) INFORMATION ON CONDITIONS.—The perform-
13 ance information made publicly available on an Internet
14 website, as described in subsection (a), shall include infor-
15 mation regarding clinical conditions to the extent such in-
16 formation is available, and the information shall, where
17 appropriate, be provider-specific and sufficiently
18 disaggregated and specific to meet the needs of patients
19 with different clinical conditions.

20 “(c) CONSULTATION.—

21 “(1) IN GENERAL.—In carrying out this sec-
22 tion, the Secretary shall consult with the entity with
23 a contract under section 1890(a) of the Social Secu-
24 rity Act, and other entities, as appropriate, to deter-
25 mine the type of information that is useful to stake-
26 holders and the format that best facilitates use of

1 the reports and of performance reporting Internet
2 websites.

3 “(2) CONSULTATION WITH STAKEHOLDERS.—

4 The entity with a contract under section 1890(a) of
5 the Social Security Act shall convene multi-stake-
6 holder groups, as described in such section, to review
7 the design and format of each Internet website made
8 available under subsection (a) and shall transmit to
9 the Secretary the views of such multi-stakeholder
10 groups with respect to each such design and format.

11 “(d) COORDINATION.—Where appropriate, the Sec-
12 retary shall coordinate the manner in which data are pre-
13 sented through Internet websites described in subsection
14 (a) and for public reporting of other quality measures by
15 the Secretary, including such quality measures under title
16 XVIII of the Social Security Act.

17 “(e) AUTHORIZATION OF APPROPRIATIONS.—To
18 carry out this section, there are authorized to be appro-
19 priated such sums as may be necessary for fiscal years
20 2010 through 2014.”.

1 **PART III—ENCOURAGING DEVELOPMENT OF**
2 **NEW PATIENT CARE MODELS**
3 **SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE**
4 **AND MEDICAID INNOVATION WITHIN CMS.**

5 (a) IN GENERAL.—Title XI of the Social Security Act
6 is amended by inserting after section 1115 the following
7 new section:

8 “CENTER FOR MEDICARE AND MEDICAID INNOVATION
9 “SEC. 1115A. (a) CENTER FOR MEDICARE AND
10 MEDICAID INNOVATION ESTABLISHED.—

11 “(1) IN GENERAL.—There is created within the
12 Centers for Medicare & Medicaid Services a Center
13 for Medicare and Medicaid Innovation (in this sec-
14 tion referred to as the ‘CMI’) to carry out the duties
15 described in this section. The purpose of the CMI is
16 to test innovative payment and service delivery mod-
17 els to reduce program expenditures under the appli-
18 cable titles while preserving or enhancing the quality
19 of care furnished to individuals under such titles. In
20 selecting such models, the Secretary shall give pref-
21 erence to models that also improve the coordination,
22 quality, and efficiency of health care services fur-
23 nished to applicable individuals defined in paragraph
24 (4)(A).

1 “(2) DEADLINE.—The Secretary shall ensure
2 that the CMI is carrying out the duties described in
3 this section by not later than January 1, 2011.

4 “(3) CONSULTATION.—In carrying out the du-
5 ties under this section, the CMI shall consult rep-
6 resentatives of relevant Federal agencies, and clin-
7 ical and analytical experts with expertise in medicine
8 and health care management. The CMI shall use
9 open door forums or other mechanisms to seek input
10 from interested parties.

11 “(4) DEFINITIONS.—In this section:

12 “(A) APPLICABLE INDIVIDUAL.—The term
13 ‘applicable individual’ means—

14 “(i) an individual who is entitled to,
15 or enrolled for, benefits under part A of
16 title XVIII or enrolled for benefits under
17 part B of such title;

18 “(ii) an individual who is eligible for
19 medical assistance under title XIX, under
20 a State plan or waiver; or

21 “(iii) an individual who meets the cri-
22 teria of both clauses (i) and (ii).

23 “(B) APPLICABLE TITLE.—The term ‘ap-
24 plicable title’ means title XVIII, title XIX, or
25 both.

1 “(b) TESTING OF MODELS (PHASE I).—

2 “(1) IN GENERAL.—The CMI shall test pay-
3 ment and service delivery models in accordance with
4 selection criteria under paragraph (2) to determine
5 the effect of applying such models under the applica-
6 ble title (as defined in subsection (a)(4)(B)) on pro-
7 gram expenditures under such titles and the quality
8 of care received by individuals receiving benefits
9 under such title.

10 “(2) SELECTION OF MODELS TO BE TESTED.—

11 “(A) IN GENERAL.—The Secretary shall
12 select models to be tested from models where
13 the Secretary determines that there is evidence
14 that the model addresses a defined population
15 for which there are deficits in care leading to
16 poor clinical outcomes or potentially avoidable
17 expenditures. The models selected under the
18 preceding sentence may include the models de-
19 scribed in subparagraph (B).

20 “(B) OPPORTUNITIES.—The models de-
21 scribed in this subparagraph are the following
22 models:

23 “(i) Promoting broad payment and
24 practice reform in primary care, including
25 patient-centered medical home models for

1 high-need applicable individuals, medical
2 homes that address women’s unique health
3 care needs, and models that transition pri-
4 mary care practices away from fee-for-serv-
5 ice based reimbursement and toward com-
6 prehensive payment or salary-based pay-
7 ment.

8 “(ii) Contracting directly with groups
9 of providers of services and suppliers to
10 promote innovative care delivery models,
11 such as through risk-based comprehensive
12 payment or salary-based payment.

13 “(iii) Utilizing geriatric assessments
14 and comprehensive care plans to coordinate
15 the care (including through interdiscipli-
16 nary teams) of applicable individuals with
17 multiple chronic conditions and at least
18 one of the following:

19 “(I) An inability to perform 2 or
20 more activities of daily living.

21 “(II) Cognitive impairment, in-
22 cluding dementia.

23 “(iv) Promote care coordination be-
24 tween providers of services and suppliers
25 that transition health care providers away

1 from fee-for-service based reimbursement
2 and toward salary-based payment.

3 “(v) Supporting care coordination for
4 chronically-ill applicable individuals at high
5 risk of hospitalization through a health in-
6 formation technology-enabled provider net-
7 work that includes care coordinators, a
8 chronic disease registry, and home tele-
9 health technology.

10 “(vi) Varying payment to physicians
11 who order advanced diagnostic imaging
12 services (as defined in section
13 1834(e)(1)(B)) according to the physi-
14 cian’s adherence to appropriateness criteria
15 for the ordering of such services, as deter-
16 mined in consultation with physician spe-
17 cialty groups and other relevant stake-
18 holders.

19 “(vii) Utilizing medication therapy
20 management services, such as those de-
21 scribed in section 935 of the Public Health
22 Service Act.

23 “(viii) Establishing community-based
24 health teams to support small-practice
25 medical homes by assisting the primary

1 care practitioner in chronic care manage-
2 ment, including patient self-management,
3 activities.

4 “(ix) Assisting applicable individuals
5 in making informed health care choices by
6 paying providers of services and suppliers
7 for using patient decision-support tools, in-
8 cluding tools that meet the standards de-
9 veloped and identified under section
10 936(c)(2)(A) of the Public Health Service
11 Act, that improve applicable individual and
12 caregiver understanding of medical treat-
13 ment options.

14 “(x) Allowing States to test and
15 evaluate fully integrating care for dual eli-
16 gible individuals in the State, including the
17 management and oversight of all funds
18 under the applicable titles with respect to
19 such individuals.

20 “(xi) Allowing States to test and
21 evaluate systems of all-payer payment re-
22 form for the medical care of residents of
23 the State, including dual eligible individ-
24 uals.

1 “(xii) Aligning nationally recognized,
2 evidence-based guidelines of cancer care
3 with payment incentives under title XVIII
4 in the areas of treatment planning and fol-
5 low-up care planning for applicable individ-
6 uals described in clause (i) or (iii) of sub-
7 section (a)(4)(A) with cancer, including the
8 identification of gaps in applicable quality
9 measures.

10 “(xiii) Improving post-acute care
11 through continuing care hospitals that
12 offer inpatient rehabilitation, long-term
13 care hospitals, and home health or skilled
14 nursing care during an inpatient stay and
15 the 30 days immediately following dis-
16 charge.

17 “(xiv) Funding home health providers
18 who offer chronic care management serv-
19 ices to applicable individuals in cooperation
20 with interdisciplinary teams.

21 “(xv) Promoting improved quality and
22 reduced cost by developing a collaborative
23 of high-quality, low-cost health care insti-
24 tutions that is responsible for—

1 “(I) developing, documenting,
2 and disseminating best practices and
3 proven care methods;

4 “(II) implementing such best
5 practices and proven care methods
6 within such institutions to dem-
7 onstrate further improvements in
8 quality and efficiency; and

9 “(III) providing assistance to
10 other health care institutions on how
11 best to employ such best practices and
12 proven care methods to improve
13 health care quality and lower costs.

14 “(xvi) Facilitate inpatient care, in-
15 cluding intensive care, of hospitalized ap-
16 plicable individuals at their local hospital
17 through the use of electronic monitoring by
18 specialists, including intensivists and crit-
19 ical care specialists, based at integrated
20 health systems.

21 “(xvii) Promoting greater efficiencies
22 and timely access to outpatient services
23 (such as outpatient physical therapy serv-
24 ices) through models that do not require a
25 physician or other health professional to

1 refer the service or be involved in estab-
2 lishing the plan of care for the service,
3 when such service is furnished by a health
4 professional who has the authority to fur-
5 nish the service under existing State law.

6 “(xviii) Establishing comprehensive
7 payments to Healthcare Innovation Zones,
8 consisting of groups of providers that in-
9 clude a teaching hospital, physicians, and
10 other clinical entities, that, through their
11 structure, operations, and joint-activity de-
12 liver a full spectrum of integrated and
13 comprehensive health care services to ap-
14 plicable individuals while also incorporating
15 innovative methods for the clinical training
16 of future health care professionals.

17 “(C) ADDITIONAL FACTORS FOR CONSID-
18 ERATION.—In selecting models for testing
19 under subparagraph (A), the CMI may consider
20 the following additional factors:

21 “(i) Whether the model includes a
22 regular process for monitoring and updat-
23 ing patient care plans in a manner that is
24 consistent with the needs and preferences
25 of applicable individuals.

1 “(ii) Whether the model places the ap-
2 plicable individual, including family mem-
3 bers and other informal caregivers of the
4 applicable individual, at the center of the
5 care team of the applicable individual.

6 “(iii) Whether the model provides for
7 in-person contact with applicable individ-
8 uals.

9 “(iv) Whether the model utilizes tech-
10 nology, such as electronic health records
11 and patient-based remote monitoring sys-
12 tems, to coordinate care over time and
13 across settings.

14 “(v) Whether the model provides for
15 the maintenance of a close relationship be-
16 tween care coordinators, primary care
17 practitioners, specialist physicians, commu-
18 nity-based organizations, and other pro-
19 viders of services and suppliers.

20 “(vi) Whether the model relies on a
21 team-based approach to interventions, such
22 as comprehensive care assessments, care
23 planning, and self-management coaching.

24 “(vii) Whether, under the model, pro-
25 viders of services and suppliers are able to

1 share information with patients, caregivers,
2 and other providers of services and sup-
3 pliers on a real time basis.

4 “(3) BUDGET NEUTRALITY.—

5 “(A) INITIAL PERIOD.—The Secretary
6 shall not require, as a condition for testing a
7 model under paragraph (1), that the design of
8 such model ensure that such model is budget
9 neutral initially with respect to expenditures
10 under the applicable title.

11 “(B) TERMINATION OR MODIFICATION.—
12 The Secretary shall terminate or modify the de-
13 sign and implementation of a model unless the
14 Secretary determines (and the Chief Actuary of
15 the Centers for Medicare & Medicaid Services,
16 with respect to program spending under the ap-
17 plicable title, certifies), after testing has begun,
18 that the model is expected to—

19 “(i) improve the quality of care (as
20 determined by the Administrator of the
21 Centers for Medicare & Medicaid Services)
22 without increasing spending under the ap-
23 plicable title;

1 “(ii) reduce spending under the appli-
2 cable title without reducing the quality of
3 care; or

4 “(iii) improve the quality of care and
5 reduce spending.

6 Such termination may occur at any time after
7 such testing has begun and before completion of
8 the testing.

9 “(4) EVALUATION.—

10 “(A) IN GENERAL.—The Secretary shall
11 conduct an evaluation of each model tested
12 under this subsection. Such evaluation shall in-
13 clude an analysis of—

14 “(i) the quality of care furnished
15 under the model, including the measure-
16 ment of patient-level outcomes and patient-
17 centeredness criteria determined appro-
18 priate by the Secretary; and

19 “(ii) the changes in spending under
20 the applicable titles by reason of the
21 model.

22 “(B) INFORMATION.—The Secretary shall
23 make the results of each evaluation under this
24 paragraph available to the public in a timely
25 fashion and may establish requirements for

1 States and other entities participating in the
2 testing of models under this section to collect
3 and report information that the Secretary de-
4 termines is necessary to monitor and evaluate
5 such models.

6 “(c) EXPANSION OF MODELS (PHASE II).—Taking
7 into account the evaluation under subsection (b)(4), the
8 Secretary may, through rulemaking, expand (including im-
9 plementation on a nationwide basis) the duration and the
10 scope of a model that is being tested under subsection (b)
11 or a demonstration project under section 1866C, to the
12 extent determined appropriate by the Secretary, if—

13 “(1) the Secretary determines that such expan-
14 sion is expected to—

15 “(A) reduce spending under applicable title
16 without reducing the quality of care; or

17 “(B) improve the quality of care and re-
18 duce spending; and

19 “(2) the Chief Actuary of the Centers for Medi-
20 care & Medicaid Services certifies that such expan-
21 sion would reduce program spending under applica-
22 ble titles.

23 “(d) IMPLEMENTATION.—

24 “(1) WAIVER AUTHORITY.—The Secretary may
25 waive such requirements of titles XI and XVIII and

1 of sections 1902(a)(1), 1902(a)(13), and
2 1903(m)(2)(A)(iii) as may be necessary solely for
3 purposes of carrying out this section with respect to
4 testing models described in subsection (b).

5 “(2) LIMITATIONS ON REVIEW.—There shall be
6 no administrative or judicial review under section
7 1869, section 1878, or otherwise of—

8 “(A) the selection of models for testing or
9 expansion under this section;

10 “(B) the selection of organizations, sites,
11 or participants to test those models selected;

12 “(C) the elements, parameters, scope, and
13 duration of such models for testing or dissemi-
14 nation;

15 “(D) determinations regarding budget neu-
16 trality under subsection (b)(3);

17 “(E) the termination or modification of the
18 design and implementation of a model under
19 subsection (b)(3)(B); and

20 “(F) determinations about expansion of
21 the duration and scope of a model under sub-
22 section (c), including the determination that a
23 model is not expected to meet criteria described
24 in paragraph (1) or (2) of such subsection.

1 “(3) ADMINISTRATION.—Chapter 35 of title 44,
2 United States Code, shall not apply to the testing
3 and evaluation of models or expansion of such mod-
4 els under this section.

5 “(e) APPLICATION TO CHIP.—The Center may carry
6 out activities under this section with respect to title XXI
7 in the same manner as provided under this section with
8 respect to the program under the applicable titles.

9 “(f) FUNDING.—

10 “(1) IN GENERAL.—There are appropriated,
11 from amounts in the Treasury not otherwise appro-
12 priated—

13 “(A) \$5,000,000 for the design, implemen-
14 tation, and evaluation of models under sub-
15 section (b) for fiscal year 2010;

16 “(B) \$10,000,000,000 for the activities
17 initiated under this section for the period of fis-
18 cal years 2011 through 2019; and

19 “(C) the amount described in subpara-
20 graph (B) for the activities initiated under this
21 section for each subsequent 10-year fiscal pe-
22 riod (beginning with the 10-year fiscal period
23 beginning with fiscal year 2020).

24 Amounts appropriated under the preceding sentence
25 shall remain available until expended.

1 “(2) USE OF CERTAIN FUNDS.—Out of
2 amounts appropriated under subparagraphs (B) and
3 (C) of paragraph (1), not less than \$25,000,000
4 shall be made available each such fiscal year to de-
5 sign, implement, and evaluate models under sub-
6 section (b).

7 “(g) REPORT TO CONGRESS.—Beginning in 2012,
8 and not less than once every other year thereafter, the
9 Secretary shall submit to Congress a report on activities
10 under this section. Each such report shall describe the
11 models tested under subsection (b), including the number
12 of individuals described in subsection (a)(4)(A)(i) and of
13 individuals described in subsection (a)(4)(A)(ii) partici-
14 pating in such models and payments made under applica-
15 ble titles for services on behalf of such individuals, any
16 models chosen for expansion under subsection (c), and the
17 results from evaluations under subsection (b)(4). In addi-
18 tion, each such report shall provide such recommendations
19 as the Secretary determines are appropriate for legislative
20 action to facilitate the development and expansion of suc-
21 cessful payment models.”.

22 (b) MEDICAID CONFORMING AMENDMENT.—Section
23 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)),
24 as amended by section 8002(b), is amended—

1 (1) in paragraph (81), by striking “and” at the
2 end;

3 (2) in paragraph (82), by striking the period at
4 the end and inserting “; and”; and

5 (3) by inserting after paragraph (82) the fol-
6 lowing new paragraph:

7 “(83) provide for implementation of the pay-
8 ment models specified by the Secretary under section
9 1115A(c) for implementation on a nationwide basis
10 unless the State demonstrates to the satisfaction of
11 the Secretary that implementation would not be ad-
12 ministratively feasible or appropriate to the health
13 care delivery system of the State.”.

14 (c) REVISIONS TO HEALTH CARE QUALITY DEM-
15 ONSTRATION PROGRAM.—Subsections (b) and (f) of sec-
16 tion 1866C of the Social Security Act (42 U.S.C. 1395cc-
17 3) are amended by striking “5-year” each place it appears.

18 **SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.**

19 Title XVIII of the Social Security Act (42 U.S.C.
20 1395 et seq.) is amended by adding at the end the fol-
21 lowing new section:

22 “SHARED SAVINGS PROGRAM

23 “SEC. 1899. (a) ESTABLISHMENT.—

24 “(1) IN GENERAL.—Not later than January 1,
25 2012, the Secretary shall establish a shared savings
26 program (in this section referred to as the ‘pro-

1 gram') that promotes accountability for a patient
2 population and coordinates items and services under
3 parts A and B, and encourages investment in infra-
4 structure and redesigned care processes for high
5 quality and efficient service delivery. Under such
6 program—

7 “(A) groups of providers of services and
8 suppliers meeting criteria specified by the Sec-
9 retary may work together to manage and co-
10 ordinate care for Medicare fee-for-service bene-
11 ficiaries through an accountable care organiza-
12 tion (referred to in this section as an ‘ACO’);
13 and

14 “(B) ACOs that meet quality performance
15 standards established by the Secretary are eligi-
16 ble to receive payments for shared savings
17 under subsection (d)(2).

18 “(b) ELIGIBLE ACOs.—

19 “(1) IN GENERAL.—Subject to the succeeding
20 provisions of this subsection, as determined appro-
21 priate by the Secretary, the following groups of pro-
22 viders of services and suppliers which have estab-
23 lished a mechanism for shared governance are eligi-
24 ble to participate as ACOs under the program under
25 this section:

1 “(A) ACO professionals in group practice
2 arrangements.

3 “(B) Networks of individual practices of
4 ACO professionals.

5 “(C) Partnerships or joint venture ar-
6 rangements between hospitals and ACO profes-
7 sionals.

8 “(D) Hospitals employing ACO profes-
9 sionals.

10 “(E) Such other groups of providers of
11 services and suppliers as the Secretary deter-
12 mines appropriate.

13 “(2) REQUIREMENTS.—An ACO shall meet the
14 following requirements:

15 “(A) The ACO shall be willing to become
16 accountable for the quality, cost, and overall
17 care of the Medicare fee-for-service beneficiaries
18 assigned to it.

19 “(B) The ACO shall enter into an agree-
20 ment with the Secretary to participate in the
21 program for not less than a 3-year period (re-
22 ferred to in this section as the ‘agreement pe-
23 riod’).

24 “(C) The ACO shall have a formal legal
25 structure that would allow the organization to

1 receive and distribute payments for shared sav-
2 ings under subsection (d)(2) to participating
3 providers of services and suppliers.

4 “(D) The ACO shall include primary care
5 ACO professionals that are sufficient for the
6 number of Medicare fee-for-service beneficiaries
7 assigned to the ACO under subsection (c). At a
8 minimum, the ACO shall have at least 5,000
9 such beneficiaries assigned to it under sub-
10 section (c) in order to be eligible to participate
11 in the ACO program.

12 “(E) The ACO shall provide the Secretary
13 with such information regarding ACO profes-
14 sionals participating in the ACO as the Sec-
15 retary determines necessary to support the as-
16 signment of Medicare fee-for-service bene-
17 ficiaries to an ACO, the implementation of
18 quality and other reporting requirements under
19 paragraph (3), and the determination of pay-
20 ments for shared savings under subsection
21 (d)(2).

22 “(F) The ACO shall have in place a leader-
23 ship and management structure that includes
24 clinical and administrative systems.

1 “(G) The ACO shall define processes to
2 promote evidence-based medicine and patient
3 engagement, report on quality and cost meas-
4 ures, and coordinate care, such as through the
5 use of telehealth, remote patient monitoring,
6 and other such enabling technologies.

7 “(H) The ACO shall demonstrate to the
8 Secretary that it meets patient-centeredness cri-
9 teria specified by the Secretary, such as the use
10 of patient and caregiver assessments or the use
11 of individualized care plans.

12 “(3) QUALITY AND OTHER REPORTING RE-
13 QUIREMENTS.—

14 “(A) IN GENERAL.—The Secretary shall
15 determine appropriate measures to assess the
16 quality of care furnished by the ACO, such as
17 measures of—

18 “(i) clinical processes and outcomes;

19 “(ii) patient and, where practicable,
20 caregiver experience of care; and

21 “(iii) utilization (such as rates of hos-
22 pital admissions for ambulatory care sen-
23 sitive conditions).

24 “(B) REPORTING REQUIREMENTS.—An
25 ACO shall submit data in a form and manner

1 specified by the Secretary on measures the Sec-
2 retary determines necessary for the ACO to re-
3 port in order to evaluate the quality of care fur-
4 nished by the ACO. Such data may include care
5 transitions across health care settings, including
6 hospital discharge planning and post-hospital
7 discharge follow-up by ACO professionals, as
8 the Secretary determines appropriate.

9 “(C) QUALITY PERFORMANCE STAND-
10 ARDS.—The Secretary shall establish quality
11 performance standards to assess the quality of
12 care furnished by ACOs. The Secretary shall
13 seek to improve the quality of care furnished by
14 ACOs over time by specifying higher standards,
15 new measures, or both for purposes of assessing
16 such quality of care.

17 “(D) OTHER REPORTING REQUIRE-
18 MENTS.—The Secretary may, as the Secretary
19 determines appropriate, incorporate reporting
20 requirements and incentive payments related to
21 the physician quality reporting initiative
22 (PQRI) under section 1848, including such re-
23 quirements and such payments related to elec-
24 tronic prescribing, electronic health records,
25 and other similar initiatives under section 1848,

1 and may use alternative criteria than would
2 otherwise apply under such section for deter-
3 mining whether to make such payments. The
4 incentive payments described in the preceding
5 sentence shall not be taken into consideration
6 when calculating any payments otherwise made
7 under subsection (d).

8 “(4) NO DUPLICATION IN PARTICIPATION IN
9 SHARED SAVINGS PROGRAMS.—A provider of services
10 or supplier that participates in any of the following
11 shall not be eligible to participate in an ACO under
12 this section:

13 “(A) A model tested or expanded under
14 section 1115A that involves shared savings
15 under this title, or any other program or dem-
16 onstration project that involves such shared
17 savings.

18 “(B) The independence at home medical
19 practice pilot program under section 1866E.

20 “(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE
21 BENEFICIARIES TO ACOS.—The Secretary shall deter-
22 mine an appropriate method to assign Medicare fee-for-
23 service beneficiaries to an ACO based on their utilization
24 of primary care services provided under this title by an
25 ACO professional described in subsection (h)(1)(A).

1 “(d) PAYMENTS AND TREATMENT OF SAVINGS.—

2 “(1) PAYMENTS.—

3 “(A) IN GENERAL.—Under the program,
4 subject to paragraph (3), payments shall con-
5 tinue to be made to providers of services and
6 suppliers participating in an ACO under the
7 original Medicare fee-for-service program under
8 parts A and B in the same manner as they
9 would otherwise be made except that a partici-
10 pating ACO is eligible to receive payment for
11 shared savings under paragraph (2) if—

12 “(i) the ACO meets quality perform-
13 ance standards established by the Sec-
14 retary under subsection (b)(3); and

15 “(ii) the ACO meets the requirement
16 under subparagraph (B)(i).

17 “(B) SAVINGS REQUIREMENT AND BENCH-
18 MARK.—

19 “(i) DETERMINING SAVINGS.—In each
20 year of the agreement period, an ACO
21 shall be eligible to receive payment for
22 shared savings under paragraph (2) only if
23 the estimated average per capita Medicare
24 expenditures under the ACO for Medicare
25 fee-for-service beneficiaries for parts A and

1 B services, adjusted for beneficiary charac-
2 teristics, is at least the percent specified by
3 the Secretary below the applicable bench-
4 mark under clause (ii). The Secretary shall
5 determine the appropriate percent de-
6 scribed in the preceding sentence to ac-
7 count for normal variation in expenditures
8 under this title, based upon the number of
9 Medicare fee-for-service beneficiaries as-
10 signed to an ACO.

11 “(ii) ESTABLISH AND UPDATE
12 BENCHMARK.—The Secretary shall esti-
13 mate a benchmark for each agreement pe-
14 riod for each ACO using the most recent
15 available 3 years of per-beneficiary expend-
16 itures for parts A and B services for Medi-
17 care fee-for-service beneficiaries assigned
18 to the ACO. Such benchmark shall be ad-
19 justed for beneficiary characteristics and
20 such other factors as the Secretary deter-
21 mines appropriate and updated by the pro-
22 jected absolute amount of growth in na-
23 tional per capita expenditures for parts A
24 and B services under the original Medicare
25 fee-for-service program, as estimated by

1 the Secretary. Such benchmark shall be
2 reset at the start of each agreement pe-
3 riod.

4 “(2) PAYMENTS FOR SHARED SAVINGS.—Sub-
5 ject to performance with respect to the quality per-
6 formance standards established by the Secretary
7 under subsection (b)(3), if an ACO meets the re-
8 quirements under paragraph (1), a percent (as de-
9 termined appropriate by the Secretary) of the dif-
10 ference between such estimated average per capita
11 Medicare expenditures in a year, adjusted for bene-
12 ficiary characteristics, under the ACO and such
13 benchmark for the ACO may be paid to the ACO as
14 shared savings and the remainder of such difference
15 shall be retained by the program under this title.
16 The Secretary shall establish limits on the total
17 amount of shared savings that may be paid to an
18 ACO under this paragraph.

19 “(3) MONITORING AVOIDANCE OF AT-RISK PA-
20 TIENTS.—If the Secretary determines that an ACO
21 has taken steps to avoid patients at risk in order to
22 reduce the likelihood of increasing costs to the ACO
23 the Secretary may impose an appropriate sanction
24 on the ACO, including termination from the pro-
25 gram.

1 “(4) TERMINATION.—The Secretary may termi-
2 nate an agreement with an ACO if it does not meet
3 the quality performance standards established by the
4 Secretary under subsection (b)(3).

5 “(e) ADMINISTRATION.—Chapter 35 of title 44,
6 United States Code, shall not apply to the program.

7 “(f) WAIVER AUTHORITY.—The Secretary may waive
8 such requirements of sections 1128A and 1128B and title
9 XVIII of this Act as may be necessary to carry out the
10 provisions of this section.

11 “(g) LIMITATIONS ON REVIEW.—There shall be no
12 administrative or judicial review under section 1869, sec-
13 tion 1878, or otherwise of—

14 “(1) the specification of criteria under sub-
15 section (a)(1)(B);

16 “(2) the assessment of the quality of care fur-
17 nished by an ACO and the establishment of perform-
18 ance standards under subsection (b)(3);

19 “(3) the assignment of Medicare fee-for-service
20 beneficiaries to an ACO under subsection (c);

21 “(4) the determination of whether an ACO is
22 eligible for shared savings under subsection (d)(2)
23 and the amount of such shared savings, including
24 the determination of the estimated average per cap-
25 ita Medicare expenditures under the ACO for Medi-

1 care fee-for-service beneficiaries assigned to the ACO
2 and the average benchmark for the ACO under sub-
3 section (d)(1)(B);

4 “(5) the percent of shared savings specified by
5 the Secretary under subsection (d)(2) and any limit
6 on the total amount of shared savings established by
7 the Secretary under such subsection; and

8 “(6) the termination of an ACO under sub-
9 section (d)(4).

10 “(h) DEFINITIONS.—In this section:

11 “(1) ACO PROFESSIONAL.—The term ‘ACO
12 professional’ means—

13 “(A) a physician (as defined in section
14 1861(r)(1)); and

15 “(B) a practitioner described in section
16 1842(b)(18)(C)(i).

17 “(2) HOSPITAL.—The term ‘hospital’ means a
18 subsection (d) hospital (as defined in section
19 1886(d)(1)(B)).

20 “(3) MEDICARE FEE-FOR-SERVICE BENE-
21 FICIARY.—The term ‘Medicare fee-for-service bene-
22 ficiary’ means an individual who is enrolled in the
23 original Medicare fee-for-service program under
24 parts A and B and is not enrolled in an MA plan

1 under part C, an eligible organization under section
2 1876, or a PACE program under section 1894.”.

3 **SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUN-**
4 **DLING.**

5 Title XVIII of the Social Security Act, as amended
6 by section 3021, is amended by inserting after section
7 1886C the following new section:

8 “NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

9 “SEC. 1866D. (a) IMPLEMENTATION.—

10 “(1) IN GENERAL.—The Secretary shall estab-
11 lish a pilot program for integrated care during an
12 episode of care provided to an applicable beneficiary
13 around a hospitalization in order to improve the co-
14 ordination, quality, and efficiency of health care
15 services under this title.

16 “(2) DEFINITIONS.—In this section:

17 “(A) APPLICABLE BENEFICIARY.—The
18 term ‘applicable beneficiary’ means an indi-
19 vidual who—

20 “(i) is entitled to, or enrolled for, ben-
21 efits under part A and enrolled for benefits
22 under part B of such title, but not enrolled
23 under part C or a PACE program under
24 section 1894; and

25 “(ii) is admitted to a hospital for an
26 applicable condition.

1 “(B) APPLICABLE CONDITION.—The term
2 ‘applicable condition’ means 1 or more of 8 con-
3 ditions selected by the Secretary. In selecting
4 conditions under the preceding sentence, the
5 Secretary shall take into consideration the fol-
6 lowing factors:

7 “(i) Whether the conditions selected
8 include a mix of chronic and acute condi-
9 tions.

10 “(ii) Whether the conditions selected
11 include a mix of surgical and medical con-
12 ditions.

13 “(iii) Whether a condition is one for
14 which there is evidence of an opportunity
15 for providers of services and suppliers to
16 improve the quality of care furnished while
17 reducing total expenditures under this
18 title.

19 “(iv) Whether a condition has signifi-
20 cant variation in—

21 “(I) the number of readmissions;

22 and

23 “(II) the amount of expenditures
24 for post-acute care spending under
25 this title.

1 “(v) Whether a condition is high-vol-
2 ume and has high post-acute care expendi-
3 tures under this title.

4 “(vi) Which conditions the Secretary
5 determines are most amenable to bundling
6 across the spectrum of care given practice
7 patterns under this title.

8 “(C) APPLICABLE SERVICES.—The term
9 ‘applicable services’ means the following:

10 “(i) Acute care inpatient services.

11 “(ii) Physicians’ services delivered in
12 and outside of an acute care hospital set-
13 ting.

14 “(iii) Outpatient hospital services, in-
15 cluding emergency department services.

16 “(iv) Post-acute care services, includ-
17 ing home health services, skilled nursing
18 services, inpatient rehabilitation services,
19 and inpatient hospital services furnished by
20 a long-term care hospital.

21 “(v) Other services the Secretary de-
22 termines appropriate.

23 “(D) EPISODE OF CARE.—

24 “(i) IN GENERAL.—Subject to clause
25 (ii), the term ‘episode of care’ means, with

1 respect to an applicable condition and an
2 applicable beneficiary, the period that in-
3 cludes—

4 “(I) the 3 days prior to the ad-
5 mission of the applicable beneficiary
6 to a hospital for the applicable condi-
7 tion;

8 “(II) the length of stay of the ap-
9 plicable beneficiary in such hospital;
10 and

11 “(III) the 30 days following the
12 discharge of the applicable beneficiary
13 from such hospital.

14 “(ii) ESTABLISHMENT OF PERIOD BY
15 THE SECRETARY.—The Secretary, as ap-
16 propriate, may establish a period (other
17 than the period described in clause (i)) for
18 an episode of care under the pilot program.

19 “(E) PHYSICIANS’ SERVICES.—The term
20 ‘physicians’ services’ has the meaning given
21 such term in section 1861(q).

22 “(F) PILOT PROGRAM.—The term ‘pilot
23 program’ means the pilot program under this
24 section.

1 “(G) PROVIDER OF SERVICES.—The term
2 ‘provider of services’ has the meaning given
3 such term in section 1861(u).

4 “(H) READMISSION.—The term ‘readmis-
5 sion’ has the meaning given such term in sec-
6 tion 1886(q)(5)(E).

7 “(I) SUPPLIER.—The term ‘supplier’ has
8 the meaning given such term in section
9 1861(d).

10 “(3) DEADLINE FOR IMPLEMENTATION.—The
11 Secretary shall establish the pilot program not later
12 than January 1, 2013.

13 “(b) DEVELOPMENTAL PHASE.—

14 “(1) DETERMINATION OF PATIENT ASSESS-
15 MENT INSTRUMENT.—The Secretary shall determine
16 which patient assessment instrument (such as the
17 Continuity Assessment Record and Evaluation
18 (CARE) tool) shall be used under the pilot program
19 to evaluate the applicable condition of an applicable
20 beneficiary for purposes of determining the most
21 clinically appropriate site for the provision of post-
22 acute care to the applicable beneficiary.

23 “(2) DEVELOPMENT OF QUALITY MEASURES
24 FOR AN EPISODE OF CARE AND FOR POST-ACUTE
25 CARE.—

1 “(A) IN GENERAL.—The Secretary, in con-
2 sultation with the Agency for Healthcare Re-
3 search and Quality and the entity with a con-
4 tract under section 1890(a) of the Social Secu-
5 rity Act, shall develop quality measures for use
6 in the pilot program—

7 “(i) for episodes of care; and

8 “(ii) for post-acute care.

9 “(B) SITE-NEUTRAL POST-ACUTE CARE
10 QUALITY MEASURES.—Any quality measures
11 developed under subparagraph (A)(ii) shall be
12 site-neutral.

13 “(C) COORDINATION WITH QUALITY MEAS-
14 SURE DEVELOPMENT AND ENDORSEMENT PRO-
15 CEDURES.—The Secretary shall ensure that the
16 development of quality measures under sub-
17 paragraph (A) is done in a manner that is con-
18 sistent with the measures developed and en-
19 dorsed under section 1890 and 1890A that are
20 applicable to all post-acute care settings.

21 “(c) DETAILS.—

22 “(1) DURATION.—

23 “(A) IN GENERAL.—Subject to subpara-
24 graph (B), the pilot program shall be conducted
25 for a period of 5 years.

1 “(B) EXTENSION.—The Secretary may ex-
2 tend the duration of the pilot program for pro-
3 viders of services and suppliers participating in
4 the pilot program as of the day before the end
5 of the 5-year period described in subparagraph
6 (A), for a period determined appropriate by the
7 Secretary, if the Secretary determines that such
8 extension will result in improving or not reduc-
9 ing the quality of patient care and reducing
10 spending under this title.

11 “(2) PARTICIPATING PROVIDERS OF SERVICES
12 AND SUPPLIERS.—

13 “(A) IN GENERAL.—An entity comprised
14 of providers of services and suppliers, including
15 a hospital, a physician group, a skilled nursing
16 facility, and a home health agency, who are oth-
17 erwise participating under this title, may sub-
18 mit an application to the Secretary to provide
19 applicable services to applicable individuals
20 under this section.

21 “(B) REQUIREMENTS.—The Secretary
22 shall develop requirements for entities to par-
23 ticipate in the pilot program under this section.
24 Such requirements shall ensure that applicable
25 beneficiaries have an adequate choice of pro-

1 viders of services and suppliers under the pilot
2 program.

3 “(3) PAYMENT METHODOLOGY.—

4 “(A) IN GENERAL.—

5 “(i) ESTABLISHMENT OF PAYMENT
6 METHODS.—The Secretary shall develop
7 payment methods for the pilot program for
8 entities participating in the pilot program.
9 Such payment methods may include bun-
10 dled payments and bids from entities for
11 episodes of care. The Secretary shall make
12 payments to the entity for services covered
13 under this section.

14 “(ii) NO ADDITIONAL PROGRAM EX-
15 PENDITURES.—Payments under this sec-
16 tion for applicable items and services under
17 this title (including payment for services
18 described in subparagraph (B)) for appli-
19 cable beneficiaries for a year shall be es-
20 tablished in a manner that does not result
21 in spending more for such entity for such
22 beneficiaries than would otherwise be ex-
23 pended for such entity for such bene-
24 ficiaries for such year if the pilot program

1 were not implemented, as estimated by the
2 Secretary.

3 “(B) INCLUSION OF CERTAIN SERVICES.—
4 A payment methodology tested under the pilot
5 program shall include payment for the fur-
6 nishing of applicable services and other appro-
7 priate services, such as care coordination, medi-
8 cation reconciliation, discharge planning, transi-
9 tional care services, and other patient-centered
10 activities as determined appropriate by the Sec-
11 retary.

12 “(C) BUNDLED PAYMENTS.—

13 “(i) IN GENERAL.—A bundled pay-
14 ment under the pilot program shall—

15 “(I) be comprehensive, covering
16 the costs of applicable services and
17 other appropriate services furnished to
18 an individual during an episode of
19 care (as determined by the Secretary);
20 and

21 “(II) be made to the entity which
22 is participating in the pilot program.

23 “(ii) REQUIREMENT FOR PROVISION
24 OF APPLICABLE SERVICES AND OTHER AP-
25 PROPRIATE SERVICES.—Applicable services

1 and other appropriate services for which
2 payment is made under this subparagraph
3 shall be furnished or directed by the entity
4 which is participating in the pilot program.

5 “(D) PAYMENT FOR POST-ACUTE CARE
6 SERVICES AFTER THE EPISODE OF CARE.—The
7 Secretary shall establish procedures, in the case
8 where an applicable beneficiary requires contin-
9 ued post-acute care services after the last day
10 of the episode of care, under which payment for
11 such services shall be made.

12 “(4) QUALITY MEASURES.—

13 “(A) IN GENERAL.—The Secretary shall
14 establish quality measures (including quality
15 measures of process, outcome, and structure)
16 related to care provided by entities participating
17 in the pilot program. Quality measures estab-
18 lished under the preceding sentence shall in-
19 clude measures of the following:

20 “(i) Functional status improvement.

21 “(ii) Reducing rates of avoidable hos-
22 pital readmissions.

23 “(iii) Rates of discharge to the com-
24 munity.

1 “(iv) Rates of admission to an emer-
2 gency room after a hospitalization.

3 “(v) Incidence of health care acquired
4 infections.

5 “(vi) Efficiency measures.

6 “(vii) Measures of patient-
7 centeredness of care.

8 “(viii) Measures of patient perception
9 of care.

10 “(ix) Other measures, including meas-
11 ures of patient outcomes, determined ap-
12 propriate by the Secretary.

13 “(B) REPORTING ON QUALITY MEAS-
14 URES.—

15 “(i) IN GENERAL.—A entity shall sub-
16 mit data to the Secretary on quality meas-
17 ures established under subparagraph (A)
18 during each year of the pilot program (in
19 a form and manner, subject to clause (iii),
20 specified by the Secretary).

21 “(ii) SUBMISSION OF DATA THROUGH
22 ELECTRONIC HEALTH RECORD.—To the
23 extent practicable, the Secretary shall
24 specify that data on measures be sub-
25 mitted under clause (i) through the use of

1 an qualified electronic health record (as de-
2 fined in section 3000(13) of the Public
3 Health Service Act (42 U.S.C. 300jj-
4 11(13)) in a manner specified by the Sec-
5 retary.

6 “(d) WAIVER.—The Secretary may waive such provi-
7 sions of this title and title XI as may be necessary to carry
8 out the pilot program.

9 “(e) INDEPENDENT EVALUATION AND REPORTS ON
10 PILOT PROGRAM.—

11 “(1) INDEPENDENT EVALUATION.—The Sec-
12 retary shall conduct an independent evaluation of
13 the pilot program, including the extent to which the
14 pilot program has—

15 “(A) improved quality measures estab-
16 lished under subsection (c)(4)(A);

17 “(B) improved health outcomes;

18 “(C) improved applicable beneficiary access
19 to care; and

20 “(D) reduced spending under this title.

21 “(2) REPORTS.—

22 “(A) INTERIM REPORT.—Not later than 2
23 years after the implementation of the pilot pro-
24 gram, the Secretary shall submit to Congress a

1 report on the initial results of the independent
2 evaluation conducted under paragraph (1).

3 “(B) FINAL REPORT.—Not later than 3
4 years after the implementation of the pilot pro-
5 gram, the Secretary shall submit to Congress a
6 report on the final results of the independent
7 evaluation conducted under paragraph (1).

8 “(f) CONSULTATION.—The Secretary shall consult
9 with representatives of small rural hospitals, including
10 critical access hospitals (as defined in section
11 1861(mm)(1)), regarding their participation in the pilot
12 program. Such consultation shall include consideration of
13 innovative methods of implementing bundled payments in
14 hospitals described in the preceding sentence, taking into
15 consideration any difficulties in doing so as a result of the
16 low volume of services provided by such hospitals.

17 “(g) IMPLEMENTATION PLAN.—

18 “(1) IN GENERAL.—Not later than January 1,
19 2016, the Secretary shall submit a plan for the im-
20 plementation of an expansion of the pilot program if
21 the Secretary determines that such expansion will
22 result in improving or not reducing the quality of
23 patient care and reducing spending under this title.

24 “(h) ADMINISTRATION.—Chapter 35 of title 44,
25 United States Code, shall not apply to the selection, test-

1 ing, and evaluation of models or the expansion of such
2 models under this section.”.

3 **SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION**
4 **PROGRAM.**

5 Title XVIII of the Social Security Act is amended by
6 inserting after section 1866D, as inserted by section 3023,
7 the following new section:

8 “INDEPENDENCE AT HOME MEDICAL PRACTICE
9 DEMONSTRATION PROGRAM

10 “SEC. 1866D. (a) ESTABLISHMENT.—

11 “(1) IN GENERAL.—The Secretary shall con-
12 duct a demonstration program (in this section re-
13 ferred to as the ‘demonstration program’) to test a
14 payment incentive and service delivery model that
15 utilizes physician and nurse practitioner directed
16 home-based primary care teams designed to reduce
17 expenditures and improve health outcomes in the
18 provision of items and services under this title to ap-
19 plicable beneficiaries (as defined in subsection (d)).

20 “(2) REQUIREMENT.—The demonstration pro-
21 gram shall test whether a model described in para-
22 graph (1), which is accountable for providing com-
23 prehensive, coordinated, continuous, and accessible
24 care to high-need populations at home and coordi-
25 nating health care across all treatment settings, re-
26 sults in—

1 “(A) reducing preventable hospitalizations;

2 “(B) preventing hospital readmissions;

3 “(C) reducing emergency room visits;

4 “(D) improving health outcomes commensurate with the beneficiaries’ stage of chronic illness;

7 “(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

10 “(F) reducing the cost of health care services covered under this title; and

12 “(G) achieving beneficiary and family caregiver satisfaction.

14 “(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

16 “(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

18 “(A) IN GENERAL.—The term ‘independence at home medical practice’ means a legal entity that—

21 “(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assist-

1 ants, pharmacists, and other health and
2 social services staff as appropriate who
3 have experience providing home-based pri-
4 mary care to applicable beneficiaries, make
5 in-home visits, and are available 24 hours
6 per day, 7 days per week to carry out
7 plans of care that are tailored to the indi-
8 vidual beneficiary’s chronic conditions and
9 designed to achieve the results in sub-
10 section (a);

11 “(ii) is organized at least in part for
12 the purpose of providing physicians’ serv-
13 ices;

14 “(iii) has documented experience in
15 providing home-based primary care serv-
16 ices to high-cost chronically ill bene-
17 ficiaries, as determined appropriate by the
18 Secretary;

19 “(iv) furnishes services to at least 200
20 applicable beneficiaries (as defined in sub-
21 section (d)) during each year of the dem-
22 onstration program;

23 “(v) has entered into an agreement
24 with the Secretary;

1 “(vi) uses electronic health informa-
2 tion systems, remote monitoring, and mo-
3 bile diagnostic technology; and

4 “(vii) meets such other criteria as the
5 Secretary determines to be appropriate to
6 participate in the demonstration program.

7 The entity shall report on quality measures (in
8 such form, manner, and frequency as specified
9 by the Secretary, which may be for the group,
10 for providers of services and suppliers, or both)
11 and report to the Secretary (in a form, manner,
12 and frequency as specified by the Secretary)
13 such data as the Secretary determines appro-
14 priate to monitor and evaluate the demonstra-
15 tion program.

16 “(B) PHYSICIAN.—The term ‘physician’ in-
17 cludes, except as the Secretary may otherwise
18 provide, any individual who furnishes services
19 for which payment may be made as physicians’
20 services and has the medical training or experi-
21 ence to fulfill the physician’s role described in
22 subparagraph (A)(i).

23 “(2) PARTICIPATION OF NURSE PRACTITIONERS
24 AND PHYSICIAN ASSISTANTS.—Nothing in this sec-
25 tion shall be construed to prevent a nurse practi-

1 tioner or physician assistant from participating in,
2 or leading, a home-based primary care team as part
3 of an independence at home medical practice if—

4 “(A) all the requirements of this section
5 are met;

6 “(B) the nurse practitioner or physician
7 assistant, as the case may be, is acting con-
8 sistent with State law; and

9 “(C) the nurse practitioner or physician
10 assistant has the medical training or experience
11 to fulfill the nurse practitioner or physician as-
12 sistant role described in paragraph (1)(A)(i).

13 “(3) INCLUSION OF PROVIDERS AND PRACTI-
14 TIONERS.—Nothing in this subsection shall be con-
15 strued as preventing an independence at home med-
16 ical practice from including a provider of services or
17 a participating practitioner described in section
18 1842(b)(18)(C) that is affiliated with the practice
19 under an arrangement structured so that such pro-
20 vider of services or practitioner participates in the
21 demonstration program and shares in any savings
22 under the demonstration program.

23 “(4) QUALITY AND PERFORMANCE STAND-
24 ARDS.—The Secretary shall develop quality perform-
25 ance standards for independence at home medical

1 practices participating in the demonstration pro-
2 gram.

3 “(c) PAYMENT METHODOLOGY.—

4 “(1) ESTABLISHMENT OF TARGET SPENDING
5 LEVEL.—The Secretary shall establish an estimated
6 annual spending target, for the amount the Sec-
7 retary estimates would have been spent in the ab-
8 sence of the demonstration, for items and services
9 covered under parts A and B furnished to applicable
10 beneficiaries for each qualifying independence at
11 home medical practice under this section. Such
12 spending targets shall be determined on a per capita
13 basis. Such spending targets shall include a risk cor-
14 ridor that takes into account normal variation in ex-
15 penditures for items and services covered under
16 parts A and B furnished to such beneficiaries with
17 the size of the corridor being related to the number
18 of applicable beneficiaries furnished services by each
19 independence at home medical practice. The spend-
20 ing targets may also be adjusted for other factors as
21 the Secretary determines appropriate.

22 “(2) INCENTIVE PAYMENTS.—Subject to per-
23 formance on quality measures, a qualifying inde-
24 pendence at home medical practice is eligible to re-
25 ceive an incentive payment under this section if ac-

1 tual expenditures for a year for the applicable bene-
2 ficiaries it enrolls are less than the estimated spend-
3 ing target established under paragraph (1) for such
4 year. An incentive payment for such year shall be
5 equal to a portion (as determined by the Secretary)
6 of the amount by which actual expenditures (includ-
7 ing incentive payments under this paragraph) for
8 applicable beneficiaries under parts A and B for
9 such year are estimated to be less than 5 percent
10 less than the estimated spending target for such
11 year, as determined under paragraph (1).

12 “(d) APPLICABLE BENEFICIARIES.—

13 “(1) DEFINITION.—In this section, the term
14 ‘applicable beneficiary’ means, with respect to a
15 qualifying independence at home medical practice,
16 an individual who the practice has determined—

17 “(A) is entitled to benefits under part A
18 and enrolled for benefits under part B;

19 “(B) is not enrolled in a Medicare Advan-
20 tage plan under part C or a PACE program
21 under section 1894;

22 “(C) has 2 or more chronic illnesses, such
23 as congestive heart failure, diabetes, other de-
24 mentias designated by the Secretary, chronic
25 obstructive pulmonary disease, ischemic heart

1 disease, stroke, Alzheimer's Disease and
2 neurodegenerative diseases, and other diseases
3 and conditions designated by the Secretary
4 which result in high costs under this title;

5 “(D) within the past 12 months has had a
6 nonelective hospital admission;

7 “(E) within the past 12 months has re-
8 ceived acute or subacute rehabilitation services;

9 “(F) has 2 or more functional depend-
10 encies requiring the assistance of another per-
11 son (such as bathing, dressing, toileting, walk-
12 ing, or feeding); and

13 “(G) meets such other criteria as the Sec-
14 retary determines appropriate.

15 “(2) PATIENT ELECTION TO PARTICIPATE.—

16 The Secretary shall determine an appropriate meth-
17 od of ensuring that applicable beneficiaries have
18 agreed to enroll in an independence at home medical
19 practice under the demonstration program. Enroll-
20 ment in the demonstration program shall be vol-
21 untary.

22 “(3) BENEFICIARY ACCESS TO SERVICES.—

23 Nothing in this section shall be construed as encour-
24 aging physicians or nurse practitioners to limit ap-
25 plicable beneficiary access to services covered under

1 this title and applicable beneficiaries shall not be re-
2 quired to relinquish access to any benefit under this
3 title as a condition of receiving services from an
4 independence at home medical practice.

5 “(e) IMPLEMENTATION.—

6 “(1) STARTING DATE.—The demonstration pro-
7 gram shall begin no later than January 1, 2012. An
8 agreement with an independence at home medical
9 practice under the demonstration program may
10 cover not more than a 3-year period.

11 “(2) NO PHYSICIAN DUPLICATION IN DEM-
12 ONSTRATION PARTICIPATION.—The Secretary shall
13 not pay an independence at home medical practice
14 under this section that participates in section 1899.

15 “(3) NO BENEFICIARY DUPLICATION IN DEM-
16 ONSTRATION PARTICIPATION.—The Secretary shall
17 ensure that no applicable beneficiary enrolled in an
18 independence at home medical practice under this
19 section is participating in the programs under sec-
20 tion 1899.

21 “(4) PREFERENCE.—In approving an independ-
22 ence at home medical practice, the Secretary shall
23 give preference to practices that are—

24 “(A) located in high-cost areas of the
25 country;

1 “(B) have experience in furnishing health
2 care services to applicable beneficiaries in the
3 home; and

4 “(C) use electronic medical records, health
5 information technology, and individualized plans
6 of care.

7 “(5) LIMITATION ON NUMBER OF PRACTICES.—
8 In selecting qualified independence at home medical
9 practices to participate under the demonstration pro-
10 gram, the Secretary shall limit the number of such
11 practices so that the number of applicable bene-
12 ficiaries that may participate in the demonstration
13 program does not exceed 10,000.

14 “(6) WAIVER.—The Secretary may waive such
15 provisions of this title and title XI as the Secretary
16 determines necessary in order to implement the dem-
17 onstration program.

18 “(7) ADMINISTRATION.—Chapter 35 of title 44,
19 United States Code, shall not apply to this section.

20 “(f) EVALUATION AND MONITORING.—

21 “(1) IN GENERAL.—The Secretary shall evalu-
22 ate each independence at home medical practice
23 under the demonstration program to assess whether
24 the practice achieved the results described in sub-
25 section (a).

1 “(2) MONITORING APPLICABLE BENE-
2 FICIARIES.—The Secretary may monitor data on ex-
3 penditures and quality of services under this title
4 after an applicable beneficiary discontinues receiving
5 services under this title through a qualifying inde-
6 pendence at home medical practice.

7 “(g) REPORTS TO CONGRESS.—The Secretary shall
8 conduct an independent evaluation of the demonstration
9 program and submit to Congress a final report, including
10 best practices under the demonstration program. Such re-
11 port shall include an analysis of the demonstration pro-
12 gram on coordination of care, expenditures under this
13 title, applicable beneficiary access to services, and the
14 quality of health care services provided to applicable bene-
15 ficiaries.

16 “(h) FUNDING.—For purposes of administering and
17 carrying out the demonstration program, other than for
18 payments for items and services furnished under this title
19 and incentive payments under subsection (c), in addition
20 to funds otherwise appropriated, there shall be transferred
21 to the Secretary for the Center for Medicare & Medicaid
22 Services Program Management Account from the Federal
23 Hospital Insurance Trust Fund under section 1817 and
24 the Federal Supplementary Medical Insurance Trust
25 Fund under section 1841 (in proportions determined ap-

1 appropriate by the Secretary) \$5,000,000 for each of fiscal
 2 years 2010 through 2015. Amounts transferred under this
 3 subsection for a fiscal year shall be available until ex-
 4 pended.

5 “(i) TERMINATION.—

6 “(1) MANDATORY TERMINATION.—The Sec-
 7 retary shall terminate an agreement with an inde-
 8 pendence at home medical practice if—

9 “(A) the Secretary estimates or determines
 10 that such practice will not receive an incentive
 11 payment for the second of 2 consecutive years
 12 under the demonstration program; or

13 “(B) such practice fails to meet quality
 14 standards during any year of the demonstration
 15 program.

16 “(2) PERMISSIVE TERMINATION.—The Sec-
 17 retary may terminate an agreement with an inde-
 18 pendence at home medical practice for such other
 19 reasons determined appropriate by the Secretary.”.

20 **SEC. 3025. HOSPITAL READMISSIONS REDUCTION PRO-**
 21 **GRAM.**

22 (a) IN GENERAL.—Section 1886 of the Social Secu-
 23 rity Act (42 U.S.C. 1395ww), as amended by sections
 24 3001 and 3008, is amended by adding at the end the fol-
 25 lowing new subsection:

1 “(q) HOSPITAL READMISSIONS REDUCTION PRO-
2 GRAM.—

3 “(1) IN GENERAL.—With respect to payment
4 for discharges from an applicable hospital (as de-
5 fined in paragraph (5)(C)) occurring during a fiscal
6 year beginning on or after October 1, 2012, in order
7 to account for excess readmissions in the hospital,
8 the Secretary shall reduce the payments that would
9 otherwise be made to such hospital under subsection
10 (d) (or section 1814(b)(3), as the case may be) for
11 such a discharge by an amount equal to the product
12 of—

13 “(A) the base operating DRG payment
14 amount (as defined in paragraph (2)) for the
15 discharge; and

16 “(B) the adjustment factor (described in
17 paragraph (3)(A)) for the hospital for the fiscal
18 year.

19 “(2) BASE OPERATING DRG PAYMENT AMOUNT
20 DEFINED.—

21 “(A) IN GENERAL.—Except as provided in
22 subparagraph (B), in this subsection, the term
23 ‘base operating DRG payment amount’ means,
24 with respect to a hospital for a fiscal year—

1 “(i) the payment amount that would
2 otherwise be made under subsection (d)
3 (determined without regard to subsection
4 (o)) for a discharge if this subsection did
5 not apply; reduced by

6 “(ii) any portion of such payment
7 amount that is attributable to payments
8 under paragraphs (5)(A), (5)(B), (5)(F),
9 and (12) of subsection (d).

10 “(B) SPECIAL RULES FOR CERTAIN HOS-
11 PITALS.—

12 “(i) SOLE COMMUNITY HOSPITALS
13 AND MEDICARE-DEPENDENT, SMALL
14 RURAL HOSPITALS.—In the case of a medi-
15 care-dependent, small rural hospital (with
16 respect to discharges occurring during fis-
17 cal years 2012 and 2013) or a sole com-
18 munity hospital, in applying subparagraph
19 (A)(i), the payment amount that would
20 otherwise be made under subsection (d)
21 shall be determined without regard to sub-
22 paragraphs (I) and (L) of subsection
23 (b)(3) and subparagraphs (D) and (G) of
24 subsection (d)(5).

1 “(ii) HOSPITALS PAID UNDER SEC-
2 TION 1814.—In the case of a hospital that
3 is paid under section 1814(b)(3), the Sec-
4 retary may exempt such hospitals provided
5 that States paid under such section submit
6 an annual report to the Secretary describ-
7 ing how a similar program in the State for
8 a participating hospital or hospitals
9 achieves or surpasses the measured results
10 in terms of patient health outcomes and
11 cost savings established herein with respect
12 to this section.

13 “(3) ADJUSTMENT FACTOR.—

14 “(A) IN GENERAL.—For purposes of para-
15 graph (1), the adjustment factor under this
16 paragraph for an applicable hospital for a fiscal
17 year is equal to the greater of—

18 “(i) the ratio described in subpara-
19 graph (B) for the hospital for the applica-
20 ble period (as defined in paragraph (5)(D))
21 for such fiscal year; or

22 “(ii) the floor adjustment factor speci-
23 fied in subparagraph (C).

1 “(B) RATIO.—The ratio described in this
2 subparagraph for a hospital for an applicable
3 period is equal to 1 minus the ratio of—

4 “(i) the aggregate payments for ex-
5 cess readmissions (as defined in paragraph
6 (4)(A)) with respect to an applicable hos-
7 pital for the applicable period; and

8 “(ii) the aggregate payments for all
9 discharges (as defined in paragraph
10 (4)(B)) with respect to such applicable
11 hospital for such applicable period.

12 “(C) FLOOR ADJUSTMENT FACTOR.—For
13 purposes of subparagraph (A), the floor adjust-
14 ment factor specified in this subparagraph
15 for—

16 “(i) fiscal year 2013 is 0.99;

17 “(ii) fiscal year 2014 is 0.98; or

18 “(iii) fiscal year 2015 and subsequent
19 fiscal years is 0.97.

20 “(4) AGGREGATE PAYMENTS, EXCESS READMIS-
21 SION RATIO DEFINED.—For purposes of this sub-
22 section:

23 “(A) AGGREGATE PAYMENTS FOR EXCESS
24 READMISSIONS.—The term ‘aggregate payments
25 for excess readmissions’ means, for a hospital

1 for an applicable period, the sum, for applicable
2 conditions (as defined in paragraph (5)(A)), of
3 the product, for each applicable condition, of—

4 “(i) the base operating DRG payment
5 amount for such hospital for such applica-
6 ble period for such condition;

7 “(ii) the number of admissions for
8 such condition for such hospital for such
9 applicable period; and

10 “(iii) the excess readmissions ratio (as
11 defined in subparagraph (C)) for such hos-
12 pital for such applicable period minus 1.

13 “(B) AGGREGATE PAYMENTS FOR ALL DIS-
14 CHARGES.—The term ‘aggregate payments for
15 all discharges’ means, for a hospital for an ap-
16 plicable period, the sum of the base operating
17 DRG payment amounts for all discharges for
18 all conditions from such hospital for such appli-
19 cable period.

20 “(C) EXCESS READMISSION RATIO.—

21 “(i) IN GENERAL.—Subject to clause
22 (ii), the term ‘excess readmissions ratio’
23 means, with respect to an applicable condi-
24 tion for a hospital for an applicable period,
25 the ratio (but not less than 1.0) of—

1 “(I) the risk adjusted readmis-
2 sions based on actual readmissions, as
3 determined consistent with a readmis-
4 sion measure methodology that has
5 been endorsed under paragraph
6 (5)(A)(ii)(I), for an applicable hospital
7 for such condition with respect to
8 such applicable period; to

9 “(II) the risk adjusted expected
10 readmissions (as determined con-
11 sistent with such a methodology) for
12 such hospital for such condition with
13 respect to such applicable period.

14 “(ii) EXCLUSION OF CERTAIN RE-
15 ADMISSIONS.—For purposes of clause (i),
16 with respect to a hospital, excess readmis-
17 sions shall not include readmissions for an
18 applicable condition for which there are
19 fewer than a minimum number (as deter-
20 mined by the Secretary) of discharges for
21 such applicable condition for the applicable
22 period and such hospital.

23 “(5) DEFINITIONS.—For purposes of this sub-
24 section:

1 “(A) APPLICABLE CONDITION.—The term
2 ‘applicable condition’ means, subject to sub-
3 paragraph (B), a condition or procedure se-
4 lected by the Secretary among conditions and
5 procedures for which—

6 “(i) readmissions (as defined in sub-
7 paragraph (E)) that represent conditions
8 or procedures that are high volume or high
9 expenditures under this title (or other cri-
10 teria specified by the Secretary); and

11 “(ii) measures of such readmissions—

12 “(I) have been endorsed by the
13 entity with a contract under section
14 1890(a); and

15 “(II) such endorsed measures
16 have exclusions for readmissions that
17 are unrelated to the prior discharge
18 (such as a planned readmission or
19 transfer to another applicable hos-
20 pital).

21 “(B) EXPANSION OF APPLICABLE CONDI-
22 TIONS.—Beginning with fiscal year 2015, the
23 Secretary shall, to the extent practicable, ex-
24 pand the applicable conditions beyond the 3
25 conditions for which measures have been en-

1 dorsed as described in subparagraph (A)(ii)(I)
2 as of the date of the enactment of this sub-
3 section to the additional 4 conditions that have
4 been identified by the Medicare Payment Advi-
5 sory Commission in its report to Congress in
6 June 2007 and to other conditions and proce-
7 dures as determined appropriate by the Sec-
8 retary. In expanding such applicable conditions,
9 the Secretary shall seek the endorsement de-
10 scribed in subparagraph (A)(ii)(I) but may
11 apply such measures without such an endorse-
12 ment in the case of a specified area or medical
13 topic determined appropriate by the Secretary
14 for which a feasible and practical measure has
15 not been endorsed by the entity with a contract
16 under section 1890(a) as long as due consider-
17 ation is given to measures that have been en-
18 dorsed or adopted by a consensus organization
19 identified by the Secretary.

20 “(C) APPLICABLE HOSPITAL.—The term
21 ‘applicable hospital’ means a subsection (d) hos-
22 pital or a hospital that is paid under section
23 1814(b)(3), as the case may be.

1 “(D) APPLICABLE PERIOD.—The term ‘ap-
2 plicable period’ means, with respect to a fiscal
3 year, such period as the Secretary shall specify.

4 “(E) READMISSION.—The term ‘readmis-
5 sion’ means, in the case of an individual who is
6 discharged from an applicable hospital, the ad-
7 mission of the individual to the same or another
8 applicable hospital within a time period speci-
9 fied by the Secretary from the date of such dis-
10 charge. Insofar as the discharge relates to an
11 applicable condition for which there is an en-
12 dorsed measure described in subparagraph
13 (A)(ii)(I), such time period (such as 30 days)
14 shall be consistent with the time period speci-
15 fied for such measure.

16 “(6) REPORTING HOSPITAL SPECIFIC INFORMA-
17 TION.—

18 “(A) IN GENERAL.—The Secretary shall
19 make information available to the public re-
20 garding readmission rates of each subsection
21 (d) hospital under the program.

22 “(B) OPPORTUNITY TO REVIEW AND SUB-
23 MIT CORRECTIONS.—The Secretary shall ensure
24 that a subsection (d) hospital has the oppor-
25 tunity to review, and submit corrections for, the

1 information to be made public with respect to
2 the hospital under subparagraph (A) prior to
3 such information being made public.

4 “(C) WEBSITE.—Such information shall be
5 posted on the Hospital Compare Internet
6 website in an easily understandable format.

7 “(7) LIMITATIONS ON REVIEW.—There shall be
8 no administrative or judicial review under section
9 1869, section 1878, or otherwise of the following:

10 “(A) The determination of base operating
11 DRG payment amounts.

12 “(B) The methodology for determining the
13 adjustment factor under paragraph (3), includ-
14 ing excess readmissions ratio under paragraph
15 (4)(C), aggregate payments for excess readmis-
16 sions under paragraph (4)(A), and aggregate
17 payments for all discharges under paragraph
18 (4)(B), and applicable periods and applicable
19 conditions under paragraph (5).

20 “(C) The measures of readmissions as de-
21 scribed in paragraph (5)(A)(ii).

22 “(8) READMISSION RATES FOR ALL PA-
23 TIENTS.—

24 “(A) CALCULATION OF READMISSION.—
25 The Secretary shall calculate readmission rates

1 for all patients (as defined in subparagraph
2 (D)) for a specified hospital (as defined in sub-
3 paragraph (D)(ii)) for an applicable condition
4 (as defined in paragraph (5)(B)) and other con-
5 ditions deemed appropriate by the Secretary for
6 an applicable period (as defined in paragraph
7 (5)(D)) in the same manner as used to cal-
8 culate such readmission rates for hospitals with
9 respect to this title and posted on the CMS
10 Hospital Compare website.

11 “(B) POSTING OF HOSPITAL SPECIFIC ALL
12 PATIENT READMISSION RATES.—The Secretary
13 shall make information on all patient readmis-
14 sion rates calculated under subparagraph (A)
15 available on the CMS Hospital Compare website
16 in a form and manner determined appropriate
17 by the Secretary. The Secretary may also make
18 other information determined appropriate by
19 the Secretary available on such website.

20 “(C) HOSPITAL SUBMISSION OF ALL PA-
21 TIENT DATA.—

22 “(i) Except as provided for in clause
23 (ii), each specified hospital (as defined in
24 subparagraph (D)(ii)) shall submit to the
25 Secretary, in a form, manner and time

1 specified by the Secretary, data and infor-
2 mation determined necessary by the Sec-
3 retary for the Secretary to calculate the all
4 patient readmission rates described in sub-
5 paragraph (A).

6 “(ii) Instead of a specified hospital
7 submitting to the Secretary the data and
8 information described in clause (i), such
9 data and information may be submitted to
10 the Secretary, on behalf of such a specified
11 hospital, by a state or an entity determined
12 appropriate by the Secretary.

13 “(D) DEFINITIONS.—For purposes of this
14 paragraph:

15 “(i) The term ‘all patients’ means pa-
16 tients who are treated on an inpatient
17 basis and discharged from a specified hos-
18 pital (as defined in clause (ii)).

19 “(ii) The term ‘specified hospital’
20 means a subsection (d) hospital, hospitals
21 described in clauses (i) through (v) of sub-
22 section (d)(1)(B) and, as determined fea-
23 sible and appropriate by the Secretary,
24 other hospitals not otherwise described in
25 this subparagraph.”.

1 (b) QUALITY IMPROVEMENT.—Part S of title III of
2 the Public Health Service Act, as amended by section
3 3015, is further amended by adding at the end the fol-
4 lowing:

5 **“SEC. 399KK. QUALITY IMPROVEMENT PROGRAM FOR HOS-**
6 **PITALS WITH A HIGH SEVERITY ADJUSTED**
7 **READMISSION RATE.**

8 “(a) ESTABLISHMENT.—

9 “(1) IN GENERAL.—Not later than 2 years
10 after the date of enactment of this section, the Sec-
11 retary shall make available a program for eligible
12 hospitals to improve their readmission rates through
13 the use of patient safety organizations (as defined in
14 section 921(4)).

15 “(2) ELIGIBLE HOSPITAL DEFINED.—In this
16 subsection, the term ‘eligible hospital’ means a hos-
17 pital that the Secretary determines has a high rate
18 of risk adjusted readmissions for the conditions de-
19 scribed in section 1886(q)(8)(A) of the Social Secu-
20 rity Act and has not taken appropriate steps to re-
21 duce such readmissions and improve patient safety
22 as evidenced through historically high rates of re-
23 admissions, as determined by the Secretary.

1 “(3) RISK ADJUSTMENT.—The Secretary shall
2 utilize appropriate risk adjustment measures to de-
3 termine eligible hospitals.

4 “(b) REPORT TO THE SECRETARY.—As determined
5 appropriate by the Secretary, eligible hospitals and patient
6 safety organizations working with those hospitals shall re-
7 port to the Secretary on the processes employed by the
8 hospital to improve readmission rates and the impact of
9 such processes on readmission rates.”.

10 **SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PRO-**
11 **GRAM.**

12 (a) IN GENERAL.—The Secretary shall establish a
13 Community-Based Care Transitions Program under which
14 the Secretary provides funding to eligible entities that fur-
15 nish improved care transition services to high-risk Medi-
16 care beneficiaries.

17 (b) DEFINITIONS.—In this section:

18 (1) ELIGIBLE ENTITY.—The term “eligible enti-
19 ty” means the following:

20 (A) A subsection (d) hospital (as defined in
21 section 1886(d)(1)(B) of the Social Security
22 Act (42 U.S.C. 1395ww(d)(1)(B))) identified by
23 the Secretary as having a high readmission
24 rate, such as under section 1886(q) of the So-
25 cial Security Act, as added by section 3025.

1 (B) An appropriate community-based orga-
2 nization that provides care transition services
3 under this section across a continuum of care
4 through arrangements with subsection (d) hos-
5 pitals (as so defined) to furnish the services de-
6 scribed in subsection (c)(2)(B)(i) and whose
7 governing body includes sufficient representa-
8 tion of multiple health care stakeholders (in-
9 cluding consumers).

10 (2) HIGH-RISK MEDICARE BENEFICIARY.—The
11 term “high-risk Medicare beneficiary” means a
12 Medicare beneficiary who has attained a minimum
13 hierarchical condition category score, as determined
14 by the Secretary, based on a diagnosis of multiple
15 chronic conditions or other risk factors associated
16 with a hospital readmission or substandard transi-
17 tion into post-hospitalization care, which may in-
18 clude 1 or more of the following:

19 (A) Cognitive impairment.

20 (B) Depression.

21 (C) A history of multiple readmissions.

22 (D) Any other chronic disease or risk fac-
23 tor as determined by the Secretary.

24 (3) MEDICARE BENEFICIARY.—The term
25 “Medicare beneficiary” means an individual who is

1 entitled to benefits under part A of title XVIII of
2 the Social Security Act (42 U.S.C. 1395 et seq.) and
3 enrolled under part B of such title, but not enrolled
4 under part C of such title.

5 (4) PROGRAM.—The term “program” means
6 the program conducted under this section.

7 (5) READMISSION.—The term “readmission”
8 has the meaning given such term in section
9 1886(q)(5)(E) of the Social Security Act, as added
10 by section 3025.

11 (6) SECRETARY.—The term “Secretary” means
12 the Secretary of Health and Human Services.

13 (c) REQUIREMENTS.—

14 (1) DURATION.—

15 (A) IN GENERAL.—The program shall be
16 conducted for a 5-year period, beginning Janu-
17 ary 1, 2011.

18 (B) EXPANSION.—The Secretary may ex-
19 pand the duration and the scope of the pro-
20 gram, to the extent determined appropriate by
21 the Secretary, if the Secretary determines (and
22 the Chief Actuary of the Centers for Medicare
23 & Medicaid Services, with respect to spending
24 under this title, certifies) that such expansion

1 would reduce spending under this title without
2 reducing quality.

3 (2) APPLICATION; PARTICIPATION.—

4 (A) IN GENERAL.—

5 (i) APPLICATION.—An eligible entity
6 seeking to participate in the program shall
7 submit an application to the Secretary at
8 such time, in such manner, and containing
9 such information as the Secretary may re-
10 quire.

11 (ii) PARTNERSHIP.—If an eligible en-
12 tity is a hospital, such hospital shall enter
13 into a partnership with a community-based
14 organization to participate in the program.

15 (B) INTERVENTION PROPOSAL.—Subject
16 to subparagraph (C), an application submitted
17 under subparagraph (A)(i) shall include a de-
18 tailed proposal for at least 1 care transition
19 intervention, which may include the following:

20 (i) Initiating care transition services
21 for a high-risk Medicare beneficiary not
22 later than 24 hours prior to the discharge
23 of the beneficiary from the eligible entity.

24 (ii) Arranging timely post-discharge
25 follow-up services to the high-risk Medicare

1 beneficiary to provide the beneficiary (and,
2 as appropriate, the primary caregiver of
3 the beneficiary) with information regarding
4 responding to symptoms that may indicate
5 additional health problems or a deterio-
6 rating condition.

7 (iii) Providing the high-risk Medicare
8 beneficiary (and, as appropriate, the pri-
9 mary caregiver of the beneficiary) with as-
10 sistance to ensure productive and timely
11 interactions between patients and post-
12 acute and outpatient providers.

13 (iv) Assessing and actively engaging
14 with a high-risk Medicare beneficiary (and,
15 as appropriate, the primary caregiver of
16 the beneficiary) through the provision of
17 self-management support and relevant in-
18 formation that is specific to the bene-
19 ficiary's condition.

20 (v) Conducting comprehensive medica-
21 tion review and management (including, if
22 appropriate, counseling and self-manage-
23 ment support).

24 (C) LIMITATION.—A care transition inter-
25 vention proposed under subparagraph (B) may

1 not include payment for services required under
2 the discharge planning process described in sec-
3 tion 1861(ee) of the Social Security Act (42
4 U.S.C. 1395x(ee)).

5 (3) SELECTION.—In selecting eligible entities to
6 participate in the program, the Secretary shall give
7 priority to eligible entities that—

8 (A) participate in a program administered
9 by the Administration on Aging to provide con-
10 current care transitions interventions with mul-
11 tiple hospitals and practitioners; or

12 (B) provide services to medically under-
13 served populations, small communities, and
14 rural areas.

15 (d) IMPLEMENTATION.—Notwithstanding any other
16 provision of law, the Secretary may implement the provi-
17 sions of this section by program instruction or otherwise.

18 (e) WAIVER AUTHORITY.—The Secretary may waive
19 such requirements of titles XI and XVIII of the Social
20 Security Act as may be necessary to carry out the pro-
21 gram.

22 (f) FUNDING.—For purposes of carrying out this sec-
23 tion, the Secretary of Health and Human Services shall
24 provide for the transfer, from the Federal Hospital Insur-
25 ance Trust Fund under section 1817 of the Social Secu-

1 rity Act (42 U.S.C. 1395i) and the Federal Supple-
2 mentary Medical Insurance Trust Fund under section
3 1841 of such Act (42 U.S.C. 1395t), in such proportion
4 as the Secretary determines appropriate, of \$500,000,000,
5 to the Centers for Medicare & Medicaid Services Program
6 Management Account for the period of fiscal years 2011
7 through 2015. Amounts transferred under the preceding
8 sentence shall remain available until expended.

9 **SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.**

10 (a) IN GENERAL.—Subsection (d)(3) of section 5007
11 of the Deficit Reduction Act of 2005 (Public Law 109–
12 171) is amended by inserting “(or September 30, 2011,
13 in the case of a demonstration project in operation as of
14 October 1, 2008)” after “December 31, 2009”.

15 (b) FUNDING.—

16 (1) IN GENERAL.—Subsection (f)(1) of such
17 section is amended by inserting “and for fiscal year
18 2010, \$1,600,000,” after “\$6,000,000,”.

19 (2) AVAILABILITY.—Subsection (f)(2) of such
20 section is amended by striking “2010” and inserting
21 “2014 or until expended”.

22 (c) REPORTS.—

23 (1) QUALITY IMPROVEMENT AND SAVINGS.—
24 Subsection (e)(3) of such section is amended by

1 striking “December 1, 2008” and inserting “March
2 31, 2011”.

3 (2) FINAL REPORT.—Subsection (e)(4) of such
4 section is amended by striking “May 1, 2010” and
5 inserting “March 31, 2013”.

6 **Subtitle B—Improving Medicare**
7 **for Patients and Providers**

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

10 **SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.**

11 Section 1848(d) of the Social Security Act (42 U.S.C.
12 1395w–4(d)) is amended by adding at the end the fol-
13 lowing new paragraph:

14 “(10) UPDATE FOR 2010.—

15 “(A) IN GENERAL.—Subject to paragraphs
16 (7)(B), (8)(B), and (9)(B), in lieu of the update
17 to the single conversion factor established in
18 paragraph (1)(C) that would otherwise apply
19 for 2010, the update to the single conversion
20 factor shall be 0.5 percent.

21 “(B) NO EFFECT ON COMPUTATION OF
22 CONVERSION FACTOR FOR 2011 AND SUBSE-
23 QUENT YEARS.—The conversion factor under
24 this subsection shall be computed under para-

1 graph (1)(A) for 2011 and subsequent years as
2 if subparagraph (A) had never applied.”.

3 **SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX**
4 **FLOOR AND REVISIONS TO THE PRACTICE**
5 **EXPENSE GEOGRAPHIC ADJUSTMENT UNDER**
6 **THE MEDICARE PHYSICIAN FEE SCHEDULE.**

7 (a) EXTENSION OF WORK GPCI FLOOR.—Section
8 1848(e)(1)(E) of the Social Security Act (42 U.S.C.
9 1395w-4(e)(1)(E)) is amended by striking “before Janu-
10 ary 1, 2010” and inserting “before January 1, 2011”.

11 (b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT
12 FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1)
13 of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is
14 amended—

15 (1) in subparagraph (A), by striking “and (G)”
16 and inserting “(G), and (H)”; and

17 (2) by adding at the end the following new sub-
18 paragraph:

19 “(H) PRACTICE EXPENSE GEOGRAPHIC
20 ADJUSTMENT FOR 2010 AND SUBSEQUENT
21 YEARS.—

22 “(i) FOR 2010.—Subject to clause (iii),
23 for services furnished during 2010, the em-
24 ployee wage and rent portions of the prac-
25 tice expense geographic index described in

1 subparagraph (A)(i) shall reflect $\frac{3}{4}$ of the
2 difference between the relative costs of em-
3 ployee wages and rents in each of the dif-
4 ferent fee schedule areas and the national
5 average of such employee wages and rents.

6 “(ii) FOR 2011.—Subject to clause
7 (iii), for services furnished during 2011,
8 the employee wage and rent portions of the
9 practice expense geographic index de-
10 scribed in subparagraph (A)(i) shall reflect
11 $\frac{1}{2}$ of the difference between the relative
12 costs of employee wages and rents in each
13 of the different fee schedule areas and the
14 national average of such employee wages
15 and rents.

16 “(iii) HOLD HARMLESS.—The practice
17 expense portion of the geographic adjust-
18 ment factor applied in a fee schedule area
19 for services furnished in 2010 or 2011
20 shall not, as a result of the application of
21 clause (i) or (ii), be reduced below the
22 practice expense portion of the geographic
23 adjustment factor under subparagraph
24 (A)(i) (as calculated prior to the applica-

1 tion of such clause (i) or (ii), respectively)
2 for such area for such year.

3 “(iv) ANALYSIS.—The Secretary shall
4 analyze current methods of establishing
5 practice expense geographic adjustments
6 under subparagraph (A)(i) and evaluate
7 data that fairly and reliably establishes
8 distinctions in the costs of operating a
9 medical practice in the different fee sched-
10 ule areas. Such analysis shall include an
11 evaluation of the following:

12 “(I) The feasibility of using ac-
13 tual data or reliable survey data devel-
14 oped by medical organizations on the
15 costs of operating a medical practice,
16 including office rents and non-physi-
17 cian staff wages, in different fee
18 schedule areas.

19 “(II) The office expense portion
20 of the practice expense geographic ad-
21 justment described in subparagraph
22 (A)(i), including the extent to which
23 types of office expenses are deter-
24 mined in local markets instead of na-
25 tional markets.

1 “(III) The weights assigned to
2 each of the categories within the prac-
3 tice expense geographic adjustment
4 described in subparagraph (A)(i).

5 “(v) REVISION FOR 2012 AND SUBSE-
6 QUENT YEARS.—As a result of the analysis
7 described in clause (iv), the Secretary
8 shall, not later than January 1, 2012,
9 make appropriate adjustments to the prac-
10 tice expense geographic adjustment de-
11 scribed in subparagraph (A)(i) to ensure
12 accurate geographic adjustments across fee
13 schedule areas, including—

14 “(I) basing the office rents com-
15 ponent and its weight on office ex-
16 penses that vary among fee schedule
17 areas; and

18 “(II) considering a representative
19 range of professional and non-profes-
20 sional personnel employed in a med-
21 ical office based on the use of the
22 American Community Survey data or
23 other reliable data for wage adjust-
24 ments.

1 Such adjustments shall be made without
2 regard to adjustments made pursuant to
3 clauses (i) and (ii) and shall be made in a
4 budget neutral manner.”.

5 **SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR**
6 **MEDICARE THERAPY CAPS.**

7 Section 1833(g)(5) of the Social Security Act (42
8 U.S.C. 1395l(g)(5)) is amended by striking “December
9 31, 2009” and inserting “December 31, 2010”.

10 **SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COM-**
11 **PONENT OF CERTAIN PHYSICIAN PATHOL-**
12 **OGY SERVICES.**

13 Section 542(c) of the Medicare, Medicaid, and
14 SCHIP Benefits Improvement and Protection Act of 2000
15 (as enacted into law by section 1(a)(6) of Public Law 106–
16 554), as amended by section 732 of the Medicare Prescrip-
17 tion Drug, Improvement, and Modernization Act of 2003
18 (42 U.S.C. 1395w–4 note), section 104 of division B of
19 the Tax Relief and Health Care Act of 2006 (42 U.S.C.
20 1395w–4 note), section 104 of the Medicare, Medicaid,
21 and SCHIP Extension Act of 2007 (Public Law 110–
22 173), and section 136 of the Medicare Improvements for
23 Patients and Providers Act of 2008 (Public Law 110–
24 275), is amended by striking “and 2009” and inserting
25 “2009, and 2010”.

1 **SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.**

2 (a) GROUND AMBULANCE.—Section 1834(l)(13)(A)
3 of the Social Security Act (42 U.S.C. 1395m(l)(13)(A))
4 is amended—

5 (1) in the matter preceding clause (i)—

6 (A) by striking “2007, and for” and in-
7 serting “2007, for”; and

8 (B) by striking “2010” and inserting
9 “2010, and for such services furnished on or
10 after April 1, 2010, and before January 1,
11 2011,”; and

12 (2) in each of clauses (i) and (ii), by inserting
13 “, and on or after April 1, 2010, and before January
14 1, 2011” after “January 1, 2010” each place it ap-
15 pears.

16 (b) AIR AMBULANCE.—Section 146(b)(1) of the
17 Medicare Improvements for Patients and Providers Act of
18 2008 (Public Law 110–275) is amended by striking “De-
19 cember 31, 2009” and inserting “December 31, 2009, and
20 during the period beginning on April 1, 2010, and ending
21 on January 1, 2011”.

22 (c) SUPER RURAL AMBULANCE.—Section
23 1834(l)(12)(A) of the Social Security Act (42 U.S.C.
24 1395m(l)(12)(A)) is amended by striking “2010” and in-
25 serting “2010, and on or after April 1, 2010, and before
26 January 1, 2011”.

1 **SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR**
2 **LONG-TERM CARE HOSPITAL SERVICES AND**
3 **OF MORATORIUM ON THE ESTABLISHMENT**
4 **OF CERTAIN HOSPITALS AND FACILITIES.**

5 (a) **EXTENSION OF CERTAIN PAYMENT RULES.—**
6 Section 114(c) of the Medicare, Medicaid, and SCHIP Ex-
7 tension Act of 2007 (42 U.S.C. 1395ww note), as amend-
8 ed by section 4302(a) of the American Recovery and Rein-
9 vestment Act (Public Law 111–5), is further amended by
10 striking “3-year period” each place it appears and insert-
11 ing “4-year period”.

12 (b) **EXTENSION OF MORATORIUM.—**Section
13 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the
14 matter preceding subparagraph (A), is amended by strik-
15 ing “3-year period” and inserting “4-year period”.

16 **SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**
17 **TAL HEALTH ADD-ON.**

18 Section 138(a)(1) of the Medicare Improvements for
19 Patients and Providers Act of 2008 (Public Law 110–275)
20 is amended by striking “December 31, 2009” and insert-
21 ing “December 31, 2010”.

22 **SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER**
23 **POST-HOSPITAL EXTENDED CARE SERVICES.**

24 (a) **ORDERING POST-HOSPITAL EXTENDED CARE**
25 **SERVICES.—**

1 (A) by inserting “and subparagraph (G)”
2 after “clause (ii)”; and

3 (B) by inserting “, except that the Sec-
4 retary shall not require a pharmacy to have
5 submitted to the Secretary such evidence of ac-
6 creditation prior to January 1, 2011” before
7 the semicolon at the end; and

8 (2) by adding at the end the following new sub-
9 paragraph:

10 “(G) APPLICATION OF ACCREDITATION RE-
11 QUIREMENT TO CERTAIN PHARMACIES.—

12 “(i) IN GENERAL.—With respect to
13 items and services furnished on or after
14 January 1, 2011, in implementing quality
15 standards under this paragraph—

16 “(I) subject to subclause (II), in
17 applying such standards and the ac-
18 creditation requirement of subpara-
19 graph (F)(i) with respect to phar-
20 macies described in clause (ii) fur-
21 nishing such items and services, such
22 standards and accreditation require-
23 ment shall not apply to such phar-
24 macies; and

1 “(II) the Secretary may apply to
2 such pharmacies an alternative ac-
3 creditation requirement established by
4 the Secretary if the Secretary deter-
5 mines such alternative accreditation
6 requirement is more appropriate for
7 such pharmacies.

8 “(ii) PHARMACIES DESCRIBED.—A
9 pharmacy described in this clause is a
10 pharmacy that meets each of the following
11 criteria:

12 “(I) The total billings by the
13 pharmacy for such items and services
14 under this title are less than 5 percent
15 of total pharmacy sales, as determined
16 based on the average total pharmacy
17 sales for the previous 3 calendar
18 years, 3 fiscal years, or other yearly
19 period specified by the Secretary.

20 “(II) The pharmacy has been en-
21 rolled under section 1866(j) as a sup-
22 plier of durable medical equipment,
23 prosthetics, orthotics, and supplies,
24 has been issued (which may include
25 the renewal of) a provider number for

1 at least 5 years, and for which a final
2 adverse action (as defined in section
3 424.57(a) of title 42, Code of Federal
4 Regulations) has not been imposed in
5 the past 5 years.

6 “(III) The pharmacy submits to
7 the Secretary an attestation, in a
8 form and manner, and at a time,
9 specified by the Secretary, that the
10 pharmacy meets the criteria described
11 in subclauses (I) and (II). Such attes-
12 tation shall be subject to section 1001
13 of title 18, United States Code.

14 “(IV) The pharmacy agrees to
15 submit materials as requested by the
16 Secretary, or during the course of an
17 audit conducted on a random sample
18 of pharmacies selected annually, to
19 verify that the pharmacy meets the
20 criteria described in subclauses (I)
21 and (II). Materials submitted under
22 the preceding sentence shall include a
23 certification by an accountant on be-
24 half of the pharmacy or the submis-
25 sion of tax returns filed by the phar-

1 macy during the relevant periods, as
2 requested by the Secretary.”.

3 (b) ADMINISTRATION.—Notwithstanding any other
4 provision of law, the Secretary may implement the amend-
5 ments made by subsection (a) by program instruction or
6 otherwise.

7 (c) RULE OF CONSTRUCTION.—Nothing in the provi-
8 sions of or amendments made by this section shall be con-
9 strued as affecting the application of an accreditation re-
10 quirement for pharmacies to qualify for bidding in a com-
11 petitive acquisition area under section 1847 of the Social
12 Security Act (42 U.S.C. 1395w-3).

13 **SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DIS-**
14 **ABLED TRICARE BENEFICIARIES.**

15 (a) IN GENERAL.—

16 (1) IN GENERAL.—Section 1837 of the Social
17 Security Act (42 U.S.C. 1395p) is amended by add-
18 ing at the end the following new subsection:

19 “(l)(1) In the case of any individual who is a covered
20 beneficiary (as defined in section 1072(5) of title 10,
21 United States Code) at the time the individual is entitled
22 to part A under section 226(b) or section 226A and who
23 is eligible to enroll but who has elected not to enroll (or
24 to be deemed enrolled) during the individual’s initial en-

1 rollment period, there shall be a special enrollment period
2 described in paragraph (2).

3 “(2) The special enrollment period described in this
4 paragraph, with respect to an individual, is the 12-month
5 period beginning on the day after the last day of the initial
6 enrollment period of the individual or, if later, the 12-
7 month period beginning with the month the individual is
8 notified of enrollment under this section.

9 “(3) In the case of an individual who enrolls during
10 the special enrollment period provided under paragraph
11 (1), the coverage period under this part shall begin on the
12 first day of the month in which the individual enrolls, or,
13 at the option of the individual, the first month after the
14 end of the individual’s initial enrollment period.

15 “(4) An individual may only enroll during the special
16 enrollment period provided under paragraph (1) one time
17 during the individual’s lifetime.

18 “(5) The Secretary shall ensure that the materials
19 relating to coverage under this part that are provided to
20 an individual described in paragraph (1) prior to the indi-
21 vidual’s initial enrollment period contain information con-
22 cerning the impact of not enrolling under this part, includ-
23 ing the impact on health care benefits under the
24 TRICARE program under chapter 55 of title 10, United
25 States Code.

1 “(6) The Secretary of Defense shall collaborate with
2 the Secretary of Health and Human Services and the
3 Commissioner of Social Security to provide for the accu-
4 rate identification of individuals described in paragraph
5 (1). The Secretary of Defense shall provide such individ-
6 uals with notification with respect to this subsection. The
7 Secretary of Defense shall collaborate with the Secretary
8 of Health and Human Services and the Commissioner of
9 Social Security to ensure appropriate follow up pursuant
10 to any notification provided under the preceding sen-
11 tence.”.

12 (2) EFFECTIVE DATE.—The amendment made
13 by paragraph (1) shall apply to elections made with
14 respect to initial enrollment periods that end after
15 the date of the enactment of this Act.

16 (b) WAIVER OF INCREASE OF PREMIUM.—Section
17 1839(b) of the Social Security Act (42 U.S.C. 1395r(b))
18 is amended by striking “section 1837(i)(4)” and inserting
19 “subsection (i)(4) or (l) of section 1837”.

20 **SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.**

21 (a) PAYMENT.—

22 (1) IN GENERAL.—Section 1848 of the Social
23 Security Act (42 U.S.C. 1395w-4) is amended—

24 (A) in subsection (b)—

1 (i) in paragraph (4)(B), by inserting
2 “, and for 2010 and 2011, dual-energy x-
3 ray absorptiometry services (as described
4 in paragraph (6))” before the period at the
5 end; and

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

8 “(6) TREATMENT OF BONE MASS SCANS.—For
9 dual-energy x-ray absorptiometry services (identified
10 in 2006 by HCPCS codes 76075 and 76077 (and
11 any succeeding codes)) furnished during 2010 and
12 2011, instead of the payment amount that would
13 otherwise be determined under this section for such
14 years, the payment amount shall be equal to 70 per-
15 cent of the product of—

16 “(A) the relative value for the service (as
17 determined in subsection (c)(2)) for 2006;

18 “(B) the conversion factor (established
19 under subsection (d)) for 2006; and

20 “(C) the geographic adjustment factor (es-
21 tablished under subsection (e)(2)) for the serv-
22 ice for the fee schedule area for 2010 and 2011,
23 respectively.”; and

24 (B) in subsection (c)(2)(B)(iv)—

1 (i) in subclause (II), by striking
2 “and” at the end;

3 (ii) in subclause (III), by striking the
4 period at the end and inserting “; and”;
5 and

6 (iii) by adding at the end the fol-
7 lowing new subclause:

8 “(IV) subsection (b)(6) shall not
9 be taken into account in applying
10 clause (ii)(II) for 2010 or 2011.”.

11 (2) IMPLEMENTATION.—Notwithstanding any
12 other provision of law, the Secretary may implement
13 the amendments made by paragraph (1) by program
14 instruction or otherwise.

15 (b) STUDY AND REPORT BY THE INSTITUTE OF
16 MEDICINE.—

17 (1) IN GENERAL.—The Secretary of Health and
18 Human Services is authorized to enter into an
19 agreement with the Institute of Medicine of the Na-
20 tional Academies to conduct a study on the ramifica-
21 tions of Medicare payment reductions for dual-en-
22 ergy x-ray absorptiometry (as described in section
23 1848(b)(6) of the Social Security Act, as added by
24 subsection (a)(1)) during 2007, 2008, and 2009 on
25 beneficiary access to bone mass density tests.

1 “complex diagnostic laboratory test” means a diag-
2 nostic laboratory test—

3 (A) that is an analysis of gene protein ex-
4 pression, topographic genotyping, or a cancer
5 chemotherapy sensitivity assay;

6 (B) that is determined by the Secretary to
7 be a laboratory test for which there is not an
8 alternative test having equivalent performance
9 characteristics;

10 (C) which is billed using a Health Care
11 Procedure Coding System (HCPCS) code other
12 than a not otherwise classified code under such
13 Coding System;

14 (D) which is approved or cleared by the
15 Food and Drug Administration or is covered
16 under title XVIII of the Social Security Act;
17 and

18 (E) is described in section 1861(s)(3) of
19 the Social Security Act (42 U.S.C.
20 1395x(s)(3)).

21 (3) SEPARATE PAYMENT DEFINED.—In this
22 section, the term “separate payment” means direct
23 payment to a laboratory (including a hospital-based
24 or independent laboratory) that performs a complex
25 diagnostic laboratory test with respect to a specimen

1 collected from an individual during a period in which
2 the individual is a patient of a hospital if the test
3 is performed after such period of hospitalization and
4 if separate payment would not otherwise be made
5 under title XVIII of the Social Security Act by rea-
6 son of sections 1862(a)(14) and 1866(a)(1)(H)(i) of
7 the such Act (42 U.S.C. 1395y(a)(14); 42 U.S.C.
8 1395cc(a)(1)(H)(i)).

9 (b) DURATION.—Subject to subsection (c)(2), the
10 Secretary shall conduct the demonstration project under
11 this section for the 2-year period beginning on July 1,
12 2011.

13 (c) PAYMENTS AND LIMITATION.—Payments under
14 the demonstration project under this section shall—

15 (1) be made from the Federal Supplemental
16 Medical Insurance Trust Fund under section 1841
17 of the Social Security Act (42 U.S.C. 1395t); and

18 (2) may not exceed \$100,000,000.

19 (d) REPORT.—Not later than 2 years after the com-
20 pletion of the demonstration project under this section, the
21 Secretary shall submit to Congress a report on the project.

22 Such report shall include—

23 (1) an assessment of the impact of the dem-
24 onstration project on access to care, quality of care,
25 health outcomes, and expenditures under title XVIII

1 of the Social Security Act (including any savings
2 under such title); and

3 (2) such recommendations as the Secretary de-
4 termines appropriate.

5 (e) IMPLEMENTATION FUNDING.—For purposes of
6 administering this section (including preparing and sub-
7 mitting the report under subsection (d)), the Secretary
8 shall provide for the transfer, from the Federal Supple-
9 mental Medical Insurance Trust Fund under section 1841
10 of the Social Security Act (42 U.S.C. 1395t), to the Cen-
11 ters for Medicare & Medicaid Services Program Manage-
12 ment Account, of \$5,000,000. Amounts transferred under
13 the preceding sentence shall remain available until ex-
14 pended.

15 **SEC. 3114. IMPROVED ACCESS FOR CERTIFIED NURSE-MID-**
16 **WIFE SERVICES.**

17 Section 1833(a)(1)(K) of the Social Security Act (42
18 U.S.C. 1395l(a)(1)(K)) is amended by inserting “(or 100
19 percent for services furnished on or after January 1,
20 2011)” after “1992, 65 percent”.

1 **PART II—RURAL PROTECTIONS**
2 **SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS**
3 **PROVISION.**

4 (a) **IN GENERAL.**—Section 1833(t)(7)(D)(i) of the
5 Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is
6 amended—

7 (1) in subclause (II)—

8 (A) in the first sentence, by striking
9 “2010” and inserting “2011”; and

10 (B) in the second sentence, by striking “or
11 2009” and inserting “, 2009, or 2010”; and

12 (2) in subclause (III), by striking “January 1,
13 2010” and inserting “January 1, 2011”.

14 (b) **PERMITTING ALL SOLE COMMUNITY HOSPITALS**
15 **TO BE ELIGIBLE FOR HOLD HARMLESS.**—Section
16 1833(t)(7)(D)(i)(III) of the Social Security Act (42
17 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at
18 the end the following new sentence: “In the case of covered
19 OPD services furnished on or after January 1, 2010, and
20 before January 1, 2011, the preceding sentence shall be
21 applied without regard to the 100-bed limitation.”.

1 **SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS**
2 **PAYMENTS FOR CERTAIN CLINICAL DIAG-**
3 **NOSTIC LABORATORY TESTS FURNISHED TO**
4 **HOSPITAL PATIENTS IN CERTAIN RURAL**
5 **AREAS.**

6 Section 416(b) of the Medicare Prescription Drug,
7 Improvement, and Modernization Act of 2003 (42 U.S.C.
8 1395l-4), as amended by section 105 of division B of the
9 Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l
10 note) and section 107 of the Medicare, Medicaid, and
11 SCHIP Extension Act of 2007 (42 U.S.C. 1395l note),
12 is amended by inserting “or during the 1-year period be-
13 ginning on July 1, 2010” before the period at the end.

14 **SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOS-**
15 **PITAL DEMONSTRATION PROGRAM.**

16 (a) ONE-YEAR EXTENSION.—Section 410A of the
17 Medicare Prescription Drug, Improvement, and Mod-
18 ernization Act of 2003 (Public Law 108-173; 117 Stat.
19 2272) is amended by adding at the end the following new
20 subsection:

21 “(g) ONE-YEAR EXTENSION OF DEMONSTRATION
22 PROGRAM.—

23 “(1) IN GENERAL.—Subject to the succeeding
24 provisions of this subsection, the Secretary shall con-
25 duct the demonstration program under this section
26 for an additional 1-year period (in this section re-

1 ferred to as the ‘1-year extension period’) that be-
2 gins on the date immediately following the last day
3 of the initial 5-year period under subsection (a)(5).

4 “(2) EXPANSION OF DEMONSTRATION
5 STATES.—Notwithstanding subsection (a)(2), during
6 the 1-year extension period, the Secretary shall ex-
7 pand the number of States with low population den-
8 sities determined by the Secretary under such sub-
9 section to 20. In determining which States to include
10 in such expansion, the Secretary shall use the same
11 criteria and data that the Secretary used to deter-
12 mine the States under such subsection for purposes
13 of the initial 5-year period.

14 “(3) INCREASE IN MAXIMUM NUMBER OF HOS-
15 PITALS PARTICIPATING IN THE DEMONSTRATION
16 PROGRAM.—Notwithstanding subsection (a)(4), dur-
17 ing the 1-year extension period, not more than 30
18 rural community hospitals may participate in the
19 demonstration program under this section.

20 “(4) NO AFFECT ON HOSPITALS IN DEM-
21 ONSTRATION PROGRAM ON DATE OF ENACTMENT.—
22 In the case of a rural community hospital that is
23 participating in the demonstration program under
24 this section as of the last day of the initial 5-year
25 period, the Secretary shall provide for the continued

1 participation of such rural community hospital in
2 the demonstration program during the 1-year exten-
3 sion period unless the rural community hospital
4 makes an election, in such form and manner as the
5 Secretary may specify, to discontinue such partici-
6 pation.”.

7 (b) CONFORMING AMENDMENTS.—Subsection (a)(5)
8 of section 410A of the Medicare Prescription Drug, Im-
9 provement, and Modernization Act of 2003 (Public Law
10 108–173; 117 Stat. 2272) is amended by inserting “(in
11 this section referred to as the ‘initial 5-year period’) and,
12 as provided in subsection (g), for the 1-year extension pe-
13 riod” after “5-year period”.

14 (c) TECHNICAL AMENDMENTS.—

15 (1) Subsection (b) of section 410A of the Medi-
16 care Prescription Drug, Improvement, and Mod-
17 ernization Act of 2003 (Public Law 108–173; 117
18 Stat. 2272) is amended—

19 (A) in paragraph (1)(B)(ii), by striking
20 “2)” and inserting “2))”; and

21 (B) in paragraph (2), by inserting “cost”
22 before “reporting period” the first place such
23 term appears in each of subparagraphs (A) and
24 (B).

1 (2) Subsection (f)(1) of section 410A of the
2 Medicare Prescription Drug, Improvement, and
3 Modernization Act of 2003 (Public Law 108–173;
4 117 Stat. 2272) is amended—

5 (A) in subparagraph (A)(ii), by striking
6 “paragraph (2)” and inserting “subparagraph
7 (B)”; and

8 (B) in subparagraph (B), by striking
9 “paragraph (1)(B)” and inserting “subpara-
10 graph (A)(ii)”.

11 **SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT**
12 **HOSPITAL (MDH) PROGRAM.**

13 (a) **EXTENSION OF PAYMENT METHODOLOGY.**—Sec-
14 tion 1886(d)(5)(G) of the Social Security Act (42 U.S.C.
15 1395ww(d)(5)(G)) is amended—

16 (1) in clause (i), by striking “October 1, 2011”
17 and inserting “October 1, 2012”; and

18 (2) in clause (ii)(II), by striking “October 1,
19 2011” and inserting “October 1, 2012”.

20 (b) **CONFORMING AMENDMENTS.**—

21 (1) **EXTENSION OF TARGET AMOUNT.**—Section
22 1886(b)(3)(D) of the Social Security Act (42 U.S.C.
23 1395ww(b)(3)(D)) is amended—

1 (A) in the matter preceding clause (i), by
2 striking “October 1, 2011” and inserting “Oc-
3 tober 1, 2012”; and

4 (B) in clause (iv), by striking “through fis-
5 cal year 2011” and inserting “through fiscal
6 year 2012”.

7 (2) PERMITTING HOSPITALS TO DECLINE RE-
8 CLASSIFICATION.—Section 13501(e)(2) of the Omni-
9 bus Budget Reconciliation Act of 1993 (42 U.S.C.
10 1395ww note) is amended by striking “through fis-
11 cal year 2011” and inserting “through fiscal year
12 2012”.

13 **SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE**
14 **INPATIENT HOSPITAL PAYMENT ADJUST-**
15 **MENT FOR LOW-VOLUME HOSPITALS.**

16 Section 1886(d)(12) of the Social Security Act (42
17 U.S.C. 1395ww(d)(12)) is amended—

18 (1) in subparagraph (A), by inserting “or (D)”
19 after “subparagraph (B)”;

20 (2) in subparagraph (B), in the matter pre-
21 ceding clause (i), by striking “The Secretary” and
22 inserting “For discharges occurring in fiscal years
23 2005 through 2010 and for discharges occurring in
24 fiscal year 2013 and subsequent fiscal years, the
25 Secretary”;

1 (3) in subparagraph (C)(i)—

2 (A) by inserting “(or, with respect to fiscal
3 years 2011 and 2012, 15 road miles)” after
4 “25 road miles”; and

5 (B) by inserting “(or, with respect to fiscal
6 years 2011 and 2012, 1,500 discharges of indi-
7 viduals entitled to, or enrolled for, benefits
8 under part A)” after “800 discharges”; and

9 (4) by adding at the end the following new sub-
10 paragraph:

11 “(D) TEMPORARY APPLICABLE PERCENT-
12 AGE INCREASE.—For discharges occurring in
13 fiscal years 2011 and 2012, the Secretary shall
14 determine an applicable percentage increase for
15 purposes of subparagraph (A) using a contin-
16 uous linear sliding scale ranging from 25 per-
17 cent for low-volume hospitals with 200 or fewer
18 discharges of individuals entitled to, or enrolled
19 for, benefits under part A in the fiscal year to
20 0 percent for low-volume hospitals with greater
21 than 1,500 discharges of such individuals in the
22 fiscal year.”.

1 **SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION**
2 **PROJECT ON COMMUNITY HEALTH INTEGRA-**
3 **TION MODELS IN CERTAIN RURAL COUNTIES.**

4 (a) REMOVAL OF LIMITATION ON NUMBER OF ELIGI-
5 BLE COUNTIES SELECTED.—Subsection (d)(3) of section
6 123 of the Medicare Improvements for Patients and Pro-
7 viders Act of 2008 (42 U.S.C. 1395i–4 note) is amended
8 by striking “not more than 6”.

9 (b) REMOVAL OF REFERENCES TO RURAL HEALTH
10 CLINIC SERVICES AND INCLUSION OF PHYSICIANS’ SERV-
11 ICES IN SCOPE OF DEMONSTRATION PROJECT.—Such
12 section 123 is amended—

13 (1) in subsection (d)(4)(B)(i)(3), by striking
14 subclause (III); and

15 (2) in subsection (j)—

16 (A) in paragraph (8), by striking subpara-
17 graph (B) and inserting the following:

18 “(B) Physicians’ services (as defined in
19 section 1861(q) of the Social Security Act (42
20 U.S.C. 1395x(q)).”;

21 (B) by striking paragraph (9); and

22 (C) by redesignating paragraph (10) as
23 paragraph (9).

1 **SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE**
2 **PAYMENTS FOR HEALTH CARE PROVIDERS**
3 **SERVING IN RURAL AREAS.**

4 (a) STUDY.—The Medicare Payment Advisory Com-
5 mission shall conduct a study on the adequacy of pay-
6 ments for items and services furnished by providers of
7 services and suppliers in rural areas under the Medicare
8 program under title XVIII of the Social Security Act (42
9 U.S.C. 1395 et seq.). Such study shall include an analysis
10 of—

11 (1) any adjustments in payments to providers
12 of services and suppliers that furnish items and
13 services in rural areas;

14 (2) access by Medicare beneficiaries to items
15 and services in rural areas;

16 (3) the adequacy of payments to providers of
17 services and suppliers that furnish items and serv-
18 ices in rural areas; and

19 (4) the quality of care furnished in rural areas.

20 (b) REPORT.—Not later than January 1, 2011, the
21 Medicare Payment Advisory Commission shall submit to
22 Congress a report containing the results of the study con-
23 ducted under subsection (a). Such report shall include rec-
24 ommendations on appropriate modifications to any adjust-
25 ments in payments to providers of services and suppliers
26 that furnish items and services in rural areas, together

1 with recommendations for such legislation and administra-
2 tive action as the Medicare Payment Advisory Commission
3 determines appropriate.

4 **SEC. 3128. TECHNICAL CORRECTION RELATED TO CRIT-**
5 **ICAL ACCESS HOSPITAL SERVICES.**

6 (a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8)
7 of section 1834 of the Social Security Act (42 U.S.C.
8 1395m) are each amended by inserting “101 percent of”
9 before “the reasonable costs”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) shall take effect as if included in the enact-
12 ment of section 405(a) of the Medicare Prescription Drug,
13 Improvement, and Modernization Act of 2003 (Public Law
14 108–173; 117 Stat. 2266).

15 **SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE**
16 **RURAL HOSPITAL FLEXIBILITY PROGRAM.**

17 (a) AUTHORIZATION.—Section 1820(j) of the Social
18 Security Act (42 U.S.C. 1395i–4(j)) is amended—

19 (1) by striking “2010, and for” and inserting
20 “2010, for”; and

21 (2) by inserting “and for making grants to all
22 States under subsection (g), such sums as may be
23 necessary in each of fiscal years 2011 and 2012, to
24 remain available until expended” before the period
25 at the end.

1 (b) USE OF FUNDS.—Section 1820(g)(3) of the So-
2 cial Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

3 (1) in subparagraph (A), by inserting “and to
4 assist such hospitals in participating in delivery sys-
5 tem reforms under the provisions of and amend-
6 ments made by the Patient Protection and Afford-
7 able Care Act, such as value-based purchasing pro-
8 grams, accountable care organizations under section
9 1899, the National pilot program on payment bun-
10 dling under section 1866D, and other delivery sys-
11 tem reform programs determined appropriate by the
12 Secretary” before the period at the end; and

13 (2) in subparagraph (E)—

14 (A) by striking “, and to offset” and in-
15 serting “, to offset”; and

16 (B) by inserting “and to participate in de-
17 livery system reforms under the provisions of
18 and amendments made by the Patient Protec-
19 tion and Affordable Care Act, such as value-
20 based purchasing programs, accountable care
21 organizations under section 1899, the National
22 pilot program on payment bundling under sec-
23 tion 1866D, and other delivery system reform
24 programs determined appropriate by the Sec-
25 retary” before the period at the end.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to grants made on or after January
3 1, 2010.

4 **PART III—IMPROVING PAYMENT ACCURACY**

5 **SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH**
6 **CARE.**

7 (a) REBASING HOME HEALTH PROSPECTIVE PAY-
8 MENT AMOUNT.—

9 (1) IN GENERAL.—Section 1895(b)(3)(A) of the
10 Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is
11 amended—

12 (A) in clause (i)(III), by striking “For pe-
13 riods” and inserting “Subject to clause (iii), for
14 periods”; and

15 (B) by adding at the end the following new
16 clause:

17 “(iii) ADJUSTMENT FOR 2013 AND
18 SUBSEQUENT YEARS.—

19 “(I) IN GENERAL.—Subject to
20 subclause (II), for 2013 and subse-
21 quent years, the amount (or amounts)
22 that would otherwise be applicable
23 under clause (i)(III) shall be adjusted
24 by a percentage determined appro-
25 priate by the Secretary to reflect such

1 factors as changes in the number of
2 visits in an episode, the mix of serv-
3 ices in an episode, the level of inten-
4 sity of services in an episode, the av-
5 erage cost of providing care per epi-
6 sode, and other factors that the Sec-
7 retary considers to be relevant. In
8 conducting the analysis under the pre-
9 ceding sentence, the Secretary may
10 consider differences between hospital-
11 based and freestanding agencies, be-
12 tween for-profit and nonprofit agen-
13 cies, and between the resource costs of
14 urban and rural agencies. Such ad-
15 justment shall be made before the up-
16 date under subparagraph (B) is ap-
17 plied for the year.

18 “(II) TRANSITION.—The Sec-
19 retary shall provide for a 4-year
20 phase-in (in equal increments) of the
21 adjustment under subclause (I), with
22 such adjustment being fully imple-
23 mented for 2016. During each year of
24 such phase-in, the amount of any ad-
25 justment under subclause (I) for the

1 year may not exceed 3.5 percent of
2 the amount (or amounts) applicable
3 under clause (i)(III) as of the date of
4 enactment of the Patient Protection
5 and Affordable Care Act.”.

6 (2) MEDPAC STUDY AND REPORT.—

7 (A) STUDY.—The Medicare Payment Advi-
8 sory Commission shall conduct a study on the
9 implementation of the amendments made by
10 paragraph (1). Such study shall include an
11 analysis of the impact of such amendments
12 on—

- 13 (i) access to care;
14 (ii) quality outcomes;
15 (iii) the number of home health agen-
16 cies; and
17 (iv) rural agencies, urban agencies,
18 for-profit agencies, and nonprofit agencies.

19 (B) REPORT.—Not later than January 1,
20 2015, the Medicare Payment Advisory Commis-
21 sion shall submit to Congress a report on the
22 study conducted under subparagraph (A), to-
23 gether with recommendations for such legisla-
24 tion and administrative action as the Commis-
25 sion determines appropriate.

1 (b) PROGRAM-SPECIFIC OUTLIER CAP.—Section
2 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b))
3 is amended—

4 (1) in paragraph (3)(C), by striking “the aggregate”
5 and all that follows through the period at the
6 end and inserting “5 percent of the total payments
7 estimated to be made based on the prospective pay-
8 ment system under this subsection for the period.”;
9 and

10 (2) in paragraph (5)—

11 (A) by striking “OUTLIERS.—The Sec-
12 retary” and inserting the following:
13 “OUTLIERS.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B), the Secretary”;

16 (B) in subparagraph (A), as added by sub-
17 paragraph (A), by striking “5 percent” and in-
18 serting “2.5 percent”; and

19 (C) by adding at the end the following new
20 subparagraph:

21 “(B) PROGRAM SPECIFIC OUTLIER CAP.—
22 The estimated total amount of additional pay-
23 ments or payment adjustments made under
24 subparagraph (A) with respect to a home health
25 agency for a year (beginning with 2011) may

1 not exceed an amount equal to 10 percent of
2 the estimated total amount of payments made
3 under this section (without regard to this para-
4 graph) with respect to the home health agency
5 for the year.”.

6 (c) APPLICATION OF THE MEDICARE RURAL HOME
7 HEALTH ADD-ON POLICY.—Section 421 of the Medicare
8 Prescription Drug, Improvement, and Modernization Act
9 of 2003 (Public Law 108–173; 117 Stat. 2283), as
10 amended by section 5201(b) of the Deficit Reduction Act
11 of 2005 (Public Law 109–171; 120 Stat. 46), is amend-
12 ed—

13 (1) in the section heading, by striking “**ONE-**
14 **YEAR**” and inserting “**TEMPORARY**”; and

15 (2) in subsection (a)—

16 (A) by striking “, and episodes” and in-
17 serting “, episodes”;

18 (B) by inserting “and episodes and visits
19 ending on or after April 1, 2010, and before
20 January 1, 2016,” after “January 1, 2007,”;
21 and

22 (C) by inserting “(or, in the case of epi-
23 sodes and visits ending on or after April 1,
24 2010, and before January 1, 2016, 3 percent)”
25 before the period at the end.

1 (d) STUDY AND REPORT ON THE DEVELOPMENT OF
2 HOME HEALTH PAYMENT REFORMS IN ORDER TO EN-
3 SURE ACCESS TO CARE AND QUALITY SERVICES.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services (in this section referred to as the
6 “Secretary”) shall conduct a study to evaluate the
7 costs and quality of care among efficient home
8 health agencies relative to other such agencies in
9 providing ongoing access to care and in treating
10 Medicare beneficiaries with varying severity levels of
11 illness. Such study shall include an analysis of the
12 following:

13 (A) Methods to revise the home health pro-
14 spective payment system under section 1895 of
15 the Social Security Act (42 U.S.C. 1395fff) to
16 more accurately account for the costs related to
17 patient severity of illness or to improving bene-
18 ficiary access to care, including—

19 (i) payment adjustments for services
20 that may be under- or over-valued;

21 (ii) necessary changes to reflect the
22 resource use relative to providing home
23 health services to low-income Medicare
24 beneficiaries or Medicare beneficiaries liv-
25 ing in medically underserved areas;

1 (iii) ways the outlier payment may be
2 improved to more accurately reflect the
3 cost of treating Medicare beneficiaries with
4 high severity levels of illness;

5 (iv) the role of quality of care incen-
6 tives and penalties in driving provider and
7 patient behavior;

8 (v) improvements in the application of
9 a wage index; and

10 (vi) other areas determined appro-
11 priate by the Secretary.

12 (B) The validity and reliability of re-
13 sponses on the OASIS instrument with par-
14 ticular emphasis on questions that relate to
15 higher payment under the home health prospec-
16 tive payment system and higher outcome scores
17 under Home Care Compare.

18 (C) Additional research or payment revi-
19 sions under the home health prospective pay-
20 ment system that may be necessary to set the
21 payment rates for home health services based
22 on costs of high-quality and efficient home
23 health agencies or to improve Medicare bene-
24 ficiary access to care.

1 (D) A timetable for implementation of any
2 appropriate changes based on the analysis of
3 the matters described in subparagraphs (A),
4 (B), and (C).

5 (E) Other areas determined appropriate by
6 the Secretary.

7 (2) CONSIDERATIONS.—In conducting the study
8 under paragraph (1), the Secretary shall consider
9 whether certain factors should be used to measure
10 patient severity of illness and access to care, such
11 as—

12 (A) population density and relative patient
13 access to care;

14 (B) variations in service costs for providing
15 care to individuals who are dually eligible under
16 the Medicare and Medicaid programs;

17 (C) the presence of severe or chronic dis-
18 eases, as evidenced by multiple, discontinuous
19 home health episodes;

20 (D) poverty status, as evidenced by the re-
21 ceipt of Supplemental Security Income under
22 title XVI of the Social Security Act;

23 (E) the absence of caregivers;

24 (F) language barriers;

25 (G) atypical transportation costs;

1 (H) security costs; and

2 (I) other factors determined appropriate by
3 the Secretary.

4 (3) REPORT.—Not later than March 1, 2011,
5 the Secretary shall submit to Congress a report on
6 the study conducted under paragraph (1), together
7 with recommendations for such legislation and ad-
8 ministrative action as the Secretary determines ap-
9 propriate.

10 (4) CONSULTATIONS.—In conducting the study
11 under paragraph (1) and preparing the report under
12 paragraph (3), the Secretary shall consult with—

13 (A) stakeholders representing home health
14 agencies;

15 (B) groups representing Medicare bene-
16 ficiaries;

17 (C) the Medicare Payment Advisory Com-
18 mission;

19 (D) the Inspector General of the Depart-
20 ment of Health and Human Services; and

21 (E) the Comptroller General of the United
22 States.

23 **SEC. 3132. HOSPICE REFORM.**

24 (a) HOSPICE CARE PAYMENT REFORMS.—

1 (1) IN GENERAL.—Section 1814(i) of the Social
2 Security Act (42 U.S.C. 1395f(i)), as amended by
3 section 3004(c), is amended—

4 (A) by redesignating paragraph (6) as
5 paragraph (7); and

6 (B) by inserting after paragraph (5) the
7 following new paragraph:

8 “(6)(A) The Secretary shall collect additional
9 data and information as the Secretary determines
10 appropriate to revise payments for hospice care
11 under this subsection pursuant to subparagraph (D)
12 and for other purposes as determined appropriate by
13 the Secretary. The Secretary shall begin to collect
14 such data by not later than January 1, 2011.

15 “(B) The additional data and information to be
16 collected under subparagraph (A) may include data
17 and information on—

18 “(i) charges and payments;

19 “(ii) the number of days of hospice care
20 which are attributable to individuals who are
21 entitled to, or enrolled for, benefits under part
22 A; and

23 “(iii) with respect to each type of service
24 included in hospice care—

1 “(I) the number of days of hospice
2 care attributable to the type of service;

3 “(II) the cost of the type of service;
4 and

5 “(III) the amount of payment for the
6 type of service;

7 “(iv) charitable contributions and other
8 revenue of the hospice program;

9 “(v) the number of hospice visits;

10 “(vi) the type of practitioner providing the
11 visit; and

12 “(vii) the length of the visit and other
13 basic information with respect to the visit.

14 “(C) The Secretary may collect the additional
15 data and information under subparagraph (A) on
16 cost reports, claims, or other mechanisms as the
17 Secretary determines to be appropriate.

18 “(D)(i) Notwithstanding the preceding para-
19 graphs of this subsection, not earlier than October
20 1, 2013, the Secretary shall, by regulation, imple-
21 ment revisions to the methodology for determining
22 the payment rates for routine home care and other
23 services included in hospice care under this part, as
24 the Secretary determines to be appropriate. Such re-
25 visions may be based on an analysis of data and in-

1 formation collected under subparagraph (A). Such
2 revisions may include adjustments to per diem pay-
3 ments that reflect changes in resource intensity in
4 providing such care and services during the course
5 of the entire episode of hospice care.

6 “(ii) Revisions in payment implemented pursu-
7 ant to clause (i) shall result in the same estimated
8 amount of aggregate expenditures under this title
9 for hospice care furnished in the fiscal year in which
10 such revisions in payment are implemented as would
11 have been made under this title for such care in
12 such fiscal year if such revisions had not been imple-
13 mented.

14 “(E) The Secretary shall consult with hospice
15 programs and the Medicare Payment Advisory Com-
16 mission regarding the additional data and informa-
17 tion to be collected under subparagraph (A) and the
18 payment revisions under subparagraph (D).”.

19 (2) CONFORMING AMENDMENTS.—Section
20 1814(i)(1)(C) of the Social Security Act (42 U.S.C.
21 1395f(i)(1)(C)) is amended—

22 (A) in clause (ii)—

23 (i) in the matter preceding subclause
24 (I), by inserting “(before the first fiscal
25 year in which the payment revisions de-

1 scribed in paragraph (6)(D) are imple-
2 mented)” after “subsequent fiscal year”;
3 and

4 (ii) in subclause (VII), by inserting
5 “(before the first fiscal year in which the
6 payment revisions described in paragraph
7 (6)(D) are implemented), subject to clause
8 (iv),” after “subsequent fiscal year”; and

9 (B) by adding at the end the following new

10 clause:

11 “(iii) With respect to routine home
12 care and other services included in hospice
13 care furnished during fiscal years subse-
14 quent to the first fiscal year in which pay-
15 ment revisions described in paragraph
16 (6)(D) are implemented, the payment rates
17 for such care and services shall be the pay-
18 ment rates in effect under this clause dur-
19 ing the preceding fiscal year increased by,
20 subject to clause (iv), the market basket
21 percentage increase (as defined in section
22 1886(b)(3)(B)(iii)) for the fiscal year.”.

23 (b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELI-
24 GIBILITY RECERTIFICATION RECOMMENDATIONS.—Sec-

1 tion 1814(a)(7) of the Social Security Act (42 U.S.C.
2 1395f(a)(7)) is amended—

3 (1) in subparagraph (B), by striking “and” at
4 the end; and

5 (2) by adding at the end the following new sub-
6 paragraph:

7 “(D) on and after January 1, 2011—

8 “(i) a hospice physician or nurse prac-
9 titioner has a face-to-face encounter with
10 the individual to determine continued eligi-
11 bility of the individual for hospice care
12 prior to the 180th-day recertification and
13 each subsequent recertification under sub-
14 paragraph (A)(ii) and attests that such
15 visit took place (in accordance with proce-
16 dures established by the Secretary); and

17 “(ii) in the case of hospice care pro-
18 vided an individual for more than 180 days
19 by a hospice program for which the num-
20 ber of such cases for such program com-
21 prises more than a percent (specified by
22 the Secretary) of the total number of such
23 cases for all programs under this title, the
24 hospice care provided to such individual is
25 medically reviewed (in accordance with

1 procedures established by the Secretary);
2 and”.

3 **SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPOR-**
4 **TIONATE SHARE HOSPITAL (DSH) PAYMENTS.**

5 Section 1886 of the Social Security Act (42 U.S.C.
6 1395ww), as amended by sections 3001, 3008, and 3025,
7 is amended—

8 (1) in subsection (d)(5)(F)(i), by striking
9 “For” and inserting “Subject to subsection (r), for”;
10 and

11 (2) by adding at the end the following new sub-
12 section:

13 “(r) **ADJUSTMENTS TO MEDICARE DSH PAY-**
14 **MENTS.—**

15 “(1) **EMPIRICALLY JUSTIFIED DSH PAY-**
16 **MENTS.—**For fiscal year 2015 and each subsequent
17 fiscal year, instead of the amount of dispropor-
18 tionate share hospital payment that would otherwise
19 be made under subsection (d)(5)(F) to a subsection
20 (d) hospital for the fiscal year, the Secretary shall
21 pay to the subsection (d) hospital 25 percent of such
22 amount (which represents the empirically justified
23 amount for such payment, as determined by the
24 Medicare Payment Advisory Commission in its
25 March 2007 Report to the Congress).

1 “(2) ADDITIONAL PAYMENT.—In addition to
2 the payment made to a subsection (d) hospital under
3 paragraph (1), for fiscal year 2015 and each subse-
4 quent fiscal year, the Secretary shall pay to such
5 subsection (d) hospitals an additional amount equal
6 to the product of the following factors:

7 “(A) FACTOR ONE.—A factor equal to the
8 difference between—

9 “(i) the aggregate amount of pay-
10 ments that would be made to subsection
11 (d) hospitals under subsection (d)(5)(F) if
12 this subsection did not apply for such fis-
13 cal year (as estimated by the Secretary);
14 and

15 “(ii) the aggregate amount of pay-
16 ments that are made to subsection (d) hos-
17 pitals under paragraph (1) for such fiscal
18 year (as so estimated).

19 “(B) FACTOR TWO.—

20 “(i) FISCAL YEARS 2015, 2016, AND
21 2017.—For each of fiscal years 2015, 2016,
22 and 2017, a factor equal to 1 minus the
23 percent change (divided by 100) in the per-
24 cent of individuals under the age of 65 who

1 are uninsured, as determined by comparing
2 the percent of such individuals—

3 “(I) who are uninsured in 2012,
4 the last year before coverage expansion
5 under the Patient Protection and
6 Affordable Care Act (as calculated by
7 the Secretary based on the most recent
8 estimates available from the Director
9 of the Congressional Budget
10 Office before a vote in either House
11 on such Act that, if determined in the
12 affirmative, would clear such Act for
13 enrollment); and

14 “(II) who are uninsured in the
15 most recent period for which data is
16 available (as so calculated).

17 “(ii) 2018 AND SUBSEQUENT
18 YEARS.—For fiscal year 2018 and each
19 subsequent fiscal year, a factor equal to 1
20 minus the percent change (divided by 100)
21 in the percent of individuals who are uninsured,
22 as determined by comparing the
23 percent of individuals—

24 “(I) who are uninsured in 2012
25 (as estimated by the Secretary, based

1 on data from the Census Bureau or
2 other sources the Secretary deter-
3 mines appropriate, and certified by
4 the Chief Actuary of the Centers for
5 Medicare & Medicaid Services); and

6 “(II) who are uninsured in the
7 most recent period for which data is
8 available (as so estimated and cer-
9 tified).

10 “(C) FACTOR THREE.—A factor equal to
11 the percent, for each subsection (d) hospital,
12 that represents the quotient of—

13 “(i) the amount of uncompensated
14 care for such hospital for a period selected
15 by the Secretary (as estimated by the Sec-
16 retary, based on appropriate data (includ-
17 ing, in the case where the Secretary deter-
18 mines that alternative data is available
19 which is a better proxy for the costs of
20 subsection (d) hospitals for treating the
21 uninsured, the use of such alternative
22 data)); and

23 “(ii) the aggregate amount of uncom-
24 pensated care for all subsection (d) hos-
25 pitals that receive a payment under this

1 subsection for such period (as so esti-
2 mated, based on such data).

3 “(3) LIMITATIONS ON REVIEW.—There shall be
4 no administrative or judicial review under section
5 1869, section 1878, or otherwise of the following:

6 “(A) Any estimate of the Secretary for
7 purposes of determining the factors described in
8 paragraph (2).

9 “(B) Any period selected by the Secretary
10 for such purposes.”.

11 **SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE**
12 **SCHEDULE.**

13 (a) IN GENERAL.—Section 1848(c)(2) of the Social
14 Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by
15 adding at the end the following new subparagraphs:

16 “(K) POTENTIALLY MISVALUED CODES.—

17 “(i) IN GENERAL.—The Secretary
18 shall—

19 “(I) periodically identify services
20 as being potentially misvalued using
21 criteria specified in clause (ii); and

22 “(II) review and make appro-
23 priate adjustments to the relative val-
24 ues established under this paragraph

1 for services identified as being poten-
2 tially misvalued under subclause (I).

3 “(ii) IDENTIFICATION OF POTEN-
4 TIALY MISVALUED CODES.—For purposes
5 of identifying potentially misvalued services
6 pursuant to clause (i)(I), the Secretary
7 shall examine (as the Secretary determines
8 to be appropriate) codes (and families of
9 codes as appropriate) for which there has
10 been the fastest growth; codes (and fami-
11 lies of codes as appropriate) that have ex-
12 perienced substantial changes in practice
13 expenses; codes for new technologies or
14 services within an appropriate period (such
15 as 3 years) after the relative values are ini-
16 tially established for such codes; multiple
17 codes that are frequently billed in conjunc-
18 tion with furnishing a single service; codes
19 with low relative values, particularly those
20 that are often billed multiple times for a
21 single treatment; codes which have not
22 been subject to review since the implemen-
23 tation of the RBRVS (the so-called ‘Har-
24 vard-valued codes’); and such other codes

1 determined to be appropriate by the Sec-
2 retary.

3 “(iii) REVIEW AND ADJUSTMENTS.—

4 “(I) The Secretary may use ex-
5 isting processes to receive rec-
6 ommendations on the review and ap-
7 propriate adjustment of potentially
8 misvalued services described in clause
9 (i)(II).

10 “(II) The Secretary may conduct
11 surveys, other data collection activi-
12 ties, studies, or other analyses as the
13 Secretary determines to be appro-
14 priate to facilitate the review and ap-
15 propriate adjustment described in
16 clause (i)(II).

17 “(III) The Secretary may use
18 analytic contractors to identify and
19 analyze services identified under
20 clause (i)(I), conduct surveys or col-
21 lect data, and make recommendations
22 on the review and appropriate adjust-
23 ment of services described in clause
24 (i)(II).

1 “(IV) The Secretary may coordi-
2 nate the review and appropriate ad-
3 justment described in clause (i)(II)
4 with the periodic review described in
5 subparagraph (B).

6 “(V) As part of the review and
7 adjustment described in clause (i)(II),
8 including with respect to codes with
9 low relative values described in clause
10 (ii), the Secretary may make appro-
11 priate coding revisions (including
12 using existing processes for consider-
13 ation of coding changes) which may
14 include consolidation of individual
15 services into bundled codes for pay-
16 ment under the fee schedule under
17 subsection (b).

18 “(VI) The provisions of subpara-
19 graph (B)(ii)(II) shall apply to adjust-
20 ments to relative value units made
21 pursuant to this subparagraph in the
22 same manner as such provisions apply
23 to adjustments under subparagraph
24 (B)(ii)(II).

1 “(L) VALIDATING RELATIVE VALUE
2 UNITS.—

3 “(i) IN GENERAL.—The Secretary
4 shall establish a process to validate relative
5 value units under the fee schedule under
6 subsection (b).

7 “(ii) COMPONENTS AND ELEMENTS
8 OF WORK.—The process described in
9 clause (i) may include validation of work
10 elements (such as time, mental effort and
11 professional judgment, technical skill and
12 physical effort, and stress due to risk) in-
13 volved with furnishing a service and may
14 include validation of the pre-, post-, and
15 intra-service components of work.

16 “(iii) SCOPE OF CODES.—The valida-
17 tion of work relative value units shall in-
18 clude a sampling of codes for services that
19 is the same as the codes listed under sub-
20 paragraph (K)(ii).

21 “(iv) METHODS.—The Secretary may
22 conduct the validation under this subpara-
23 graph using methods described in sub-
24 clauses (I) through (V) of subparagraph

1 (K)(iii) as the Secretary determines to be
2 appropriate.

3 “(v) ADJUSTMENTS.—The Secretary
4 shall make appropriate adjustments to the
5 work relative value units under the fee
6 schedule under subsection (b). The provi-
7 sions of subparagraph (B)(ii)(II) shall
8 apply to adjustments to relative value units
9 made pursuant to this subparagraph in the
10 same manner as such provisions apply to
11 adjustments under subparagraph
12 (B)(ii)(II).”.

13 (b) IMPLEMENTATION.—

14 (1) ADMINISTRATION.—

15 (A) Chapter 35 of title 44, United States
16 Code and the provisions of the Federal Advisory
17 Committee Act (5 U.S.C. App.) shall not apply
18 to this section or the amendment made by this
19 section.

20 (B) Notwithstanding any other provision of
21 law, the Secretary may implement subpara-
22 graphs (K) and (L) of 1848(c)(2) of the Social
23 Security Act, as added by subsection (a), by
24 program instruction or otherwise.

1 (C) Section 4505(d) of the Balanced
2 Budget Act of 1997 is repealed.

3 (D) Except for provisions related to con-
4 fidentiality of information, the provisions of the
5 Federal Acquisition Regulation shall not apply
6 to this section or the amendment made by this
7 section.

8 (2) FOCUSING CMS RESOURCES ON POTEN-
9 Tially OVERVALUED CODES.—Section 1868(a) of
10 the Social Security Act (42 U.S.C. 1395ee(a)) is re-
11 pealed.

12 **SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION**
13 **FACTOR FOR ADVANCED IMAGING SERVICES.**

14 (a) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
15 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848
16 of the Social Security Act (42 U.S.C. 1395w-4) is amend-
17 ed—

18 (1) in subsection (b)(4)—

19 (A) in subparagraph (B), by striking “sub-
20 paragraph (A)” and inserting “this paragraph”;
21 and

22 (B) by adding at the end the following new
23 subparagraph:

24 “(C) ADJUSTMENT IN PRACTICE EXPENSE
25 TO REFLECT HIGHER PRESUMED UTILIZA-

1 TION.—Consistent with the methodology for
2 computing the number of practice expense rel-
3 ative value units under subsection (c)(2)(C)(ii)
4 with respect to advanced diagnostic imaging
5 services (as defined in section 1834(e)(1)(B))
6 furnished on or after January 1, 2010, the Sec-
7 retary shall adjust such number of units so it
8 reflects—

9 “(i) in the case of services furnished
10 on or after January 1, 2010, and before
11 January 1, 2013, a 65 percent (rather
12 than 50 percent) presumed rate of utiliza-
13 tion of imaging equipment;

14 “(ii) in the case of services furnished
15 on or after January 1, 2013, and before
16 January 1, 2014, a 70 percent (rather
17 than 50 percent) presumed rate of utiliza-
18 tion of imaging equipment; and

19 “(iii) in the case of services furnished
20 on or after January 1, 2014, a 75 percent
21 (rather than 50 percent) presumed rate of
22 utilization of imaging equipment.”; and

23 (2) in subsection (c)(2)(B)(v), by adding at the
24 end the following new subclauses:

1 “(III) CHANGE IN PRESUMED
2 UTILIZATION LEVEL OF CERTAIN AD-
3 VANCED DIAGNOSTIC IMAGING SERV-
4 ICES FOR 2010 THROUGH 2012.—Effec-
5 tive for fee schedules established be-
6 ginning with 2010 and ending with
7 2012, reduced expenditures attrib-
8 utable to the presumed rate of utiliza-
9 tion of imaging equipment of 65 per-
10 cent under subsection (b)(4)(C)(i) in-
11 stead of a presumed rate of utilization
12 of such equipment of 50 percent.

13 “(IV) CHANGE IN PRESUMED
14 UTILIZATION LEVEL OF CERTAIN AD-
15 VANCED DIAGNOSTIC IMAGING SERV-
16 ICES FOR 2013.—Effective for fee
17 schedules established for 2013, re-
18 duced expenditures attributable to the
19 presumed rate of utilization of imag-
20 ing equipment of 70 percent under
21 subsection (b)(4)(C)(ii) instead of a
22 presumed rate of utilization of such
23 equipment of 50 percent.

24 “(V) CHANGE IN PRESUMED UTI-
25 LIZATION LEVEL OF CERTAIN AD-

1 VANCED DIAGNOSTIC IMAGING SERV-
2 ICES FOR 2014 AND SUBSEQUENT
3 YEARS.—Effective for fee schedules
4 established beginning with 2014, re-
5 duced expenditures attributable to the
6 presumed rate of utilization of imag-
7 ing equipment of 75 percent under
8 subsection (b)(4)(C)(iii) instead of a
9 presumed rate of utilization of such
10 equipment of 50 percent.”.

11 (b) ADJUSTMENT IN TECHNICAL COMPONENT “DIS-
12 COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE
13 BODY PARTS.—Section 1848 of the Social Security Act
14 (42 U.S.C. 1395w-4), as amended by subsection (a), is
15 amended—

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

18 “(D) ADJUSTMENT IN TECHNICAL COMPO-
19 NENT DISCOUNT ON SINGLE-SESSION IMAGING
20 INVOLVING CONSECUTIVE BODY PARTS.—For
21 services furnished on or after July 1, 2010, the
22 Secretary shall increase the reduction in pay-
23 ments attributable to the multiple procedure
24 payment reduction applicable to the technical
25 component for imaging under the final rule

1 published by the Secretary in the Federal Reg-
2 ister on November 21, 2005 (part 405 of title
3 42, Code of Federal Regulations) from 25 per-
4 cent to 50 percent.”; and

5 (2) in subsection (c)(2)(B)(v), by adding at the
6 end the following new subclause:

7 “(VI) ADDITIONAL REDUCED
8 PAYMENT FOR MULTIPLE IMAGING
9 PROCEDURES.—Effective for fee
10 schedules established beginning with
11 2010 (but not applied for services fur-
12 nished prior to July 1, 2010), reduced
13 expenditures attributable to the in-
14 crease in the multiple procedure pay-
15 ment reduction from 25 to 50 percent
16 (as described in subsection
17 (b)(4)(D)).”.

18 (c) ANALYSIS BY THE CHIEF ACTUARY OF THE CEN-
19 TERS FOR MEDICARE & MEDICAID SERVICES.—Not later
20 than January 1, 2013, the Chief Actuary of the Centers
21 for Medicare & Medicaid Services shall make publicly
22 available an analysis of whether, for the period of 2010
23 through 2019, the cumulative expenditure reductions
24 under title XVIII of the Social Security Act that are at-

1 tributable to the adjustments under the amendments made
2 by this section are projected to exceed \$3,000,000,000.

3 **SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN**
4 **WHEELCHAIRS.**

5 (a) IN GENERAL.—Section 1834(a)(7)(A) of the So-
6 cial Security Act (42 U.S.C. 1395m(a)(7)(A)) is amend-
7 ed—

8 (1) in clause (i)—

9 (A) in subclause (II), by inserting “sub-
10 clause (III) and” after “Subject to”; and

11 (B) by adding at the end the following new
12 subclause:

13 “(III) SPECIAL RULE FOR
14 POWER-DRIVEN WHEELCHAIRS.—For
15 purposes of payment for power-driven
16 wheelchairs, subclause (II) shall be
17 applied by substituting ‘15 percent’
18 and ‘6 percent’ for ‘10 percent’ and
19 ‘7.5 percent’, respectively.”; and

20 (2) in clause (iii)—

21 (A) in the heading, by inserting “COM-
22 PLEX, REHABILITATIVE” before “POWER-DRIV-
23 EN”; and

24 (B) by inserting “complex, rehabilitative”
25 before “power-driven”.

1 (b) TECHNICAL AMENDMENT.—Section
2 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C.
3 1395m(a)(7)(C)(ii)(II)) is amended by striking “(A)(ii)
4 or”.

5 (c) EFFECTIVE DATE.—

6 (1) IN GENERAL.—Subject to paragraph (2),
7 the amendments made by subsection (a) shall take
8 effect on January 1, 2011, and shall apply to power-
9 driven wheelchairs furnished on or after such date.

10 (2) APPLICATION TO COMPETITIVE BIDDING.—

11 The amendments made by subsection (a) shall not
12 apply to payment made for items and services fur-
13 nished pursuant to contracts entered into under sec-
14 tion 1847 of the Social Security Act (42 U.S.C.
15 1395w-3) prior to January 1, 2011, pursuant to the
16 implementation of subsection (a)(1)(B)(i)(I) of such
17 section 1847.

18 **SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.**

19 (a) EXTENSION OF SECTION 508 HOSPITAL RECLAS-
20 SIFICATIONS.—

21 (1) IN GENERAL.—Subsection (a) of section
22 106 of division B of the Tax Relief and Health Care
23 Act of 2006 (42 U.S.C. 1395 note), as amended by
24 section 117 of the Medicare, Medicaid, and SCHIP
25 Extension Act of 2007 (Public Law 110-173) and

1 section 124 of the Medicare Improvements for Pa-
2 tients and Providers Act of 2008 (Public Law 110-
3 275), is amended by striking “September 30, 2009”
4 and inserting “September 30, 2010”.

5 (2) USE OF PARTICULAR WAGE INDEX IN FIS-
6 CAL YEAR 2010.—For purposes of implementation of
7 the amendment made by this subsection during fis-
8 cal year 2010, the Secretary shall use the hospital
9 wage index that was promulgated by the Secretary
10 in the Federal Register on August 27, 2009 (74
11 Fed. Reg. 43754), and any subsequent corrections.

12 (b) PLAN FOR REFORMING THE MEDICARE HOS-
13 PITAL WAGE INDEX SYSTEM.—

14 (1) IN GENERAL.—Not later than December 31,
15 2011, the Secretary of Health and Human Services
16 (in this section referred to as the “Secretary”) shall
17 submit to Congress a report that includes a plan to
18 reform the hospital wage index system under section
19 1886 of the Social Security Act.

20 (2) DETAILS.—In developing the plan under
21 paragraph (1), the Secretary shall take into account
22 the goals for reforming such system set forth in the
23 Medicare Payment Advisory Commission June 2007
24 report entitled “Report to Congress: Promoting
25 Greater Efficiency in Medicare”, including estab-

1 lishing a new hospital compensation index system
2 that—

3 (A) uses Bureau of Labor Statistics data,
4 or other data or methodologies, to calculate rel-
5 ative wages for each geographic area involved;

6 (B) minimizes wage index adjustments be-
7 tween and within metropolitan statistical areas
8 and statewide rural areas;

9 (C) includes methods to minimize the vola-
10 tility of wage index adjustments that result
11 from implementation of policy, while maintain-
12 ing budget neutrality in applying such adjust-
13 ments;

14 (D) takes into account the effect that im-
15 plementation of the system would have on
16 health care providers and on each region of the
17 country;

18 (E) addresses issues related to occupa-
19 tional mix, such as staffing practices and ratios,
20 and any evidence on the effect on quality of
21 care or patient safety as a result of the imple-
22 mentation of the system; and

23 (F) provides for a transition.

1 (3) CONSULTATION.—In developing the plan
2 under paragraph (1), the Secretary shall consult
3 with relevant affected parties.

4 (c) USE OF PARTICULAR CRITERIA FOR DETER-
5 MINING RECLASSIFICATIONS.—Notwithstanding any other
6 provision of law, in making decisions on applications for
7 reclassification of a subsection (d) hospital (as defined in
8 paragraph (1)(B) of section 1886(d) of the Social Security
9 Act (42 U.S.C. 1395ww(d)) for the purposes described in
10 paragraph (10)(D)(v) of such section for fiscal year 2011
11 and each subsequent fiscal year (until the first fiscal year
12 beginning on or after the date that is 1 year after the
13 Secretary of Health and Human Services submits the re-
14 port to Congress under subsection (b)), the Geographic
15 Classification Review Board established under paragraph
16 (10) of such section shall use the average hourly wage
17 comparison criteria used in making such decisions as of
18 September 30, 2008. The preceding sentence shall be ef-
19 fected in a budget neutral manner.

20 **SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.**

21 Section 1833(t) of the Social Security Act (42 U.S.C.
22 1395l(t)) is amended by adding at the end the following
23 new paragraph:

24 “(18) AUTHORIZATION OF ADJUSTMENT FOR
25 CANCER HOSPITALS.—

1 “(A) STUDY.—The Secretary shall conduct
2 a study to determine if, under the system under
3 this subsection, costs incurred by hospitals de-
4 scribed in section 1886(d)(1)(B)(v) with respect
5 to ambulatory payment classification groups ex-
6 ceed those costs incurred by other hospitals fur-
7 nishing services under this subsection (as deter-
8 mined appropriate by the Secretary). In con-
9 ducting the study under this subparagraph, the
10 Secretary shall take into consideration the cost
11 of drugs and biologicals incurred by such hos-
12 pitals.

13 “(B) AUTHORIZATION OF ADJUSTMENT.—
14 Insofar as the Secretary determines under sub-
15 paragraph (A) that costs incurred by hospitals
16 described in section 1886(d)(1)(B)(v) exceed
17 those costs incurred by other hospitals fur-
18 nishing services under this subsection, the Sec-
19 retary shall provide for an appropriate adjust-
20 ment under paragraph (2)(E) to reflect those
21 higher costs effective for services furnished on
22 or after January 1, 2011.”.

1 **SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PROD-**
2 **UCTS.**

3 (a) IN GENERAL.—Section 1847A of the Social Secu-
4 rity Act (42 U.S.C. 1395w–3a) is amended—

5 (1) in subsection (b)—

6 (A) in paragraph (1)—

7 (i) in subparagraph (A), by striking
8 “or” at the end;

9 (ii) in subparagraph (B), by striking
10 the period at the end and inserting “; or”;
11 and

12 (iii) by adding at the end the fol-
13 lowing new subparagraph:

14 “(C) in the case of a biosimilar biological
15 product (as defined in subsection (e)(6)(H)),
16 the amount determined under paragraph (8).”;
17 and

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

20 “(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The
21 amount specified in this paragraph for a biosimilar
22 biological product described in paragraph (1)(C) is
23 the sum of—

24 “(A) the average sales price as determined
25 using the methodology described under para-
26 graph (6) applied to a biosimilar biological

1 product for all National Drug Codes assigned to
2 such product in the same manner as such para-
3 graph is applied to drugs described in such
4 paragraph; and

5 “(B) 6 percent of the amount determined
6 under paragraph (4) for the reference biological
7 product (as defined in subsection (c)(6)(I)).”;
8 and

9 (2) in subsection (c)(6), by adding at the end
10 the following new subparagraph:

11 “(H) BIOSIMILAR BIOLOGICAL PRODUCT.—
12 The term ‘biosimilar biological product’ means
13 a biological product approved under an abbrevi-
14 ated application for a license of a biological
15 product that relies in part on data or informa-
16 tion in an application for another biological
17 product licensed under section 351 of the Pub-
18 lic Health Service Act.

19 “(I) REFERENCE BIOLOGICAL PRODUCT.—
20 The term ‘reference biological product’ means
21 the biological product licensed under such sec-
22 tion 351 that is referred to in the application
23 described in subparagraph (H) of the biosimilar
24 biological product.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to payments for biosimilar bio-
3 logical products beginning with the first day of the second
4 calendar quarter after enactment of legislation providing
5 for a biosimilar pathway (as determined by the Secretary).

6 **SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEM-**
7 **ONSTRATION PROGRAM.**

8 (a) ESTABLISHMENT.—

9 (1) IN GENERAL.—The Secretary of Health and
10 Human Services (in this section referred to as the
11 “Secretary”) shall establish a Medicare Hospice
12 Concurrent Care demonstration program at partici-
13 pating hospice programs under which Medicare
14 beneficiaries are furnished, during the same period,
15 hospice care and any other items or services covered
16 under title XVIII of the Social Security Act (42
17 U.S.C. 1395 et seq.) from funds otherwise paid
18 under such title to such hospice programs.

19 (2) DURATION.—The demonstration program
20 under this section shall be conducted for a 3-year
21 period.

22 (3) SITES.—The Secretary shall select not more
23 than 15 hospice programs at which the demonstra-
24 tion program under this section shall be conducted.

1 Such hospice programs shall be located in urban and
2 rural areas.

3 (b) INDEPENDENT EVALUATION AND REPORTS.—

4 (1) INDEPENDENT EVALUATION.—The Sec-
5 retary shall provide for the conduct of an inde-
6 pendent evaluation of the demonstration program
7 under this section. Such independent evaluation
8 shall determine whether the demonstration program
9 has improved patient care, quality of life, and cost-
10 effectiveness for Medicare beneficiaries participating
11 in the demonstration program.

12 (2) REPORTS.—The Secretary shall submit to
13 Congress a report containing the results of the eval-
14 uation conducted under paragraph (1), together with
15 such recommendations as the Secretary determines
16 appropriate.

17 (c) BUDGET NEUTRALITY.—With respect to the 3-
18 year period of the demonstration program under this sec-
19 tion, the Secretary shall ensure that the aggregate expend-
20 itures under title XVIII for such period shall not exceed
21 the aggregate expenditures that would have been expended
22 under such title if the demonstration program under this
23 section had not been implemented.

1 **SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NA-**
2 **TIONAL BASIS IN THE CALCULATION OF THE**
3 **MEDICARE HOSPITAL WAGE INDEX FLOOR.**

4 In the case of discharges occurring on or after Octo-
5 ber 1, 2010, for purposes of applying section 4410 of the
6 Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)
7 and paragraph (h)(4) of section 412.64 of title 42, Code
8 of Federal Regulations, the Secretary of Health and
9 Human Services shall administer subsection (b) of such
10 section 4410 and paragraph (e) of such section 412.64
11 in the same manner as the Secretary administered such
12 subsection (b) and paragraph (e) for discharges occurring
13 during fiscal year 2008 (through a uniform, national ad-
14 justment to the area wage index).

15 **SEC. 3142. HHS STUDY ON URBAN MEDICARE-DEPENDENT**
16 **HOSPITALS.**

17 (a) STUDY.—

18 (1) IN GENERAL.—The Secretary of Health and
19 Human Services (in this section referred to as the
20 “Secretary”) shall conduct a study on the need for
21 an additional payment for urban Medicare-depend-
22 ent hospitals for inpatient hospital services under
23 section 1886 of the Social Security Act (42 U.S.C.
24 1395ww). Such study shall include an analysis of—

25 (A) the Medicare inpatient margins of
26 urban Medicare-dependent hospitals, as com-

1 pared to other hospitals which receive 1 or more
2 additional payments or adjustments under such
3 section (including those payments or adjust-
4 ments described in paragraph (2)(A)); and

5 (B) whether payments to medicare-depend-
6 ent, small rural hospitals under subsection
7 (d)(5)(G) of such section should be applied to
8 urban Medicare-dependent hospitals.

9 (2) URBAN MEDICARE-DEPENDENT HOSPITAL
10 DEFINED.—For purposes of this section, the term
11 “urban Medicare-dependent hospital” means a sub-
12 section (d) hospital (as defined in subsection
13 (d)(1)(B) of such section) that—

14 (A) does not receive any additional pay-
15 ment or adjustment under such section, such as
16 payments for indirect medical education costs
17 under subsection (d)(5)(B) of such section, dis-
18 proportionate share payments under subsection
19 (d)(5)(A) of such section, payments to a rural
20 referral center under subsection (d)(5)(C) of
21 such section, payments to a critical access hos-
22 pital under section 1814(l) of such Act (42
23 U.S.C. 1395f(l)), payments to a sole community
24 hospital under subsection (d)(5)(D) of such sec-
25 tion 1886, or payments to a medicare-depend-

1 ent, small rural hospital under subsection
2 (d)(5)(G) of such section 1886; and

3 (B) for which more than 60 percent of its
4 inpatient days or discharges during 2 of the 3
5 most recently audited cost reporting periods for
6 which the Secretary has a settled cost report
7 were attributable to inpatients entitled to bene-
8 fits under part A of title XVIII of such Act.

9 (b) REPORT.—Not later than 9 months after the date
10 of enactment of this Act, the Secretary shall submit to
11 Congress a report containing the results of the study con-
12 ducted under subsection (a), together with recommenda-
13 tions for such legislation and administrative action as the
14 Secretary determines appropriate.

15 **Subtitle C—Provisions Relating to** 16 **Part C**

17 **SEC. 3201. MEDICARE ADVANTAGE PAYMENT.**

18 (a) MA BENCHMARK BASED ON PLAN'S COMPETI-
19 TIVE BIDS.—

20 (1) IN GENERAL.—Section 1853(j) of the Social
21 Security Act (42 U.S.C. 1395w–23(j)) is amended—

22 (A) by striking “AMOUNTS.—For pur-
23 poses” and inserting “AMOUNTS.—

24 “(1) IN GENERAL.—For purposes”;

1 (B) by redesignating paragraphs (1) and
2 (2) as subparagraphs (A) and (B), respectively,
3 and indenting the subparagraphs appropriately;

4 (C) in subparagraph (A), as redesignated
5 by subparagraph (B)—

6 (i) by redesignating subparagraphs
7 (A) and (B) as clauses (i) and (ii), respec-
8 tively, and indenting the clauses appro-
9 priately; and

10 (ii) in clause (i), as redesignated by
11 clause (i), by striking “an amount equal
12 to” and all that follows through the end
13 and inserting “an amount equal to—

14 “(I) for years before 2007, $\frac{1}{12}$ of
15 the annual MA capitation rate under
16 section 1853(c)(1) for the area for the
17 year, adjusted as appropriate for the
18 purpose of risk adjustment;

19 “(II) for 2007 through 2011, $\frac{1}{12}$
20 of the applicable amount determined
21 under subsection (k)(1) for the area
22 for the year;

23 “(III) for 2012, the sum of—

24 “(aa) $\frac{2}{3}$ of the quotient
25 of—

1 “(AA) the applicable
2 amount determined under
3 subsection (k)(1) for the
4 area for the year; and

5 “(BB) 12; and

6 “(bb) $\frac{1}{3}$ of the MA competi-
7 tive benchmark amount (deter-
8 mined under paragraph (2)) for
9 the area for the month;

10 “(IV) for 2013, the sum of—

11 “(aa) $\frac{1}{3}$ of the quotient
12 of—

13 “(AA) the applicable
14 amount determined under
15 subsection (k)(1) for the
16 area for the year; and

17 “(BB) 12; and

18 “(bb) $\frac{2}{3}$ of the MA competi-
19 tive benchmark amount (as so
20 determined) for the area for the
21 month;

22 “(V) for 2014, the MA competi-
23 tive benchmark amount for the area
24 for a month in 2013 (as so deter-
25 mined), increased by the national per

1 capita MA growth percentage, de-
2 scribed in subsection (c)(6) for 2014,
3 but not taking into account any ad-
4 justment under subparagraph (C) of
5 such subsection for a year before
6 2004; and

7 “(VI) for 2015 and each subse-
8 quent year, the MA competitive
9 benchmark amount (as so determined)
10 for the area for the month; or”;

11 (iii) in clause (ii), as redesignated by
12 clause (i), by striking “subparagraph (A)”
13 and inserting “clause (i)”;

14 (D) by adding at the end the following new
15 paragraphs:

16 “(2) COMPUTATION OF MA COMPETITIVE
17 BENCHMARK AMOUNT.—

18 “(A) IN GENERAL.—Subject to subpara-
19 graph (B) and paragraph (3), for months in
20 each year (beginning with 2012) for each MA
21 payment area the Secretary shall compute an
22 MA competitive benchmark amount equal to the
23 weighted average of the unadjusted MA statu-
24 tory non-drug monthly bid amount (as defined
25 in section 1854(b)(2)(E)) for each MA plan in

1 the area, with the weight for each plan being
2 equal to the average number of beneficiaries en-
3 rolled under such plan in the reference month
4 (as defined in section 1858(f)(4), except that,
5 in applying such definition for purposes of this
6 paragraph, ‘to compute the MA competitive
7 benchmark amount under section 1853(j)(2)’
8 shall be substituted for ‘to compute the percent-
9 age specified in subparagraph (A) and other
10 relevant percentages under this part’).

11 “(B) WEIGHTING RULES.—

12 “(i) SINGLE PLAN RULE.—In the case
13 of an MA payment area in which only a
14 single MA plan is being offered, the weight
15 under subparagraph (A) shall be equal to
16 1.

17 “(ii) USE OF SIMPLE AVERAGE AMONG
18 MULTIPLE PLANS IF NO PLANS OFFERED
19 IN PREVIOUS YEAR.—In the case of an MA
20 payment area in which no MA plan was of-
21 fered in the previous year and more than
22 1 MA plan is offered in the current year,
23 the Secretary shall use a simple average of
24 the unadjusted MA statutory non-drug
25 monthly bid amount (as so defined) for

1 purposes of computing the MA competitive
2 benchmark amount under subparagraph
3 (A).

4 “(3) CAP ON MA COMPETITIVE BENCHMARK
5 AMOUNT.—In no case shall the MA competitive
6 benchmark amount for an area for a month in a
7 year be greater than the applicable amount that
8 would (but for the application of this subsection) be
9 determined under subsection (k)(1) for the area for
10 the month in the year.”; and

11 (E) in subsection (k)(2)(B)(ii)(III), by
12 striking “(j)(1)(A)” and inserting
13 “(j)(1)(A)(i)”.

14 (2) CONFORMING AMENDMENTS.—

15 (A) Section 1853(k)(2) of the Social Secu-
16 rity Act (42 U.S.C. 1395w-23(k)(2)) is amend-
17 ed—

18 (i) in subparagraph (A), by striking
19 “through 2010” and inserting “and subse-
20 quent years”; and

21 (ii) in subparagraph (C)—

22 (I) in clause (iii), by striking
23 “and” at the end;

1 (II) in clause (iv), by striking the
2 period at the end and inserting “;
3 and”; and

4 (III) by adding at the end the
5 following new clause:

6 “(v) for 2011 and subsequent years,
7 0.00.”.

8 (B) Section 1854(b) of the Social Security
9 Act (42 U.S.C. 1395w-24(b)) is amended—

10 (i) in paragraph (3)(B)(i), by striking
11 “1853(j)(1)” and inserting
12 “1853(j)(1)(A)”; and

13 (ii) in paragraph (4)(B)(i), by striking
14 “1853(j)(2)” and inserting
15 “1853(j)(1)(B)”.

16 (C) Section 1858(f) of the Social Security
17 Act (42 U.S.C. 1395w-27(f)) is amended—

18 (i) in paragraph (1), by striking
19 “1853(j)(2)” and inserting
20 “1853(j)(1)(B)”; and

21 (ii) in paragraph (3)(A), by striking
22 “1853(j)(1)(A)” and inserting
23 “1853(j)(1)(A)(i)”.

24 (D) Section 1860C-1(d)(1)(A) of the So-
25 cial Security Act (42 U.S.C. 1395w-

1 29(d)(1)(A)) is amended by striking
2 “1853(j)(1)(A)” and inserting
3 “1853(j)(1)(A)(i)”.

4 (b) REDUCTION OF NATIONAL PER CAPITA GROWTH
5 PERCENTAGE FOR 2011.—Section 1853(e)(6) of the So-
6 cial Security Act (42 U.S.C. 1395w-23(c)(6)) is amend-
7 ed—

8 (1) in clause (v), by striking “and” at the end;
9 (2) in clause (vi)—

10 (A) by striking “for a year after 2002”
11 and inserting “for 2003 through 2010”; and

12 (B) by striking the period at the end and
13 inserting a comma; and

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

16 “(vii) for 2011, 3 percentage points;

17 and

18 “(viii) for a year after 2011, 0 per-
19 centage points.”.

20 (c) ENHANCEMENT OF BENEFICIARY REBATES.—
21 Section 1854(b)(1)(C)(i) of the Social Security Act (42
22 U.S.C. 1395w-24(b)(1)(C)(i)) is amended by inserting
23 “(or 100 percent in the case of plan years beginning on
24 or after January 1, 2014)” after “75 percent”.

25 (d) BIDDING RULES.—

1 (1) REQUIREMENTS FOR INFORMATION SUB-
 2 MITTED.—Section 1854(a)(6)(A) of the Social Secu-
 3 rity Act (42 U.S.C. 1395w-24(a)(6)(A)) is amended,
 4 in the flush matter following clause (v), by adding
 5 at the end the following sentence: “Information to
 6 be submitted under this paragraph shall be certified
 7 by a qualified member of the American Academy of
 8 Actuaries and shall meet actuarial guidelines and
 9 rules established by the Secretary under subpara-
 10 graph (B)(v).”.

11 (2) ESTABLISHMENT OF ACTUARIAL GUIDE-
 12 LINES.—Section 1854(a)(6)(B) of the Social Secu-
 13 rity Act (42 U.S.C. 1395w-24(a)(6)(B)) is amend-
 14 ed—

15 (A) in clause (i), by striking “(iii) and
 16 (iv)” and inserting “(iii), (iv), and (v)”; and

17 (B) by adding at the end the following new
 18 clause:

19 “(v) ESTABLISHMENT OF ACTUARIAL
 20 GUIDELINES.—

21 “(I) IN GENERAL.—In order to
 22 establish fair MA competitive bench-
 23 marks under section 1853(j)(1)(A)(i),
 24 the Secretary, acting through the
 25 Chief Actuary of the Centers for

1 Medicare & Medicaid Services (in this
2 clause referred to as the ‘Chief Actu-
3 ary’), shall establish—

4 “(aa) actuarial guidelines
5 for the submission of bid infor-
6 mation under this paragraph;
7 and

8 “(bb) bidding rules that are
9 appropriate to ensure accurate
10 bids and fair competition among
11 MA plans.

12 “(II) DENIAL OF BID
13 AMOUNTS.—The Secretary shall deny
14 monthly bid amounts submitted under
15 subparagraph (A) that do not meet
16 the actuarial guidelines and rules es-
17 tablished under subclause (I).

18 “(III) REFUSAL TO ACCEPT CER-
19 TAIN BIDS DUE TO MISREPRESENTA-
20 TIONS AND FAILURES TO ADE-
21 QUATELY MEET REQUIREMENTS.—In
22 the case where the Secretary deter-
23 mines that information submitted by
24 an MA organization under subpara-
25 graph (A) contains consistent mis-

1 representations and failures to ade-
2 quately meet requirements of the or-
3 ganization, the Secretary may refuse
4 to accept any additional such bid
5 amounts from the organization for the
6 plan year and the Chief Actuary shall,
7 if the Chief Actuary determines that
8 the actuaries of the organization were
9 complicit in those misrepresentations
10 and failures, report those actuaries to
11 the Actuarial Board for Counseling
12 and Discipline.”.

13 (3) EFFECTIVE DATE.—The amendments made
14 by this subsection shall apply to bid amounts sub-
15 mitted on or after January 1, 2012.

16 (e) MA LOCAL PLAN SERVICE AREAS.—

17 (1) IN GENERAL.—Section 1853(d) of the So-
18 cial Security Act (42 U.S.C. 1395w-23(d)) is
19 amended—

20 (A) in the subsection heading, by striking
21 “MA REGION” and inserting “MA REGION; MA
22 LOCAL PLAN SERVICE AREA”;

23 (B) in paragraph (1), by striking subpara-
24 graph (A) and inserting the following:

25 “(A) with respect to an MA local plan—

1 “(i) for years before 2012, an MA
2 local area (as defined in paragraph (2));
3 and

4 “(ii) for 2012 and succeeding years, a
5 service area that is an entire urban or
6 rural area, as applicable (as described in
7 paragraph (5)); and”; and

8 (C) by adding at the end the following new
9 paragraph:

10 “(5) MA LOCAL PLAN SERVICE AREA.—For
11 2012 and succeeding years, the service area for an
12 MA local plan shall be an entire urban or rural area
13 in each State as follows:

14 “(A) URBAN AREAS.—

15 “(i) IN GENERAL.—Subject to clause
16 (ii) and subparagraphs (C) and (D), the
17 service area for an MA local plan in an
18 urban area shall be the Core Based Statis-
19 tical Area (in this paragraph referred to as
20 a ‘CBSA’) or, if applicable, a conceptually
21 similar alternative classification, as defined
22 by the Director of the Office of Manage-
23 ment and Budget.

24 “(ii) CBSA COVERING MORE THAN
25 ONE STATE.—In the case of a CBSA (or

1 alternative classification) that covers more
2 than one State, the Secretary shall divide
3 the CBSA (or alternative classification)
4 into separate service areas with respect to
5 each State covered by the CBSA (or alter-
6 native classification).

7 “(B) RURAL AREAS.—Subject to subpara-
8 graphs (C) and (D), the service area for an MA
9 local plan in a rural area shall be a county that
10 does not qualify for inclusion in a CBSA (or al-
11 ternative classification), as defined by the Di-
12 rector of the Office of Management and Budg-
13 et.

14 “(C) REFINEMENTS TO SERVICE AREAS.—
15 For 2015 and succeeding years, in order to re-
16 flect actual patterns of health care service utili-
17 zation, the Secretary may adjust the boundaries
18 of service areas for MA local plans in urban
19 areas and rural areas under subparagraphs (A)
20 and (B), respectively, but may only do so based
21 on recent analyses of actual patterns of care.

22 “(D) ADDITIONAL AUTHORITY TO MAKE
23 LIMITED EXCEPTIONS TO SERVICE AREA RE-
24 QUIREMENTS FOR MA LOCAL PLANS.—The Sec-
25 retary may, in addition to any adjustments

1 under subparagraph (C), make limited excep-
2 tions to service area requirements otherwise ap-
3 plicable under this part for MA local plans that
4 have in effect (as of the date of enactment of
5 the Patient Protection and Affordable Care
6 Act)—

7 “(i) agreements with another MA or-
8 ganization or MA plan that preclude the
9 offering of benefits throughout an entire
10 service area; or

11 “(ii) limitations in their structural ca-
12 pacity to support adequate networks
13 throughout an entire service area as a re-
14 sult of the delivery system model of the
15 MA local plan.”.

16 (2) CONFORMING AMENDMENTS.—

17 (A) IN GENERAL.—

18 (i) Section 1851(b)(1) of the Social
19 Security Act (42 U.S.C. 1395w–21(b)(1))
20 is amended by striking subparagraph (C).

21 (ii) Section 1853(b)(1)(B)(i) of such
22 Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

23 (I) in the matter preceding sub-
24 clause (I), by striking “MA payment

1 area” and inserting “MA local area
2 (as defined in subsection (d)(2))”; and

3 (II) in subclause (I), by striking
4 “MA payment area” and inserting
5 “MA local area (as so defined)”.

6 (iii) Section 1853(b)(4) of such Act
7 (42 U.S.C. 1395w-23(b)(4)) is amended
8 by striking “Medicare Advantage payment
9 area” and inserting “MA local area (as so
10 defined)”.

11 (iv) Section 1853(c)(1) of such Act
12 (42 U.S.C. 1395w-23(c)(1)) is amended—

13 (I) in the matter preceding sub-
14 paragraph (A), by striking “a Medi-
15 care Advantage payment area that
16 is”; and

17 (II) in subparagraph (D)(i), by
18 striking “MA payment area” and in-
19 serting “MA local area (as defined in
20 subsection (d)(2))”.

21 (v) Section 1854 of such Act (42
22 U.S.C. 1395w-24) is amended by striking
23 subsection (h).

1 (B) EFFECTIVE DATE.—The amendments
2 made by this paragraph shall take effect on
3 January 1, 2012.

4 (f) PERFORMANCE BONUSES.—

5 (1) MA PLANS.—

6 (A) IN GENERAL.—Section 1853 of the So-
7 cial Security Act (42 U.S.C. 1395w–23) is
8 amended by adding at the end the following
9 new subsection:

10 “(n) PERFORMANCE BONUSES.—

11 “(1) CARE COORDINATION AND MANAGEMENT
12 PERFORMANCE BONUS.—

13 “(A) IN GENERAL.—For years beginning
14 with 2014, subject to subparagraph (B), in the
15 case of an MA plan that conducts 1 or more
16 programs described in subparagraph (C) with
17 respect to the year, the Secretary shall, in addi-
18 tion to any other payment provided under this
19 part, make monthly payments, with respect to
20 coverage of an individual under this part, to the
21 MA plan in an amount equal to the product
22 of—

23 “(i) 0.5 percent of the national
24 monthly per capita cost for expenditures
25 for individuals enrolled under the original

1 medicare fee-for-service program for the
2 year; and

3 “(ii) the total number of programs de-
4 scribed in clauses (i) through (ix) of sub-
5 paragraph (C) that the Secretary deter-
6 mines the plan is conducting for the year
7 under such subparagraph.

8 “(B) LIMITATION.—In no case may the
9 total amount of payment with respect to a year
10 under subparagraph (A) be greater than 2 per-
11 cent of the national monthly per capita cost for
12 expenditures for individuals enrolled under the
13 original medicare fee-for-service program for
14 the year, as determined prior to the application
15 of risk adjustment under paragraph (4).

16 “(C) PROGRAMS DESCRIBED.—The fol-
17 lowing programs are described in this para-
18 graph:

19 “(i) Care management programs
20 that—

21 “(I) target individuals with 1 or
22 more chronic conditions;

23 “(II) identify gaps in care; and

24 “(III) facilitate improved care by
25 using additional resources like nurses,

1 nurse practitioners, and physician as-
2 sistants.

3 “(ii) Programs that focus on patient
4 education and self-management of health
5 conditions, including interventions that—

6 “(I) help manage chronic condi-
7 tions;

8 “(II) reduce declines in health
9 status; and

10 “(III) foster patient and provider
11 collaboration.

12 “(iii) Transitional care interventions
13 that focus on care provided around a hos-
14 pital inpatient episode, including programs
15 that target post-discharge patient care in
16 order to reduce unnecessary health com-
17 plications and readmissions.

18 “(iv) Patient safety programs, includ-
19 ing provisions for hospital-based patient
20 safety programs in contracts that the
21 Medicare Advantage organization offering
22 the MA plan has with hospitals.

23 “(v) Financial policies that promote
24 systematic coordination of care by primary
25 care physicians across the full spectrum of

1 specialties and sites of care, such as med-
2 ical homes, capitation arrangements, or
3 pay-for-performance programs.

4 “(vi) Programs that address, identify,
5 and ameliorate health care disparities
6 among principal at-risk subpopulations.

7 “(vii) Medication therapy manage-
8 ment programs that are more extensive
9 than is required under section 1860D-4(c)
10 (as determined by the Secretary).

11 “(viii) Health information technology
12 programs, including clinical decision sup-
13 port and other tools to facilitate data col-
14 lection and ensure patient-centered, appro-
15 priate care.

16 “(ix) Such other care management
17 and coordination programs as the Sec-
18 retary determines appropriate.

19 “(D) CONDUCT OF PROGRAM IN URBAN
20 AND RURAL AREAS.—An MA plan may conduct
21 a program described in subparagraph (C) in a
22 manner appropriate for an urban or rural area,
23 as applicable.

24 “(E) REPORTING OF DATA.—Each Medi-
25 care Advantage organization shall provide to

1 the Secretary the information needed to deter-
2 mine whether they are eligible for a care coordi-
3 nation and management performance bonus at
4 a time and in a manner specified by the Sec-
5 retary.

6 “(F) PERIODIC AUDITING.—The Secretary
7 shall provide for the annual auditing of pro-
8 grams described in subparagraph (C) for which
9 an MA plan receives a care coordination and
10 management performance bonus under this
11 paragraph. The Comptroller General shall mon-
12 itor auditing activities conducted under this
13 subparagraph.

14 “(2) QUALITY PERFORMANCE BONUSES.—

15 “(A) QUALITY BONUS.—For years begin-
16 ning with 2014, the Secretary shall, in addition
17 to any other payment provided under this part,
18 make monthly payments, with respect to cov-
19 erage of an individual under this part, to an
20 MA plan that achieves at least a 3 star rating
21 (or comparable rating) on a rating system de-
22 scribed in subparagraph (C) in an amount
23 equal to—

24 “(i) in the case of a plan that achieves
25 a 3 star rating (or comparable rating) on

1 such system 2 percent of the national
2 monthly per capita cost for expenditures
3 for individuals enrolled under the original
4 medicare fee-for-service program for the
5 year; and

6 “(ii) in the case of a plan that
7 achieves a 4 or 5 star rating (or com-
8 parable rating on such system, 4 percent
9 of such national monthly per capita cost
10 for the year.

11 “(B) IMPROVED QUALITY BONUS.—For
12 years beginning with 2014, in the case of an
13 MA plan that does not receive a quality bonus
14 under subparagraph (A) and is an improved
15 quality MA plan with respect to the year (as
16 identified by the Secretary), the Secretary shall,
17 in addition to any other payment provided
18 under this part, make monthly payments, with
19 respect to coverage of an individual under this
20 part, to the MA plan in an amount equal to 1
21 percent of such national monthly per capita
22 cost for the year.

23 “(C) USE OF RATING SYSTEM.—For pur-
24 poses of subparagraph (A), a rating system de-
25 scribed in this paragraph is—

1 “(i) a rating system that uses up to 5
2 stars to rate clinical quality and enrollee
3 satisfaction and performance at the Medi-
4 care Advantage contract or MA plan level;
5 or

6 “(ii) such other system established by
7 the Secretary that provides for the deter-
8 mination of a comparable quality perform-
9 ance rating to the rating system described
10 in clause (i).

11 “(D) DATA USED IN DETERMINING
12 SCORE.—

13 “(i) IN GENERAL.—The rating of an
14 MA plan under the rating system described
15 in subparagraph (C) with respect to a year
16 shall be based on based on the most recent
17 data available.

18 “(ii) PLANS THAT FAIL TO REPORT
19 DATA.—An MA plan which does not report
20 data that enables the Secretary to rate the
21 plan for purposes of subparagraph (A) or
22 identify the plan for purposes of subpara-
23 graph (B) shall be counted, for purposes of
24 such rating or identification, as having the
25 lowest plan performance rating and the

1 lowest percentage improvement, respec-
2 tively.

3 “(3) QUALITY BONUS FOR NEW AND LOW EN-
4 ROLLMENT MA PLANS.—

5 “(A) NEW MA PLANS.—For years begin-
6 ning with 2014, in the case of an MA plan that
7 first submits a bid under section 1854(a)(1)(A)
8 for 2012 or a subsequent year, only receives en-
9 rollments made during the coverage election pe-
10 riods described in section 1851(e), and is not
11 able to receive a bonus under subparagraph (A)
12 or (B) of paragraph (2) for the year, the Sec-
13 retary shall, in addition to any other payment
14 provided under this part, make monthly pay-
15 ments, with respect to coverage of an individual
16 under this part, to the MA plan in an amount
17 equal to 2 percent of national monthly per cap-
18 ita cost for expenditures for individuals enrolled
19 under the original medicare fee-for-service pro-
20 gram for the year. In its fourth year of oper-
21 ation, the MA plan shall be paid in the same
22 manner as other MA plans with comparable en-
23 rollment.

24 “(B) LOW ENROLLMENT PLANS.—For
25 years beginning with 2014, in the case of an

1 MA plan that has low enrollment (as defined by
2 the Secretary) and would not otherwise be able
3 to receive a bonus under subparagraph (A) or
4 (B) of paragraph (2) or subparagraph (A) of
5 this paragraph for the year (referred to in this
6 subparagraph as a ‘low enrollment plan’), the
7 Secretary shall use a regional or local mean of
8 the rating of all MA plans in the region or local
9 area, as determined appropriate by the Sec-
10 retary, on measures used to determine whether
11 MA plans are eligible for a quality or an im-
12 proved quality bonus, as applicable, to deter-
13 mine whether the low enrollment plan is eligible
14 for a bonus under such a subparagraph.

15 “(4) RISK ADJUSTMENT.—The Secretary shall
16 risk adjust a performance bonus under this sub-
17 section in the same manner as the Secretary risk ad-
18 justs beneficiary rebates described in section
19 1854(b)(1)(C).

20 “(5) NOTIFICATION.—The Secretary, in the an-
21 nual announcement required under subsection
22 (b)(1)(B) for 2014 and each succeeding year, shall
23 notify the Medicare Advantage organization of any
24 performance bonus (including a care coordination
25 and management performance bonus under para-

1 graph (1), a quality performance bonus under para-
 2 graph (2), and a quality bonus for new and low en-
 3 rollment plans under paragraph (3)) that the organi-
 4 zation will receive under this subsection with respect
 5 to the year. The Secretary shall provide for the pub-
 6 lication of the information described in the previous
 7 sentence on the Internet website of the Centers for
 8 Medicare & Medicaid Services.”

9 (B) CONFORMING AMENDMENT.—Section
 10 1853(a)(1)(B) of the Social Security Act (42
 11 U.S.C. 1395w–23(a)(1)(B)) is amended—

12 (i) in clause (i), by inserting “and any
 13 performance bonus under subsection (n)”
 14 before the period at the end; and

15 (ii) in clause (ii), by striking “(G)”
 16 and inserting “(G), plus the amount (if
 17 any) of any performance bonus under sub-
 18 section (n)”.

19 (2) APPLICATION OF PERFORMANCE BONUSES
 20 TO MA REGIONAL PLANS.—Section 1858 of the So-
 21 cial Security Act (42 U.S.C. 1395w–27a) is amend-
 22 ed—

23 (A) in subsection (f)(1), by striking “sub-
 24 section (e)” and inserting “subsections (e) and
 25 (i)”; and

1 (B) by adding at the end the following new
2 subsection:

3 “(i) APPLICATION OF PERFORMANCE BONUSES TO
4 MA REGIONAL PLANS.—For years beginning with 2014,
5 the Secretary shall apply the performance bonuses under
6 section 1853(n) (relating to bonuses for care coordination
7 and management, quality performance, and new and low
8 enrollment MA plans) to MA regional plans in a similar
9 manner as such performance bonuses apply to MA plans
10 under such subsection.”.

11 (g) GRANDFATHERING SUPPLEMENTAL BENEFITS
12 FOR CURRENT ENROLLEES AFTER IMPLEMENTATION OF
13 COMPETITIVE BIDDING.—Section 1853 of the Social Se-
14 curity Act (42 U.S.C. 1395w-23), as amended by sub-
15 section (f), is amended by adding at the end the following
16 new subsection:

17 “(o) GRANDFATHERING SUPPLEMENTAL BENEFITS
18 FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF
19 COMPETITIVE BIDDING.—

20 “(1) IDENTIFICATION OF AREAS.—The Sec-
21 retary shall identify MA local areas in which, with
22 respect to 2009, average bids submitted by an MA
23 organization under section 1854(a) for MA local
24 plans in the area are not greater than 75 percent of
25 the adjusted average per capita cost for the year in-

1 involved, determined under section 1876(a)(4), for the
2 area for individuals who are not enrolled in an MA
3 plan under this part for the year, but adjusted to ex-
4 clude costs attributable to payments under section
5 1848(o), 1886(n), and 1886(h).

6 “(2) ELECTION TO PROVIDE REBATES TO
7 GRANDFATHERED ENROLLEES.—

8 “(A) IN GENERAL.—For years beginning
9 with 2012, each Medicare Advantage organiza-
10 tion offering an MA local plan in an area iden-
11 tified by the Secretary under paragraph (1)
12 may elect to provide rebates to grandfathered
13 enrollees under section 1854(b)(1)(C). In the
14 case where an MA organization makes such an
15 election, the monthly per capita dollar amount
16 of such rebates shall not exceed the applicable
17 amount for the year (as defined in subpara-
18 graph (B)).

19 “(B) APPLICABLE AMOUNT.—For purposes
20 of this subsection, the term ‘applicable amount’
21 means—

22 “(i) for 2012, the monthly per capita
23 dollar amount of such rebates provided to
24 enrollees under the MA local plan with re-
25 spect to 2011; and

1 “(ii) for a subsequent year, 95 percent
2 of the amount determined under this sub-
3 paragraph for the preceding year.

4 “(3) SPECIAL RULES FOR PLANS IN IDENTI-
5 FIED AREAS.—Notwithstanding any other provision
6 of this part, the following shall apply with respect to
7 each Medicare Advantage organization offering an
8 MA local plan in an area identified by the Secretary
9 under paragraph (1) that makes an election de-
10 scribed in paragraph (2):

11 “(A) PAYMENTS.—The amount of the
12 monthly payment under this section to the
13 Medicare Advantage organization, with respect
14 to coverage of a grandfathered enrollee under
15 this part in the area for a month, shall be equal
16 to—

17 “(i) for 2012 and 2013, the sum of—

18 “(I) the bid amount under sec-
19 tion 1854(a) for the MA local plan;
20 and

21 “(II) the applicable amount (as
22 defined in paragraph (2)(B)) for the
23 MA local plan for the year.

24 “(ii) for 2014 and subsequent years,
25 the sum of—

1 “(I) the MA competitive bench-
2 mark amount under subsection
3 (j)(1)(A)(i) for the area for the
4 month, adjusted, only to the extent
5 the Secretary determines necessary, to
6 account for induced utilization as a
7 result of rebates provided to grand-
8 fathered enrollees (except that such
9 adjustment shall not exceed 0.5 per-
10 cent of such MA competitive bench-
11 mark amount); and

12 “(II) the applicable amount (as
13 so defined) for the MA local plan for
14 the year.

15 “(B) REQUIREMENT TO SUBMIT BIDS
16 UNDER COMPETITIVE BIDDING.—The Medicare
17 Advantage organization shall submit a single
18 bid amount under section 1854(a) for the MA
19 local plan. The Medicare Advantage organiza-
20 tion shall remove from such bid amount any ef-
21 fects of induced demand for care that may re-
22 sult from the higher rebates available to grand-
23 fathered enrollees under this subsection.

24 “(C) NONAPPLICATION OF BONUS PAY-
25 MENTS AND ANY OTHER REBATES.—The Medi-

1 care Advantage organization offering the MA
2 local plan shall not be eligible for any bonus
3 payment under subsection (n) or any rebate
4 under this part (other than as provided under
5 this subsection) with respect to grandfathered
6 enrollees.

7 “(D) NONAPPLICATION OF UNIFORM BID
8 AND PREMIUM AMOUNTS TO GRANDFATHERED
9 ENROLLEES.—Section 1854(c) shall not apply
10 with respect to the MA local plan.

11 “(E) NONAPPLICATION OF LIMITATION ON
12 APPLICATION OF PLAN REBATES TOWARD PAY-
13 MENT OF PART B PREMIUM.—Notwithstanding
14 clause (iii) of section 1854(b)(1)(C), in the case
15 of a grandfathered enrollee, a rebate under such
16 section may be used for the purpose described
17 in clause (ii)(III) of such section.

18 “(F) RISK ADJUSTMENT.—The Secretary
19 shall risk adjust rebates to grandfathered en-
20 rollees under this subsection in the same man-
21 ner as the Secretary risk adjusts beneficiary re-
22 bates described in section 1854(b)(1)(C).

23 “(4) DEFINITION OF GRANDFATHERED EN-
24 ROLLEE.—In this subsection, the term ‘grand-
25 fathered enrollee’ means an individual who is en-

1 rolled (effective as of the date of enactment of this
 2 subsection) in an MA local plan in an area that is
 3 identified by the Secretary under paragraph (1).”.

4 (h) TRANSITIONAL EXTRA BENEFITS.—Section 1853
 5 of the Social Security Act (42 U.S.C. 1395w-23), as
 6 amended by subsections (f) and (g), is amended by adding
 7 at the end the following new subsection:

8 “(p) TRANSITIONAL EXTRA BENEFITS.—

9 “(1) IN GENERAL.—For years beginning with
 10 2012, the Secretary shall provide transitional re-
 11 bates under section 1854(b)(1)(C) for the provision
 12 of extra benefits (as specified by the Secretary) to
 13 enrollees described in paragraph (2).

14 “(2) ENROLLEES DESCRIBED.—An enrollee de-
 15 scribed in this paragraph is an individual who—

16 “(A) enrolls in an MA local plan in an ap-
 17 plicable area; and

18 “(B) experiences a significant reduction in
 19 extra benefits described in clause (ii) of section
 20 1854(b)(1)(C) as a result of competitive bidding
 21 under this part (as determined by the Sec-
 22 retary).

23 “(3) APPLICABLE AREAS.—In this subsection,
 24 the term ‘applicable area’ means the following:

1 “(A) The 2 largest metropolitan statistical
2 areas, if the Secretary determines that the total
3 amount of such extra benefits for each enrollee
4 for the month in those areas is greater than
5 \$100.

6 “(B) A county where—

7 “(i) the MA area-specific non-drug
8 monthly benchmark amount for a month in
9 2011 is equal to the legacy urban floor
10 amount (as described in subsection
11 (c)(1)(B)(iii)), as determined by the Sec-
12 retary for the area for 2011;

13 “(ii) the percentage of Medicare Ad-
14 vantage eligible beneficiaries in the county
15 who are enrolled in an MA plan for 2009
16 is greater than 30 percent (as determined
17 by the Secretary); and

18 “(iii) average bids submitted by an
19 MA organization under section 1854(a) for
20 MA local plans in the county for 2011 are
21 not greater than the adjusted average per
22 capita cost for the year involved, deter-
23 mined under section 1876(a)(4), for the
24 county for individuals who are not enrolled
25 in an MA plan under this part for the

1 year, but adjusted to exclude costs attrib-
2 utable to payments under section 1848(o),
3 1886(n), and 1886(h).

4 “(C) If the Secretary determines appro-
5 priate, a county contiguous to an area or coun-
6 ty described in subparagraph (A) or (B), re-
7 spectively.

8 “(4) REVIEW OF PLAN BIDS.—In the case of a
9 bid submitted by an MA organization under section
10 1854(a) for an MA local plan in an applicable area,
11 the Secretary shall review such bid in order to en-
12 sure that extra benefits (as specified by the Sec-
13 retary) are provided to enrollees described in para-
14 graph (2).

15 “(5) FUNDING.—The Secretary shall provide
16 for the transfer from the Federal Hospital Insurance
17 Trust Fund under section 1817 and the Federal
18 Supplementary Medical Insurance Trust Fund es-
19 tablished under section 1841, in such proportion as
20 the Secretary determines appropriate, of an amount
21 not to exceed \$5,000,000,000 for the period of fiscal
22 years 2012 through 2019 for the purpose of pro-
23 viding transitional rebates under section
24 1854(b)(1)(C) for the provision of extra benefits
25 under this subsection.”.

1 (i) NONAPPLICATION OF COMPETITIVE BIDDING AND
2 RELATED PROVISIONS AND CLARIFICATION OF MA PAY-
3 MENT AREA FOR PACE PROGRAMS.—

4 (1) NONAPPLICATION OF COMPETITIVE BID-
5 DING AND RELATED PROVISIONS FOR PACE PRO-
6 GRAMS.—Section 1894 of the Social Security Act
7 (42 U.S.C. 1395eee) is amended—

8 (A) by redesignating subsections (h) and
9 (i) as subsections (i) and (j), respectively;

10 (B) by inserting after subsection (g) the
11 following new subsection:

12 “(h) NONAPPLICATION OF COMPETITIVE BIDDING
13 AND RELATED PROVISIONS UNDER PART C.—With re-
14 spect to a PACE program under this section, the following
15 provisions (and regulations relating to such provisions)
16 shall not apply:

17 “(1) Section 1853(j)(1)(A)(i), relating to MA
18 area-specific non-drug monthly benchmark amount
19 being based on competitive bids.

20 “(2) Section 1853(d)(5), relating to the estab-
21 lishment of MA local plan service areas.

22 “(3) Section 1853(n), relating to the payment
23 of performance bonuses.

1 “(4) Section 1853(o), relating to
2 grandfathering supplemental benefits for current en-
3 rollees after implementation of competitive bidding.

4 “(5) Section 1853(p), relating to transitional
5 extra benefits.”.

6 (2) SPECIAL RULE FOR MA PAYMENT AREA FOR
7 PACE PROGRAMS.—Section 1853(d) of the Social Se-
8 curity Act (42 U.S.C. 1395w–23(d)), as amended by
9 subsection (e), is amended by adding at the end the
10 following new paragraph:

11 “(6) SPECIAL RULE FOR MA PAYMENT AREA
12 FOR PACE PROGRAMS.—For years beginning with
13 2012, in the case of a PACE program under section
14 1894, the MA payment area shall be the MA local
15 area (as defined in paragraph (2)).”.

16 **SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.**

17 (a) LIMITATION ON VARIATION OF COST SHARING
18 FOR CERTAIN BENEFITS.—

19 (1) IN GENERAL.—Section 1852(a)(1)(B) of the
20 Social Security Act (42 U.S.C. 1395w–22(a)(1)(B))
21 is amended—

22 (A) in clause (i), by inserting “, subject to
23 clause (iii),” after “and B or”; and

24 (B) by adding at the end the following new
25 clauses:

1 “(iii) LIMITATION ON VARIATION OF
2 COST SHARING FOR CERTAIN BENEFITS.—
3 Subject to clause (v), cost-sharing for serv-
4 ices described in clause (iv) shall not ex-
5 ceed the cost-sharing required for those
6 services under parts A and B.

7 “(iv) SERVICES DESCRIBED.—The fol-
8 lowing services are described in this clause:

9 “(I) Chemotherapy administra-
10 tion services.

11 “(II) Renal dialysis services (as
12 defined in section 1881(b)(14)(B)).

13 “(III) Skilled nursing care.

14 “(IV) Such other services that
15 the Secretary determines appropriate
16 (including services that the Secretary
17 determines require a high level of pre-
18 dictability and transparency for bene-
19 ficiaries).

20 “(v) EXCEPTION.—In the case of
21 services described in clause (iv) for which
22 there is no cost-sharing required under
23 parts A and B, cost-sharing may be re-
24 quired for those services in accordance
25 with clause (i).”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to plan years begin-
3 ning on or after January 1, 2011.

4 (b) APPLICATION OF REBATES, PERFORMANCE BO-
5 NUSES, AND PREMIUMS.—

6 (1) APPLICATION OF REBATES.—Section
7 1854(b)(1)(C) of the Social Security Act (42 U.S.C.
8 1395w-24(b)(1)(C)) is amended—

9 (A) in clause (ii), by striking “REBATE.—
10 A rebate” and inserting “REBATE FOR PLAN
11 YEARS BEFORE 2012.—For plan years before
12 2012, a rebate”;

13 (B) by redesignating clauses (iii) and (iv)
14 as clauses (iv) and (v); and

15 (C) by inserting after clause (ii) the fol-
16 lowing new clause:

17 “(iii) FORM OF REBATE FOR PLAN
18 YEAR 2012 AND SUBSEQUENT PLAN
19 YEARS.—For plan years beginning on or
20 after January 1, 2012, a rebate required
21 under this subparagraph may not be used
22 for the purpose described in clause (ii)(III)
23 and shall be provided through the applica-
24 tion of the amount of the rebate in the fol-
25 lowing priority order:

1 “(I) First, to use the most sig-
2 nificant share to meaningfully reduce
3 cost-sharing otherwise applicable for
4 benefits under the original medicare
5 fee-for-service program under parts A
6 and B and for qualified prescription
7 drug coverage under part D, including
8 the reduction of any deductibles, co-
9 payments, and maximum limitations
10 on out-of-pocket expenses otherwise
11 applicable. Any reduction of maximum
12 limitations on out-of-pocket expenses
13 under the preceding sentence shall
14 apply to all benefits under the original
15 medicare fee-for-service program op-
16 tion. The Secretary may provide guid-
17 ance on meaningfully reducing cost-
18 sharing under this subclause, except
19 that such guidance may not require a
20 particular amount of cost-sharing or
21 reduction in cost-sharing.

22 “(II) Second, to use the next
23 most significant share to meaningfully
24 provide coverage of preventive and
25 wellness health care benefits (as de-

1 fined by the Secretary) which are not
2 benefits under the original medicare
3 fee-for-service program, such as smok-
4 ing cessation, a free flu shot, and an
5 annual physical examination.

6 “(III) Third, to use the remain-
7 ing share to meaningfully provide cov-
8 erage of other health care benefits
9 which are not benefits under the origi-
10 nal medicare fee-for-service program,
11 such as eye examinations and dental
12 coverage, and are not benefits de-
13 scribed in subclause (II).”.

14 (2) APPLICATION OF PERFORMANCE BO-
15 NUSES.—Section 1853(n) of the Social Security Act,
16 as added by section 3201(f), is amended by adding
17 at the end the following new paragraph:

18 “(6) APPLICATION OF PERFORMANCE BO-
19 NUSES.—For plan years beginning on or after Janu-
20 ary 1, 2014, any performance bonus paid to an MA
21 plan under this subsection shall be used for the pur-
22 poses, and in the priority order, described in sub-
23 clauses (I) through (III) of section
24 1854(b)(1)(C)(iii).”.

1 (3) APPLICATION OF MA MONTHLY SUPPLE-
 2 MENTARY BENEFICIARY PREMIUM.—Section
 3 1854(b)(2)(C) of the Social Security Act (42 U.S.C.
 4 1395w–24(b)(2)(C)) is amended—

5 (A) by striking “PREMIUM.—The term”
 6 and inserting “PREMIUM.—

7 “(i) IN GENERAL.—The term”; and

8 (B) by adding at the end the following new
 9 clause:

10 “(ii) APPLICATION OF MA MONTHLY
 11 SUPPLEMENTARY BENEFICIARY PRE-
 12 MIUM.—For plan years beginning on or
 13 after January 1, 2012, any MA monthly
 14 supplementary beneficiary premium
 15 charged to an individual enrolled in an MA
 16 plan shall be used for the purposes, and in
 17 the priority order, described in subclauses
 18 (I) through (III) of paragraph
 19 (1)(C)(iii).”.

20 **SEC. 3203. APPLICATION OF CODING INTENSITY ADJUST-**
 21 **MENT DURING MA PAYMENT TRANSITION.**

22 Section 1853(a)(1)(C) of the Social Security Act (42
 23 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the
 24 end the following new clause:

1 “(iii) APPLICATION OF CODING IN-
2 TENSITY ADJUSTMENT FOR 2011 AND SUB-
3 SEQUENT YEARS.—

4 “(I) REQUIREMENT TO APPLY IN
5 2011 THROUGH 2013.—In order to en-
6 sure payment accuracy, the Secretary
7 shall conduct an analysis of the dif-
8 ferences described in clause (ii)(I).
9 The Secretary shall ensure that the
10 results of such analysis are incor-
11 porated into the risk scores for 2011,
12 2012, and 2013.

13 “(II) AUTHORITY TO APPLY IN
14 2014 AND SUBSEQUENT YEARS.—The
15 Secretary may, as appropriate, incor-
16 porate the results of such analysis
17 into the risk scores for 2014 and sub-
18 sequent years.”.

19 **SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY**
20 **ELECTION PERIODS.**

21 (a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT
22 FROM MA PLANS TO ELECT TO RECEIVE BENEFITS
23 UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE
24 PROGRAM.—

1 (1) IN GENERAL.—Section 1851(e)(2)(C) of the
2 Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is
3 amended to read as follows:

4 “(C) ANNUAL 45-DAY PERIOD FOR
5 DISENROLLMENT FROM MA PLANS TO ELECT TO
6 RECEIVE BENEFITS UNDER THE ORIGINAL
7 MEDICARE FEE-FOR-SERVICE PROGRAM.—Sub-
8 ject to subparagraph (D), at any time during
9 the first 45 days of a year (beginning with
10 2011), an individual who is enrolled in a Medi-
11 care Advantage plan may change the election
12 under subsection (a)(1), but only with respect
13 to coverage under the original medicare fee-for-
14 service program under parts A and B, and may
15 elect qualified prescription drug coverage in ac-
16 cordance with section 1860D–1.”.

17 (2) EFFECTIVE DATE.—The amendment made
18 by paragraph (1) shall apply with respect to 2011
19 and succeeding years.

20 (b) TIMING OF THE ANNUAL, COORDINATED ELEC-
21 TION PERIOD UNDER PARTS C AND D.—Section
22 1851(e)(3)(B) of the Social Security Act (42 U.S.C.
23 1395w–1(e)(3)(B)) is amended—

24 (1) in clause (iii), by striking “and” at the end;

25 (2) in clause (iv)—

1 (A) by striking “and succeeding years”
 2 and inserting “, 2008, 2009, and 2010”; and

3 (B) by striking the period at the end and
 4 inserting “; and”; and

5 (3) by adding at the end the following new
 6 clause:

7 “(v) with respect to 2012 and suc-
 8 ceeding years, the period beginning on Oc-
 9 tober 15 and ending on December 7 of the
 10 year before such year.”.

11 **SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR**
 12 **SPECIAL NEEDS INDIVIDUALS.**

13 (a) **EXTENSION OF SNP AUTHORITY.**—Section
 14 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w-
 15 28(f)(1)), as amended by section 164(a) of the Medicare
 16 Improvements for Patients and Providers Act of 2008
 17 (Public Law 110–275), is amended by striking “2011”
 18 and inserting “2014”.

19 (b) **AUTHORITY TO APPLY FRAILTY ADJUSTMENT**
 20 **UNDER PACE PAYMENT RULES.**—Section 1853(a)(1)(B)
 21 of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B))
 22 is amended by adding at the end the following new clause:

23 “(iv) **AUTHORITY TO APPLY FRAILTY**
 24 **ADJUSTMENT UNDER PACE PAYMENT**
 25 **RULES FOR CERTAIN SPECIALIZED MA**

1 PLANS FOR SPECIAL NEEDS INDIVID-
2 UALS.—

3 “(I) IN GENERAL.—Notwith-
4 standing the preceding provisions of
5 this paragraph, for plan year 2011
6 and subsequent plan years, in the case
7 of a plan described in subclause (II),
8 the Secretary may apply the payment
9 rules under section 1894(d) (other
10 than paragraph (3) of such section)
11 rather than the payment rules that
12 would otherwise apply under this part,
13 but only to the extent necessary to re-
14 flect the costs of treating high con-
15 centrations of frail individuals.

16 “(II) PLAN DESCRIBED.—A plan
17 described in this subclause is a spe-
18 cialized MA plan for special needs in-
19 dividuals described in section
20 1859(b)(6)(B)(ii) that is fully inte-
21 grated with capitated contracts with
22 States for Medicaid benefits, including
23 long-term care, and that have similar
24 average levels of frailty (as deter-

1 mined by the Secretary) as the PACE
2 program.”.

3 (c) TRANSITION AND EXCEPTION REGARDING RE-
4 STRICTION ON ENROLLMENT.—Section 1859(f) of the So-
5 cial Security Act (42 U.S.C. 1395w–28(f)) is amended by
6 adding at the end the following new paragraph:

7 “(6) TRANSITION AND EXCEPTION REGARDING
8 RESTRICTION ON ENROLLMENT.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (C), the Secretary shall establish proce-
11 dures for the transition of applicable individuals
12 to—

13 “(i) a Medicare Advantage plan that
14 is not a specialized MA plan for special
15 needs individuals (as defined in subsection
16 (b)(6)); or

17 “(ii) the original medicare fee-for-
18 service program under parts A and B.

19 “(B) APPLICABLE INDIVIDUALS.—For pur-
20 poses of clause (i), the term ‘applicable indi-
21 vidual’ means an individual who—

22 “(i) is enrolled under a specialized
23 MA plan for special needs individuals (as
24 defined in subsection (b)(6)); and

1 “(ii) is not within the 1 or more of
2 the classes of special needs individuals to
3 which enrollment under the plan is re-
4 stricted to.

5 “(C) EXCEPTION.—The Secretary shall
6 provide for an exception to the transition de-
7 scribed in subparagraph (A) for a limited pe-
8 riod of time for individuals enrolled under a
9 specialized MA plan for special needs individ-
10 uals described in subsection (b)(6)(B)(ii) who
11 are no longer eligible for medical assistance
12 under title XIX.

13 “(D) TIMELINE FOR INITIAL TRANSI-
14 TION.—The Secretary shall ensure that applica-
15 ble individuals enrolled in a specialized MA plan
16 for special needs individuals (as defined in sub-
17 section (b)(6)) prior to January 1, 2010, are
18 transitioned to a plan or the program described
19 in subparagraph (A) by not later than January
20 1, 2013.”.

21 (d) TEMPORARY EXTENSION OF AUTHORITY TO OP-
22 ERATE BUT NO SERVICE AREA EXPANSION FOR DUAL
23 SPECIAL NEEDS PLANS THAT DO NOT MEET CERTAIN
24 REQUIREMENTS.—Section 164(c)(2) of the Medicare Im-
25 provements for Patients and Providers Act of 2008 (Pub-

1 lie Law 110–275) is amended by striking “December 31,
2 2010” and inserting “December 31, 2012”.

3 (e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS
4 BE NCQA APPROVED.—Section 1859(f) of the Social Se-
5 curity Act (42 U.S.C. 1395w–28(f)), as amended by sub-
6 sections (a) and (c), is amended—

7 (1) in paragraph (2), by adding at the end the
8 following new subparagraph:

9 “(C) If applicable, the plan meets the re-
10 quirement described in paragraph (7).”;

11 (2) in paragraph (3), by adding at the end the
12 following new subparagraph:

13 “(E) If applicable, the plan meets the re-
14 quirement described in paragraph (7).”;

15 (3) in paragraph (4), by adding at the end the
16 following new subparagraph:

17 “(C) If applicable, the plan meets the re-
18 quirement described in paragraph (7).”; and

19 (4) by adding at the end the following new
20 paragraph:

21 “(7) AUTHORITY TO REQUIRE SPECIAL NEEDS
22 PLANS BE NCQA APPROVED.—For 2012 and subse-
23 quent years, the Secretary shall require that a Medi-
24 care Advantage organization offering a specialized
25 MA plan for special needs individuals be approved

1 by the National Committee for Quality Assurance
2 (based on standards established by the Secretary).”.

3 (f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of
4 the Social Security Act (42 U.S.C. 1395i–23(a)(1)(C)) is
5 amended by adding at the end the following new clause:

6 “(iii) IMPROVEMENTS TO RISK AD-
7 JUSTMENT FOR SPECIAL NEEDS INDIVID-
8 UALS WITH CHRONIC HEALTH CONDI-
9 TIONS.—

10 “(I) IN GENERAL.—For 2011
11 and subsequent years, for purposes of
12 the adjustment under clause (i) with
13 respect to individuals described in
14 subclause (II), the Secretary shall use
15 a risk score that reflects the known
16 underlying risk profile and chronic
17 health status of similar individuals.
18 Such risk score shall be used instead
19 of the default risk score for new en-
20 rollees in Medicare Advantage plans
21 that are not specialized MA plans for
22 special needs individuals (as defined
23 in section 1859(b)(6)).

24 “(II) INDIVIDUALS DE-
25 SCRIBED.—An individual described in

1 this subclause is a special needs indi-
2 vidual described in subsection
3 (b)(6)(B)(iii) who enrolls in a special-
4 ized MA plan for special needs indi-
5 viduals on or after January 1, 2011.

6 “(III) EVALUATION.—For 2011
7 and periodically thereafter, the Sec-
8 retary shall evaluate and revise the
9 risk adjustment system under this
10 subparagraph in order to, as accu-
11 rately as possible, account for higher
12 medical and care coordination costs
13 associated with frailty, individuals
14 with multiple, comorbid chronic condi-
15 tions, and individuals with a diagnosis
16 of mental illness, and also to account
17 for costs that may be associated with
18 higher concentrations of beneficiaries
19 with those conditions.

20 “(IV) PUBLICATION OF EVALUA-
21 TION AND REVISIONS.—The Secretary
22 shall publish, as part of an announce-
23 ment under subsection (b), a descrip-
24 tion of any evaluation conducted
25 under subclause (III) during the pre-

1 ceding year and any revisions made
2 under such subclause as a result of
3 such evaluation.”.

4 (g) TECHNICAL CORRECTION.—Section 1859(f)(5) of
5 the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is
6 amended, in the matter preceding subparagraph (A), by
7 striking “described in subsection (b)(6)(B)(i)”.

8 **SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.**

9 Section 1876(h)(5)(C)(ii) of the Social Security Act
10 (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the mat-
11 ter preceding subclause (I), by striking “January 1, 2010”
12 and inserting “January 1, 2013”.

13 **SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-**
14 **FOR-SERVICE PLANS.**

15 For plan year 2011 and subsequent plan years, to
16 the extent that the Secretary of Health and Human Serv-
17 ices is applying the 2008 service area extension waiver pol-
18 icy (as modified in the April 11, 2008, Centers for Medi-
19 care & Medicaid Services’ memorandum with the subject
20 “2009 Employer Group Waiver-Modification of the 2008
21 Service Area Extension Waiver Granted to Certain MA
22 Local Coordinated Care Plans”) to Medicare Advantage
23 coordinated care plans, the Secretary shall extend the ap-
24 plication of such waiver policy to employers who contract
25 directly with the Secretary as a Medicare Advantage pri-

1 vate fee-for-service plan under section 1857(i)(2) of the
2 Social Security Act (42 U.S.C. 1395w-27(i)(2)) and that
3 had enrollment as of October 1, 2009.

4 **SEC. 3208. MAKING SENIOR HOUSING FACILITY DEM-**
5 **ONSTRATION PERMANENT.**

6 (a) IN GENERAL.—Section 1859 of the Social Secu-
7 rity Act (42 U.S.C. 1395w-28) is amended by adding at
8 the end the following new subsection:

9 “(g) SPECIAL RULES FOR SENIOR HOUSING FACIL-
10 ITY PLANS.—

11 “(1) IN GENERAL.—In the case of a Medicare
12 Advantage senior housing facility plan described in
13 paragraph (2), notwithstanding any other provision
14 of this part to the contrary and in accordance with
15 regulations of the Secretary, the service area of such
16 plan may be limited to a senior housing facility in
17 a geographic area.

18 “(2) MEDICARE ADVANTAGE SENIOR HOUSING
19 FACILITY PLAN DESCRIBED.—For purposes of this
20 subsection, a Medicare Advantage senior housing fa-
21 cility plan is a Medicare Advantage plan that—

22 “(A) restricts enrollment of individuals
23 under this part to individuals who reside in a
24 continuing care retirement community (as de-
25 fined in section 1852(l)(4)(B));

1 “(B) provides primary care services onsite
2 and has a ratio of accessible physicians to bene-
3 ficiaries that the Secretary determines is ade-
4 quate;

5 “(C) provides transportation services for
6 beneficiaries to specialty providers outside of
7 the facility; and

8 “(D) has participated (as of December 31,
9 2009) in a demonstration project established by
10 the Secretary under which such a plan was of-
11 fered for not less than 1 year.”.

12 (b) **EFFECTIVE DATE.**—The amendment made by
13 this section shall take effect on January 1, 2010, and shall
14 apply to plan years beginning on or after such date.

15 **SEC. 3209. AUTHORITY TO DENY PLAN BIDS.**

16 (a) **IN GENERAL.**—Section 1854(a)(5) of the Social
17 Security Act (42 U.S.C. 1395w-24(a)(5)) is amended by
18 adding at the end the following new subparagraph:

19 “(C) **REJECTION OF BIDS.**—

20 “(i) **IN GENERAL.**—Nothing in this
21 section shall be construed as requiring the
22 Secretary to accept any or every bid sub-
23 mitted by an MA organization under this
24 subsection.

1 “(ii) AUTHORITY TO DENY BIDS THAT
2 PROPOSE SIGNIFICANT INCREASES IN COST
3 SHARING OR DECREASES IN BENEFITS.—
4 The Secretary may deny a bid submitted
5 by an MA organization for an MA plan if
6 it proposes significant increases in cost
7 sharing or decreases in benefits offered
8 under the plan.”.

9 (b) APPLICATION UNDER PART D.—Section 1860D–
10 11(d) of such Act (42 U.S.C. 1395w–111(d)) is amended
11 by adding at the end the following new paragraph:

12 “(3) REJECTION OF BIDS.—Paragraph (5)(C)
13 of section 1854(a) shall apply with respect to bids
14 submitted by a PDP sponsor under subsection (b) in
15 the same manner as such paragraph applies to bids
16 submitted by an MA organization under such section
17 1854(a).”.

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to bids submitted for contract
20 years beginning on or after January 1, 2011.

21 **SEC. 3210. DEVELOPMENT OF NEW STANDARDS FOR CER-**
22 **TAIN MEDIGAP PLANS.**

23 (a) IN GENERAL.—Section 1882 of the Social Secu-
24 rity Act (42 U.S.C. 1395ss) is amended by adding at the
25 end the following new subsection:

1 “(y) DEVELOPMENT OF NEW STANDARDS FOR CER-
2 TAIN MEDICARE SUPPLEMENTAL POLICIES.—

3 “(1) IN GENERAL.—The Secretary shall request
4 the National Association of Insurance Commis-
5 sioners to review and revise the standards for benefit
6 packages described in paragraph (2) under sub-
7 section (p)(1), to otherwise update standards to in-
8 clude requirements for nominal cost sharing to en-
9 courage the use of appropriate physicians’ services
10 under part B. Such revisions shall be based on evi-
11 dence published in peer-reviewed journals or current
12 examples used by integrated delivery systems and
13 made consistent with the rules applicable under sub-
14 section (p)(1)(E) with the reference to the ‘1991
15 NAIC Model Regulation’ deemed a reference to the
16 NAIC Model Regulation as published in the Federal
17 Register on December 4, 1998, and as subsequently
18 updated by the National Association of Insurance
19 Commissioners to reflect previous changes in law
20 and the reference to ‘date of enactment of this sub-
21 section’ deemed a reference to the date of enactment
22 of the Patient Protection and Affordable Care Act.
23 To the extent practicable, such revision shall provide
24 for the implementation of revised standards for ben-
25 efit packages as of January 1, 2015.

1 “(2) have entered into and have in effect an
2 agreement described in subsection (b) of such sec-
3 tion with the Secretary; and

4 “(3) have entered into and have in effect, under
5 terms and conditions specified by the Secretary, a
6 contract with a third party that the Secretary has
7 entered into a contract with under subsection (d)(3)
8 of such section.

9 “(b) EFFECTIVE DATE.—Subsection (a) shall apply
10 to covered part D drugs dispensed under this part on or
11 after July 1, 2010.

12 “(c) AUTHORIZING COVERAGE FOR DRUGS NOT COV-
13 ERED UNDER AGREEMENTS.—Subsection (a) shall not
14 apply to the dispensing of a covered part D drug if—

15 “(1) the Secretary has made a determination
16 that the availability of the drug is essential to the
17 health of beneficiaries under this part; or

18 “(2) the Secretary determines that in the period
19 beginning on July 1, 2010, and ending on December
20 31, 2010, there were extenuating circumstances.

21 “(d) DEFINITION OF MANUFACTURER.—In this sec-
22 tion, the term ‘manufacturer’ has the meaning given such
23 term in section 1860D–14A(g)(5).”.

24 (b) MEDICARE COVERAGE GAP DISCOUNT PRO-
25 GRAM.—Part D of title XVIII of the Social Security Act

1 (42 U.S.C. 1395w-101) is amended by inserting after sec-
2 tion 1860D-14 the following new section:

3 “MEDICARE COVERAGE GAP DISCOUNT PROGRAM

4 “SEC. 1860D-14A. (a) ESTABLISHMENT.—The Sec-
5 retary shall establish a Medicare coverage gap discount
6 program (in this section referred to as the ‘program’) by
7 not later than July 1, 2010. Under the program, the Sec-
8 retary shall enter into agreements described in subsection
9 (b) with manufacturers and provide for the performance
10 of the duties described in subsection (c)(1). The Secretary
11 shall establish a model agreement for use under the pro-
12 gram by not later than April 1, 2010, in consultation with
13 manufacturers, and allow for comment on such model
14 agreement.

15 “(b) TERMS OF AGREEMENT.—

16 “(1) IN GENERAL.—

17 “(A) AGREEMENT.—An agreement under
18 this section shall require the manufacturer to
19 provide applicable beneficiaries access to dis-
20 counted prices for applicable drugs of the man-
21 ufacturer.

22 “(B) PROVISION OF DISCOUNTED PRICES
23 AT THE POINT-OF-SALE.—Except as provided in
24 subsection (c)(1)(A)(iii), such discounted prices
25 shall be provided to the applicable beneficiary at

1 the pharmacy or by the mail order service at
2 the point-of-sale of an applicable drug.

3 “(C) TIMING OF AGREEMENT.—

4 “(i) SPECIAL RULE FOR 2010 AND
5 2011.—In order for an agreement with a
6 manufacturer to be in effect under this
7 section with respect to the period begin-
8 ning on July 1, 2010, and ending on De-
9 cember 31, 2011, the manufacturer shall
10 enter into such agreement not later than
11 May 1, 2010.

12 “(ii) 2012 AND SUBSEQUENT
13 YEARS.—In order for an agreement with a
14 manufacturer to be in effect under this
15 section with respect to plan year 2012 or
16 a subsequent plan year, the manufacturer
17 shall enter into such agreement (or such
18 agreement shall be renewed under para-
19 graph (4)(A)) not later than January 30 of
20 the preceding year.

21 “(2) PROVISION OF APPROPRIATE DATA.—Each
22 manufacturer with an agreement in effect under this
23 section shall collect and have available appropriate
24 data, as determined by the Secretary, to ensure that

1 it can demonstrate to the Secretary compliance with
2 the requirements under the program.

3 “(3) COMPLIANCE WITH REQUIREMENTS FOR
4 ADMINISTRATION OF PROGRAM.—Each manufac-
5 turer with an agreement in effect under this section
6 shall comply with requirements imposed by the Sec-
7 retary or a third party with a contract under sub-
8 section (d)(3), as applicable, for purposes of admin-
9 istering the program, including any determination
10 under clause (i) of subsection (c)(1)(A) or proce-
11 dures established under such subsection (c)(1)(A).

12 “(4) LENGTH OF AGREEMENT.—

13 “(A) IN GENERAL.—An agreement under
14 this section shall be effective for an initial pe-
15 riod of not less than 18 months and shall be
16 automatically renewed for a period of not less
17 than 1 year unless terminated under subpara-
18 graph (B).

19 “(B) TERMINATION.—

20 “(i) BY THE SECRETARY.—The Sec-
21 retary may provide for termination of an
22 agreement under this section for a knowing
23 and willful violation of the requirements of
24 the agreement or other good cause shown.

25 Such termination shall not be effective ear-

1 lier than 30 days after the date of notice
2 to the manufacturer of such termination.
3 The Secretary shall provide, upon request,
4 a manufacturer with a hearing concerning
5 such a termination, and such hearing shall
6 take place prior to the effective date of the
7 termination with sufficient time for such
8 effective date to be repealed if the Sec-
9 retary determines appropriate.

10 “(ii) BY A MANUFACTURER.—A man-
11 ufacturer may terminate an agreement
12 under this section for any reason. Any
13 such termination shall be effective, with re-
14 spect to a plan year—

15 “(I) if the termination occurs be-
16 fore January 30 of a plan year, as of
17 the day after the end of the plan year;
18 and

19 “(II) if the termination occurs on
20 or after January 30 of a plan year, as
21 of the day after the end of the suc-
22 ceeding plan year.

23 “(iii) EFFECTIVENESS OF TERMI-
24 NATION.—Any termination under this sub-
25 paragraph shall not affect discounts for

1 applicable drugs of the manufacturer that
2 are due under the agreement before the ef-
3 fective date of its termination.

4 “(iv) NOTICE TO THIRD PARTY.—The
5 Secretary shall provide notice of such ter-
6 mination to a third party with a contract
7 under subsection (d)(3) within not less
8 than 30 days before the effective date of
9 such termination.

10 “(c) DUTIES DESCRIBED AND SPECIAL RULE FOR
11 SUPPLEMENTAL BENEFITS.—

12 “(1) DUTIES DESCRIBED.—The duties de-
13 scribed in this subsection are the following:

14 “(A) ADMINISTRATION OF PROGRAM.—Ad-
15 ministering the program, including—

16 “(i) the determination of the amount
17 of the discounted price of an applicable
18 drug of a manufacturer;

19 “(ii) except as provided in clause (iii),
20 the establishment of procedures under
21 which discounted prices are provided to ap-
22 plicable beneficiaries at pharmacies or by
23 mail order service at the point-of-sale of an
24 applicable drug;

1 “(iii) in the case where, during the pe-
2 riod beginning on July 1, 2010, and end-
3 ing on December 31, 2011, it is not prac-
4 ticable to provide such discounted prices at
5 the point-of-sale (as described in clause
6 (ii)), the establishment of procedures to
7 provide such discounted prices as soon as
8 practicable after the point-of-sale;

9 “(iv) the establishment of procedures
10 to ensure that, not later than the applica-
11 ble number of calendar days after the dis-
12 pensing of an applicable drug by a phar-
13 macy or mail order service, the pharmacy
14 or mail order service is reimbursed for an
15 amount equal to the difference between—

16 “(I) the negotiated price of the
17 applicable drug; and

18 “(II) the discounted price of the
19 applicable drug;

20 “(v) the establishment of procedures
21 to ensure that the discounted price for an
22 applicable drug under this section is ap-
23 plied before any coverage or financial as-
24 sistance under other health benefit plans
25 or programs that provide coverage or fi-

1 nancial assistance for the purchase or pro-
2 vision of prescription drug coverage on be-
3 half of applicable beneficiaries as the Sec-
4 retary may specify;

5 “(vi) the establishment of procedures
6 to implement the special rule for supple-
7 mental benefits under paragraph (2); and

8 “(vii) providing a reasonable dispute
9 resolution mechanism to resolve disagree-
10 ments between manufacturers, applicable
11 beneficiaries, and the third party with a
12 contract under subsection (d)(3).

13 “(B) MONITORING COMPLIANCE.—

14 “(i) IN GENERAL.—The Secretary
15 shall monitor compliance by a manufac-
16 turer with the terms of an agreement
17 under this section.

18 “(ii) NOTIFICATION.—If a third party
19 with a contract under subsection (d)(3) de-
20 termines that the manufacturer is not in
21 compliance with such agreement, the third
22 party shall notify the Secretary of such
23 noncompliance for appropriate enforcement
24 under subsection (e).

1 “(C) COLLECTION OF DATA FROM PRE-
2 SCRIPTION DRUG PLANS AND MA–PD PLANS.—

3 The Secretary may collect appropriate data
4 from prescription drug plans and MA–PD plans
5 in a timeframe that allows for discounted prices
6 to be provided for applicable drugs under this
7 section.

8 “(2) SPECIAL RULE FOR SUPPLEMENTAL BENE-
9 FITS.—For plan year 2010 and each subsequent
10 plan year, in the case where an applicable bene-
11 ficiary has supplemental benefits with respect to ap-
12 plicable drugs under the prescription drug plan or
13 MA–PD plan that the applicable beneficiary is en-
14 rolled in, the applicable beneficiary shall not be pro-
15 vided a discounted price for an applicable drug
16 under this section until after such supplemental ben-
17 efits have been applied with respect to the applicable
18 drug.

19 “(d) ADMINISTRATION.—

20 “(1) IN GENERAL.—Subject to paragraph (2),
21 the Secretary shall provide for the implementation of
22 this section, including the performance of the duties
23 described in subsection (e)(1).

24 “(2) LIMITATION.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), in providing for such implementa-
3 tion, the Secretary shall not receive or dis-
4 tribute any funds of a manufacturer under the
5 program.

6 “(B) EXCEPTION.—The limitation under
7 subparagraph (A) shall not apply to the Sec-
8 retary with respect to drugs dispensed during
9 the period beginning on July 1, 2010, and end-
10 ing on December 31, 2010, but only if the Sec-
11 retary determines that the exception to such
12 limitation under this subparagraph is necessary
13 in order for the Secretary to begin implementa-
14 tion of this section and provide applicable bene-
15 ficiaries timely access to discounted prices dur-
16 ing such period.

17 “(3) CONTRACT WITH THIRD PARTIES.—The
18 Secretary shall enter into a contract with 1 or more
19 third parties to administer the requirements estab-
20 lished by the Secretary in order to carry out this
21 section. At a minimum, the contract with a third
22 party under the preceding sentence shall require
23 that the third party—

24 “(A) receive and transmit information be-
25 tween the Secretary, manufacturers, and other

1 individuals or entities the Secretary determines
2 appropriate;

3 “(B) receive, distribute, or facilitate the
4 distribution of funds of manufacturers to ap-
5 propriate individuals or entities in order to
6 meet the obligations of manufacturers under
7 agreements under this section;

8 “(C) provide adequate and timely informa-
9 tion to manufacturers, consistent with the
10 agreement with the manufacturer under this
11 section, as necessary for the manufacturer to
12 fulfill its obligations under this section; and

13 “(D) permit manufacturers to conduct
14 periodic audits, directly or through contracts, of
15 the data and information used by the third
16 party to determine discounts for applicable
17 drugs of the manufacturer under the program.

18 “(4) PERFORMANCE REQUIREMENTS.—The
19 Secretary shall establish performance requirements
20 for a third party with a contract under paragraph
21 (3) and safeguards to protect the independence and
22 integrity of the activities carried out by the third
23 party under the program under this section.

1 “(5) IMPLEMENTATION.—The Secretary may
2 implement the program under this section by pro-
3 gram instruction or otherwise.

4 “(6) ADMINISTRATION.—Chapter 35 of title 44,
5 United States Code, shall not apply to the program
6 under this section.

7 “(e) ENFORCEMENT.—

8 “(1) AUDITS.—Each manufacturer with an
9 agreement in effect under this section shall be sub-
10 ject to periodic audit by the Secretary.

11 “(2) CIVIL MONEY PENALTY.—

12 “(A) IN GENERAL.—The Secretary shall
13 impose a civil money penalty on a manufacturer
14 that fails to provide applicable beneficiaries dis-
15 counts for applicable drugs of the manufacturer
16 in accordance with such agreement for each
17 such failure in an amount the Secretary deter-
18 mines is commensurate with the sum of—

19 “(i) the amount that the manufac-
20 turer would have paid with respect to such
21 discounts under the agreement, which will
22 then be used to pay the discounts which
23 the manufacturer had failed to provide;
24 and

25 “(ii) 25 percent of such amount.

1 “(B) APPLICATION.—The provisions of
2 section 1128A (other than subsections (a) and
3 (b)) shall apply to a civil money penalty under
4 this paragraph in the same manner as such
5 provisions apply to a penalty or proceeding
6 under section 1128A(a).

7 “(f) CLARIFICATION REGARDING AVAILABILITY OF
8 OTHER COVERED PART D DRUGS.—Nothing in this sec-
9 tion shall prevent an applicable beneficiary from pur-
10 chasing a covered part D drug that is not an applicable
11 drug (including a generic drug or a drug that is not on
12 the formulary of the prescription drug plan or MA-PD
13 plan that the applicable beneficiary is enrolled in).

14 “(g) DEFINITIONS.—In this section:

15 “(1) APPLICABLE BENEFICIARY.—The term
16 ‘applicable beneficiary’ means an individual who, on
17 the date of dispensing an applicable drug—

18 “(A) is enrolled in a prescription drug plan
19 or an MA-PD plan;

20 “(B) is not enrolled in a qualified retiree
21 prescription drug plan;

22 “(C) is not entitled to an income-related
23 subsidy under section 1860D-14(a);

24 “(D) is not subject to a reduction in pre-
25 mium subsidy under section 1839(i); and

1 “(E) who—

2 “(i) has reached or exceeded the ini-
3 tial coverage limit under section 1860D-
4 2(b)(3) during the year; and

5 “(ii) has not incurred costs for cov-
6 ered part D drugs in the year equal to the
7 annual out-of-pocket threshold specified in
8 section 1860D-2(b)(4)(B).

9 “(2) APPLICABLE DRUG.—The term ‘applicable
10 drug’ means, with respect to an applicable bene-
11 ficiary, a covered part D drug—

12 “(A) approved under a new drug applica-
13 tion under section 505(b) of the Federal Food,
14 Drug, and Cosmetic Act or, in the case of a bio-
15 logic product, licensed under section 351 of the
16 Public Health Service Act (other than a product
17 licensed under subsection (k) of such section
18 351); and

19 “(B)(i) if the PDP sponsor of the prescrip-
20 tion drug plan or the MA organization offering
21 the MA-PD plan uses a formulary, which is on
22 the formulary of the prescription drug plan or
23 MA-PD plan that the applicable beneficiary is
24 enrolled in;

1 “(ii) if the PDP sponsor of the prescrip-
 2 tion drug plan or the MA organization offering
 3 the MA–PD plan does not use a formulary, for
 4 which benefits are available under the prescrip-
 5 tion drug plan or MA–PD plan that the appli-
 6 cable beneficiary is enrolled in; or

7 “(iii) is provided through an exception or
 8 appeal.

9 “(3) APPLICABLE NUMBER OF CALENDAR
 10 DAYS.—The term ‘applicable number of calendar
 11 days’ means—

12 “(A) with respect to claims for reimburse-
 13 ment submitted electronically, 14 days; and

14 “(B) with respect to claims for reimburse-
 15 ment submitted otherwise, 30 days.

16 “(4) DISCOUNTED PRICE.—

17 “(A) IN GENERAL.—The term ‘discounted
 18 price’ means 50 percent of the negotiated price
 19 of the applicable drug of a manufacturer.

20 “(B) CLARIFICATION.—Nothing in this
 21 section shall be construed as affecting the re-
 22 sponsibility of an applicable beneficiary for pay-
 23 ment of a dispensing fee for an applicable drug.

24 “(C) SPECIAL CASE FOR CERTAIN
 25 CLAIMS.—In the case where the entire amount

1 of the negotiated price of an individual claim
2 for an applicable drug with respect to an appli-
3 cable beneficiary does not fall at or above the
4 initial coverage limit under section 1860D-
5 2(b)(3) and below the annual out-of-pocket
6 threshold specified in section 1860D-2(b)(4)(B)
7 for the year, the manufacturer of the applicable
8 drug shall provide the discounted price under
9 this section on only the portion of the nego-
10 tiated price of the applicable drug that falls at
11 or above such initial coverage limit and below
12 such annual out-of-pocket threshold.

13 “(5) MANUFACTURER.—The term ‘manufac-
14 turer’ means any entity which is engaged in the pro-
15 duction, preparation, propagation, compounding,
16 conversion, or processing of prescription drug prod-
17 ucts, either directly or indirectly by extraction from
18 substances of natural origin, or independently by
19 means of chemical synthesis, or by a combination of
20 extraction and chemical synthesis. Such term does
21 not include a wholesale distributor of drugs or a re-
22 tail pharmacy licensed under State law.

23 “(6) NEGOTIATED PRICE.—The term ‘nego-
24 tiated price’ has the meaning given such term in sec-
25 tion 423.100 of title 42, Code of Federal Regula-

1 tions (as in effect on the date of enactment of this
2 section), except that such negotiated price shall not
3 include any dispensing fee for the applicable drug.

4 “(7) QUALIFIED RETIREE PRESCRIPTION DRUG
5 PLAN.—The term ‘qualified retiree prescription drug
6 plan’ has the meaning given such term in section
7 1860D–22(a)(2).”.

8 (c) INCLUSION IN INCURRED COSTS.—

9 (1) IN GENERAL.—Section 1860D–2(b)(4) of
10 the Social Security Act (42 U.S.C. 1395w–
11 102(b)(4)) is amended—

12 (A) in subparagraph (C), in the matter
13 preceding clause (i), by striking “In applying”
14 and inserting “Except as provided in subpara-
15 graph (E), in applying”; and

16 (B) by adding at the end the following new
17 subparagraph:

18 “(E) INCLUSION OF COSTS OF APPLICABLE
19 DRUGS UNDER MEDICARE COVERAGE GAP DIS-
20 COUNT PROGRAM.—In applying subparagraph
21 (A), incurred costs shall include the negotiated
22 price (as defined in paragraph (6) of section
23 1860D–14A(g)) of an applicable drug (as de-
24 fined in paragraph (2) of such section) of a
25 manufacturer that is furnished to an applicable

1 beneficiary (as defined in paragraph (1) of such
2 section) under the Medicare coverage gap dis-
3 count program under section 1860D–14A, re-
4 gardless of whether part of such costs were paid
5 by a manufacturer under such program.”.

6 (2) EFFECTIVE DATE.—The amendments made
7 by this subsection shall apply to costs incurred on or
8 after July 1, 2010.

9 (d) CONFORMING AMENDMENT PERMITTING PRE-
10 SCRIPTON DRUG DISCOUNTS.—

11 (1) IN GENERAL.—Section 1128B(b)(3) of the
12 Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is
13 amended—

14 (A) by striking “and” at the end of sub-
15 paragraph (G);

16 (B) in the subparagraph (H) added by sec-
17 tion 237(d) of the Medicare Prescription Drug,
18 Improvement, and Modernization Act of 2003
19 (Public Law 108–173; 117 Stat. 2213)—

20 (i) by moving such subparagraph 2
21 ems to the left; and

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

24 (C) in the subparagraph (H) added by sec-
25 tion 431(a) of such Act (117 Stat. 2287)—

1 (i) by redesignating such subpara-
2 graph as subparagraph (I);

3 (ii) by moving such subparagraph 2
4 ems to the left; and

5 (iii) by striking the period at the end
6 and inserting “; and”; and

7 (D) by adding at the end the following new
8 subparagraph:

9 “(J) a discount in the price of an applica-
10 ble drug (as defined in paragraph (2) of section
11 1860D–14A(g)) of a manufacturer that is fur-
12 nished to an applicable beneficiary (as defined
13 in paragraph (1) of such section) under the
14 Medicare coverage gap discount program under
15 section 1860D–14A.”.

16 (2) CONFORMING AMENDMENT TO DEFINITION
17 OF BEST PRICE UNDER MEDICAID.—Section
18 1927(c)(1)(C)(i)(VI) of the Social Security Act (42
19 U.S.C. 1396r–8(c)(1)(C)(i)(VI)) is amended by in-
20 sserting “, or any discounts provided by manufactur-
21 ers under the Medicare coverage gap discount pro-
22 gram under section 1860D–14A” before the period
23 at the end.

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply to drugs dispensed on
3 or after July 1, 2010.

4 **SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDI-**
5 **CARE PART D LOW-INCOME BENCHMARK**
6 **PREMIUM.**

7 (a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii)
8 of the Social Security Act (42 U.S.C. 1395w–
9 114(b)(2)(B)(iii)) is amended by inserting “, determined
10 without regard to any reduction in such premium as a re-
11 sult of any beneficiary rebate under section 1854(b)(1)(C)
12 or bonus payment under section 1853(n)” before the pe-
13 riod at the end.

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall apply to premiums for months begin-
16 ning on or after January 1, 2011.

17 **SEC. 3303. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY**
18 **ELIGIBLE INDIVIDUALS UNDER PRESCRIP-**
19 **TION DRUG PLANS AND MA-PD PLANS.**

20 (a) IN GENERAL.—Section 1860D–14(a) of the So-
21 cial Security Act (42 U.S.C. 1395w–114(a)) is amended
22 by adding at the end the following new paragraph:

23 “(5) WAIVER OF DE MINIMIS PREMIUMS.—The
24 Secretary shall, under procedures established by the
25 Secretary, permit a prescription drug plan or an

1 MA–PD plan to waive the monthly beneficiary pre-
2 mium for a subsidy eligible individual if the amount
3 of such premium is de minimis. If such premium is
4 waived under the plan, the Secretary shall not reas-
5 sign subsidy eligible individuals enrolled in the plan
6 to other plans based on the fact that the monthly
7 beneficiary premium under the plan was greater
8 than the low-income benchmark premium amount.”.

9 (b) AUTHORIZING THE SECRETARY TO AUTO-EN-
10 ROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT
11 WAIVE DE MINIMIS PREMIUMS.—Section 1860D–1(b)(1)
12 of the Social Security Act (42 U.S.C. 1395w–101(b)(1))
13 is amended—

14 (1) in subparagraph (C), by inserting “except
15 as provided in subparagraph (D),” after “shall in-
16 clude,”

17 (2) by adding at the end the following new sub-
18 paragraph:

19 “(D) SPECIAL RULE FOR PLANS THAT
20 WAIVE DE MINIMIS PREMIUMS.—The process
21 established under subparagraph (A) may in-
22 clude, in the case of a part D eligible individual
23 who is a subsidy eligible individual (as defined
24 in section 1860D–14(a)(3)) who has failed to
25 enroll in a prescription drug plan or an MA–PD

1 plan, for the enrollment in a prescription drug
 2 plan or MA–PD plan that has waived the
 3 monthly beneficiary premium for such subsidy
 4 eligible individual under section 1860D–
 5 14(a)(5). If there is more than one such plan
 6 available, the Secretary shall enroll such an in-
 7 dividual under the preceding sentence on a ran-
 8 dom basis among all such plans in the PDP re-
 9 gion. Nothing in the previous sentence shall
 10 prevent such an individual from declining or
 11 changing such enrollment.”.

12 (c) EFFECTIVE DATE.—The amendments made by
 13 this subsection shall apply to premiums for months, and
 14 enrollments for plan years, beginning on or after January
 15 1, 2011.

16 **SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS RE-**
 17 **GARDING ELIGIBILITY FOR LOW-INCOME AS-**
 18 **SISTANCE.**

19 (a) IN GENERAL.—Section 1860D–14(a)(3)(B) of
 20 the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B))
 21 is amended by adding at the end the following new clause:

22 “(vi) SPECIAL RULE FOR WIDOWS
 23 AND WIDOWERS.—Notwithstanding the
 24 preceding provisions of this subparagraph,
 25 in the case of an individual whose spouse

1 dies during the effective period for a deter-
2 mination or redetermination that has been
3 made under this subparagraph, such effec-
4 tive period shall be extended through the
5 date that is 1 year after the date on which
6 the determination or redetermination
7 would (but for the application of this
8 clause) otherwise cease to be effective.”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall take effect on January 1, 2011.

11 **SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGI-**
12 **BLE INDIVIDUALS REASSIGNED TO PRE-**
13 **SCRIPTION DRUG PLANS AND MA-PD PLANS.**

14 Section 1860D–14 of the Social Security Act (42
15 U.S.C. 1395w–114) is amended—

16 (1) by redesignating subsection (d) as sub-
17 section (e); and

18 (2) by inserting after subsection (c) the fol-
19 lowing new subsection:

20 “(d) FACILITATION OF REASSIGNMENTS.—Beginning
21 not later than January 1, 2011, the Secretary shall, in
22 the case of a subsidy eligible individual who is enrolled
23 in one prescription drug plan and is subsequently reas-
24 signed by the Secretary to a new prescription drug plan,

1 provide the individual, within 30 days of such reassign-
 2 ment, with—

3 “(1) information on formulary differences be-
 4 tween the individual’s former plan and the plan to
 5 which the individual is reassigned with respect to the
 6 individual’s drug regimens; and

7 “(2) a description of the individual’s right to
 8 request a coverage determination, exception, or re-
 9 consideration under section 1860D–4(g), bring an
 10 appeal under section 1860D–4(h), or resolve a griev-
 11 ance under section 1860D–4(f).”.

12 **SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR**
 13 **LOW-INCOME PROGRAMS.**

14 (a) **ADDITIONAL FUNDING FOR STATE HEALTH IN-**
 15 **SURANCE PROGRAMS.**—Subsection (a)(1)(B) of section
 16 119 of the Medicare Improvements for Patients and Pro-
 17 viders Act of 2008 (42 U.S.C. 1395b–3 note) is amended
 18 by striking “(42 U.S.C. 1395w–23(f))” and all that fol-
 19 lows through the period at the end and inserting “(42
 20 U.S.C. 1395w–23(f)), to the Centers for Medicare & Med-
 21 icaid Services Program Management Account—

22 “(i) for fiscal year 2009, of
 23 \$7,500,000; and

24 “(ii) for the period of fiscal years
 25 2010 through 2012, of \$15,000,000.

1 Amounts appropriated under this subparagraph
2 shall remain available until expended.”.

3 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON
4 AGING.—Subsection (b)(1)(B) of such section 119 is
5 amended by striking “(42 U.S.C. 1395w–23(f))” and all
6 that follows through the period at the end and inserting
7 “(42 U.S.C. 1395w–23(f)), to the Administration on
8 Aging—

9 “(i) for fiscal year 2009, of
10 \$7,500,000; and

11 “(ii) for the period of fiscal years
12 2010 through 2012, of \$15,000,000.

13 Amounts appropriated under this subparagraph
14 shall remain available until expended.”.

15 (c) ADDITIONAL FUNDING FOR AGING AND DIS-
16 ABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of
17 such section 119 is amended by striking “(42 U.S.C.
18 1395w–23(f))” and all that follows through the period at
19 the end and inserting “(42 U.S.C. 1395w–23(f)), to the
20 Administration on Aging—

21 “(i) for fiscal year 2009, of
22 \$5,000,000; and

23 “(ii) for the period of fiscal years
24 2010 through 2012, of \$10,000,000.

1 Amounts appropriated under this subparagraph
2 shall remain available until expended.”.

3 (d) ADDITIONAL FUNDING FOR CONTRACT WITH
4 THE NATIONAL CENTER FOR BENEFITS AND OUTREACH
5 ENROLLMENT.—Subsection (d)(2) of such section 119 is
6 amended by striking “(42 U.S.C. 1395w–23(f))” and all
7 that follows through the period at the end and inserting
8 “(42 U.S.C. 1395w–23(f)), to the Administration on
9 Aging—

10 “(i) for fiscal year 2009, of
11 \$5,000,000; and

12 “(ii) for the period of fiscal years
13 2010 through 2012, of \$5,000,000.

14 Amounts appropriated under this subparagraph
15 shall remain available until expended.”.

16 (e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT
17 IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such
18 section 119 is amended by adding at the end the following
19 new subsection:

20 “(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT
21 IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The
22 Secretary may request that an entity awarded a grant
23 under this section support the conduct of outreach activi-
24 ties aimed at preventing disease and promoting wellness.
25 Notwithstanding any other provision of this section, an en-

1 tity may use a grant awarded under this subsection to sup-
 2 port the conduct of activities described in the preceding
 3 sentence.”.

4 **SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR**
 5 **PRESCRIPTION DRUG PLANS AND MA-PD**
 6 **PLANS WITH RESPECT TO CERTAIN CAT-**
 7 **EGORIES OR CLASSES OF DRUGS.**

8 (a) IMPROVING FORMULARY REQUIREMENTS.—Sec-
 9 tion 1860D–4(b)(3)(G) of the Social Security Act is
 10 amended to read as follows:

11 “(G) REQUIRED INCLUSION OF DRUGS IN
 12 CERTAIN CATEGORIES AND CLASSES.—

13 “(i) FORMULARY REQUIREMENTS.—

14 “(I) IN GENERAL.—Subject to
 15 subclause (II), a PDP sponsor offer-
 16 ing a prescription drug plan shall be
 17 required to include all covered part D
 18 drugs in the categories and classes
 19 identified by the Secretary under
 20 clause (ii)(I).

21 “(II) EXCEPTIONS.—The Sec-
 22 retary may establish exceptions that
 23 permit a PDP sponsor offering a pre-
 24 scription drug plan to exclude from its
 25 formulary a particular covered part D

1 drug in a category or class that is
2 otherwise required to be included in
3 the formulary under subclause (I) (or
4 to otherwise limit access to such a
5 drug, including through prior author-
6 ization or utilization management).

7 “(ii) IDENTIFICATION OF DRUGS IN
8 CERTAIN CATEGORIES AND CLASSES.—

9 “(I) IN GENERAL.—Subject to
10 clause (iv), the Secretary shall iden-
11 tify, as appropriate, categories and
12 classes of drugs for which the Sec-
13 retary determines are of clinical con-
14 cern.

15 “(II) CRITERIA.—The Secretary
16 shall use criteria established by the
17 Secretary in making any determina-
18 tion under subclause (I).

19 “(iii) IMPLEMENTATION.—The Sec-
20 retary shall establish the criteria under
21 clause (ii)(II) and any exceptions under
22 clause (i)(II) through the promulgation of
23 a regulation which includes a public notice
24 and comment period.

1 “(iv) REQUIREMENT FOR CERTAIN
2 CATEGORIES AND CLASSES UNTIL CRI-
3 TERIA ESTABLISHED.—Until such time as
4 the Secretary establishes the criteria under
5 clause (ii)(II) the following categories and
6 classes of drugs shall be identified under
7 clause (ii)(I):

8 “(I) Anticonvulsants.

9 “(II) Antidepressants.

10 “(III) Antineoplastics.

11 “(IV) Antipsychotics.

12 “(V) Antiretrovirals.

13 “(VI) Immunosuppressants for
14 the treatment of transplant rejec-
15 tion.”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to plan year 2011 and subsequent
18 plan years.

19 **SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR**
20 **HIGH-INCOME BENEFICIARIES.**

21 (a) INCOME-RELATED INCREASE IN PART D PRE-
22 MIUM.—

23 (1) IN GENERAL.—Section 1860D–13(a) of the
24 Social Security Act (42 U.S.C. 1395w–113(a)) is

1 amended by adding at the end the following new
2 paragraph:

3 “(7) INCREASE IN BASE BENEFICIARY PREMIUM
4 BASED ON INCOME.—

5 “(A) IN GENERAL.—In the case of an indi-
6 vidual whose modified adjusted gross income
7 exceeds the threshold amount applicable under
8 paragraph (2) of section 1839(i) (including ap-
9 plication of paragraph (5) of such section) for
10 the calendar year, the monthly amount of the
11 beneficiary premium applicable under this sec-
12 tion for a month after December 2010 shall be
13 increased by the monthly adjustment amount
14 specified in subparagraph (B).

15 “(B) MONTHLY ADJUSTMENT AMOUNT.—
16 The monthly adjustment amount specified in
17 this subparagraph for an individual for a month
18 in a year is equal to the product of—

19 “(i) the quotient obtained by divid-
20 ing—

21 “(I) the applicable percentage de-
22 termined under paragraph (3)(C) of
23 section 1839(i) (including application
24 of paragraph (5) of such section) for

1 the individual for the calendar year
2 reduced by 25.5 percent; by

3 “(II) 25.5 percent; and

4 “(ii) the base beneficiary premium (as
5 computed under paragraph (2)).

6 “(C) MODIFIED ADJUSTED GROSS IN-
7 COME.—For purposes of this paragraph, the
8 term ‘modified adjusted gross income’ has the
9 meaning given such term in subparagraph (A)
10 of section 1839(i)(4), determined for the tax-
11 able year applicable under subparagraphs (B)
12 and (C) of such section.

13 “(D) DETERMINATION BY COMMISSIONER
14 OF SOCIAL SECURITY.—The Commissioner of
15 Social Security shall make any determination
16 necessary to carry out the income-related in-
17 crease in the base beneficiary premium under
18 this paragraph.

19 “(E) PROCEDURES TO ASSURE CORRECT
20 INCOME-RELATED INCREASE IN BASE BENE-
21 FICIARY PREMIUM.—

22 “(i) DISCLOSURE OF BASE BENE-
23 FICIARY PREMIUM.—Not later than Sep-
24 tember 15 of each year beginning with
25 2010, the Secretary shall disclose to the

1 Commissioner of Social Security the
2 amount of the base beneficiary premium
3 (as computed under paragraph (2)) for the
4 purpose of carrying out the income-related
5 increase in the base beneficiary premium
6 under this paragraph with respect to the
7 following year.

8 “(ii) ADDITIONAL DISCLOSURE.—Not
9 later than October 15 of each year begin-
10 ning with 2010, the Secretary shall dis-
11 close to the Commissioner of Social Secu-
12 rity the following information for the pur-
13 pose of carrying out the income-related in-
14 crease in the base beneficiary premium
15 under this paragraph with respect to the
16 following year:

17 “(I) The modified adjusted gross
18 income threshold applicable under
19 paragraph (2) of section 1839(i) (in-
20 cluding application of paragraph (5)
21 of such section).

22 “(II) The applicable percentage
23 determined under paragraph (3)(C) of
24 section 1839(i) (including application
25 of paragraph (5) of such section).

1 “(III) The monthly adjustment
2 amount specified in subparagraph
3 (B).

4 “(IV) Any other information the
5 Commissioner of Social Security de-
6 termines necessary to carry out the
7 income-related increase in the base
8 beneficiary premium under this para-
9 graph.

10 “(F) RULE OF CONSTRUCTION.—The for-
11 mula used to determine the monthly adjustment
12 amount specified under subparagraph (B) shall
13 only be used for the purpose of determining
14 such monthly adjustment amount under such
15 subparagraph.”.

16 (2) COLLECTION OF MONTHLY ADJUSTMENT
17 AMOUNT.—Section 1860D–13(c) of the Social Secu-
18 rity Act (42 U.S.C. 1395w–113(c)) is amended—

19 (A) in paragraph (1), by striking “(2) and
20 (3)” and inserting “(2), (3), and (4)”; and

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

23 “(4) COLLECTION OF MONTHLY ADJUSTMENT
24 AMOUNT.—

1 “(A) IN GENERAL.—Notwithstanding any
2 provision of this subsection or section
3 1854(d)(2), subject to subparagraph (B), the
4 amount of the income-related increase in the
5 base beneficiary premium for an individual for
6 a month (as determined under subsection
7 (a)(7)) shall be paid through withholding from
8 benefit payments in the manner provided under
9 section 1840.

10 “(B) AGREEMENTS.—In the case where
11 the monthly benefit payments of an individual
12 that are withheld under subparagraph (A) are
13 insufficient to pay the amount described in such
14 subparagraph, the Commissioner of Social Se-
15 curity shall enter into agreements with the Sec-
16 retary, the Director of the Office of Personnel
17 Management, and the Railroad Retirement
18 Board as necessary in order to allow other
19 agencies to collect the amount described in sub-
20 paragraph (A) that was not withheld under
21 such subparagraph.”.

22 (b) CONFORMING AMENDMENTS.—

23 (1) MEDICARE.—Section 1860D–13(a)(1) of
24 the Social Security Act (42 U.S.C. 1395w–
25 113(a)(1)) is amended—

1 (A) by redesignating subparagraph (F) as
2 subparagraph (G);

3 (B) in subparagraph (G), as redesignated
4 by subparagraph (A), by striking “(D) and
5 (E)” and inserting “(D), (E), and (F)”;

6 (C) by inserting after subparagraph (E)
7 the following new subparagraph:

8 “(F) INCREASE BASED ON INCOME.—The
9 monthly beneficiary premium shall be increased
10 pursuant to paragraph (7).”.

11 (2) INTERNAL REVENUE CODE.—Section
12 6103(l)(20) of the Internal Revenue Code of 1986
13 (relating to disclosure of return information to carry
14 out Medicare part B premium subsidy adjustment)
15 is amended—

16 (A) in the heading, by inserting “AND
17 PART D BASE BENEFICIARY PREMIUM IN-
18 CREASE” after “PART B PREMIUM SUBSIDY AD-
19 JUSTMENT”;

20 (B) in subparagraph (A)—

21 (i) in the matter preceding clause (i),
22 by inserting “or increase under section
23 1860D–13(a)(7)” after “1839(i)”; and

24 (ii) in clause (vii), by inserting after
25 “subsection (i) of such section” the fol-

1 lowing: “or increase under section 1860D–
2 13(a)(7) of such Act”; and

3 (C) in subparagraph (B)—

4 (i) by striking “Return information”
5 and inserting the following:

6 “(i) IN GENERAL.—Return informa-
7 tion”;

8 (ii) by inserting “or increase under
9 such section 1860D–13(a)(7)” before the
10 period at the end;

11 (iii) as amended by clause (i), by in-
12 serting “or for the purpose of resolving
13 taxpayer appeals with respect to any such
14 premium adjustment or increase” before
15 the period at the end; and

16 (iv) by adding at the end the following
17 new clause:

18 “(ii) DISCLOSURE TO OTHER AGEN-
19 CIES.—Officers, employees, and contrac-
20 tors of the Social Security Administration
21 may disclose—

22 “(I) the taxpayer identity infor-
23 mation and the amount of the pre-
24 mium subsidy adjustment or premium
25 increase with respect to a taxpayer de-

1 scribed in subparagraph (A) to offi-
2 cers, employees, and contractors of
3 the Centers for Medicare and Med-
4 icaid Services, to the extent that such
5 disclosure is necessary for the collec-
6 tion of the premium subsidy amount
7 or the increased premium amount,

8 “(II) the taxpayer identity infor-
9 mation and the amount of the pre-
10 mium subsidy adjustment or the in-
11 creased premium amount with respect
12 to a taxpayer described in subpara-
13 graph (A) to officers and employees of
14 the Office of Personnel Management
15 and the Railroad Retirement Board,
16 to the extent that such disclosure is
17 necessary for the collection of the pre-
18 mium subsidy amount or the in-
19 creased premium amount,

20 “(III) return information with re-
21 spect to a taxpayer described in sub-
22 paragraph (A) to officers and employ-
23 ees of the Department of Health and
24 Human Services to the extent nec-
25 essary to resolve administrative ap-

1 peals of such premium subsidy adjust-
2 ment or increased premium, and

3 “(IV) return information with re-
4 spect to a taxpayer described in sub-
5 paragraph (A) to officers and employ-
6 ees of the Department of Justice for
7 use in judicial proceedings to the ex-
8 tent necessary to carry out the pur-
9 poses described in clause (i).”.

10 **SEC. 3309. ELIMINATION OF COST SHARING FOR CERTAIN**
11 **DUAL ELIGIBLE INDIVIDUALS.**

12 Section 1860D–14(a)(1)(D)(i) of the Social Security
13 Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by in-
14 serting “or, effective on a date specified by the Secretary
15 (but in no case earlier than January 1, 2012), who would
16 be such an institutionalized individual or couple, if the
17 full-benefit dual eligible individual were not receiving serv-
18 ices under a home and community-based waiver authorized
19 for a State under section 1115 or subsection (c) or (d)
20 of section 1915 or under a State plan amendment under
21 subsection (i) of such section or services provided through
22 enrollment in a medicaid managed care organization with
23 a contract under section 1903(m) or under section 1932”
24 after “1902(q)(1)(B))”.

1 **SEC. 3310. REDUCING WASTEFUL DISPENSING OF OUT-**
2 **PATIENT PRESCRIPTION DRUGS IN LONG-**
3 **TERM CARE FACILITIES UNDER PRESCRIP-**
4 **TION DRUG PLANS AND MA-PD PLANS.**

5 (a) IN GENERAL.—Section 1860D–4(c) of the Social
6 Security Act (42 U.S.C. 1395w–104(c)) is amended by
7 adding at the end the following new paragraph:

8 “(3) REDUCING WASTEFUL DISPENSING OF
9 OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM
10 CARE FACILITIES.—The Secretary shall require PDP
11 sponsors of prescription drug plans to utilize spe-
12 cific, uniform dispensing techniques, as determined
13 by the Secretary, in consultation with relevant stake-
14 holders (including representatives of nursing facili-
15 ties, residents of nursing facilities, pharmacists, the
16 pharmacy industry (including retail and long-term
17 care pharmacy), prescription drug plans, MA–PD
18 plans, and any other stakeholders the Secretary de-
19 termines appropriate), such as weekly, daily, or
20 automated dose dispensing, when dispensing covered
21 part D drugs to enrollees who reside in a long-term
22 care facility in order to reduce waste associated with
23 30-day fills.”.

24 (b) EFFECTIVE DATE.—The amendment made by
25 subsection (a) shall apply to plan years beginning on or
26 after January 1, 2012.

1 **SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG**
2 **PLAN AND MA-PD PLAN COMPLAINT SYSTEM.**

3 (a) **IN GENERAL.**—The Secretary shall develop and
4 maintain a complaint system, that is widely known and
5 easy to use, to collect and maintain information on MA-
6 PD plan and prescription drug plan complaints that are
7 received (including by telephone, letter, e-mail, or any
8 other means) by the Secretary (including by a regional of-
9 fice of the Department of Health and Human Services,
10 the Medicare Beneficiary Ombudsman, a subcontractor, a
11 carrier, a fiscal intermediary, and a Medicare administra-
12 tive contractor under section 1874A of the Social Security
13 Act (42 U.S.C. 1395kk)) through the date on which the
14 complaint is resolved. The system shall be able to report
15 and initiate appropriate interventions and monitoring
16 based on substantial complaints and to guide quality im-
17 provement.

18 (b) **MODEL ELECTRONIC COMPLAINT FORM.**—The
19 Secretary shall develop a model electronic complaint form
20 to be used for reporting plan complaints under the system.
21 Such form shall be prominently displayed on the front
22 page of the Medicare.gov Internet website and on the
23 Internet website of the Medicare Beneficiary Ombudsman.

24 (c) **ANNUAL REPORTS BY THE SECRETARY.**—The
25 Secretary shall submit to Congress annual reports on the
26 system. Such reports shall include an analysis of the num-

1 ber and types of complaints reported in the system, geo-
 2 graphic variations in such complaints, the timeliness of
 3 agency or plan responses to such complaints, and the reso-
 4 lution of such complaints.

5 (d) DEFINITIONS.—In this section:

6 (1) MA-PD PLAN.—The term “MA-PD plan”
 7 has the meaning given such term in section 1860D-
 8 41(a)(9) of such Act (42 U.S.C. 1395w-151(a)(9)).

9 (2) PRESCRIPTION DRUG PLAN.—The term
 10 “prescription drug plan” has the meaning given
 11 such term in section 1860D-41(a)(14) of such Act
 12 (42 U.S.C. 1395w-151(a)(14)).

13 (3) SECRETARY.—The term “Secretary” means
 14 the Secretary of Health and Human Services.

15 (4) SYSTEM.—The term “system” means the
 16 plan complaint system developed and maintained
 17 under subsection (a).

18 **SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS**
 19 **FOR PRESCRIPTION DRUG PLANS AND MA-PD**
 20 **PLANS.**

21 (a) IN GENERAL.—Section 1860D-4(b)(3) of the So-
 22 cial Security Act (42 U.S.C. 1395w-104(b)(3)) is amend-
 23 ed by adding at the end the following new subparagraph:

24 “(H) USE OF SINGLE, UNIFORM EXCEP-
 25 TIONS AND APPEALS PROCESS.—Notwith-

1 standing any other provision of this part, each
2 PDP sponsor of a prescription drug plan
3 shall—

4 “(i) use a single, uniform exceptions
5 and appeals process (including, to the ex-
6 tent the Secretary determines feasible, a
7 single, uniform model form for use under
8 such process) with respect to the deter-
9 mination of prescription drug coverage for
10 an enrollee under the plan; and

11 “(ii) provide instant access to such
12 process by enrollees through a toll-free
13 telephone number and an Internet
14 website.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to exceptions and appeals on
17 or after January 1, 2012.

18 **SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES**

19 **AND REPORTS.**

20 (a) STUDY AND ANNUAL REPORT ON PART D
21 FORMULARIES’ INCLUSION OF DRUGS COMMONLY USED
22 BY DUAL ELIGIBLES.—

23 (1) STUDY.—The Inspector General of the De-
24 partment of Health and Human Services shall con-
25 duct a study of the extent to which formularies used

1 by prescription drug plans and MA–PD plans under
2 part D include drugs commonly used by full-benefit
3 dual eligible individuals (as defined in section
4 1935(e)(6) of the Social Security Act (42 U.S.C.
5 1396u–5(c)(6))).

6 (2) ANNUAL REPORTS.—Not later than July 1
7 of each year (beginning with 2011), the Inspector
8 General shall submit to Congress a report on the
9 study conducted under paragraph (1), together with
10 such recommendations as the Inspector General de-
11 termines appropriate.

12 (b) STUDY AND REPORT ON PRESCRIPTION DRUG
13 PRICES UNDER MEDICARE PART D AND MEDICAID.—

14 (1) STUDY.—

15 (A) IN GENERAL.—The Inspector General
16 of the Department of Health and Human Serv-
17 ices shall conduct a study on prices for covered
18 part D drugs under the Medicare prescription
19 drug program under part D of title XVIII of
20 the Social Security Act and for covered out-
21 patient drugs under title XIX. Such study shall
22 include the following:

23 (i) A comparison, with respect to the
24 200 most frequently dispensed covered
25 part D drugs under such program and cov-

1 ered outpatient drugs under such title (as
2 determined by the Inspector General based
3 on volume and expenditures), of—

4 (I) the prices paid for covered
5 part D drugs by PDP sponsors of
6 prescription drug plans and Medicare
7 Advantage organizations offering MA-
8 PD plans; and

9 (II) the prices paid for covered
10 outpatient drugs by a State plan
11 under title XIX.

12 (ii) An assessment of—

13 (I) the financial impact of any
14 discrepancies in such prices on the
15 Federal Government; and

16 (II) the financial impact of any
17 such discrepancies on enrollees under
18 part D or individuals eligible for med-
19 ical assistance under a State plan
20 under title XIX.

21 (B) PRICE.—For purposes of subpara-
22 graph (A), the price of a covered part D drug
23 or a covered outpatient drug shall include any
24 rebate or discount under such program or such
25 title, respectively, including any negotiated price

1 concession described in section 1860D–
2 2(d)(1)(B) of the Social Security Act (42
3 U.S.C. 1395w–102(d)(1)(B)) or rebate under
4 an agreement under section 1927 of the Social
5 Security Act (42 U.S.C. 1396r–8).

6 (C) AUTHORITY TO COLLECT ANY NEC-
7 ESSARY INFORMATION.—Notwithstanding any
8 other provision of law, the Inspector General of
9 the Department of Health and Human Services
10 shall be able to collect any information related
11 to the prices of covered part D drugs under
12 such program and covered outpatient drugs
13 under such title XIX necessary to carry out the
14 comparison under subparagraph (A).

15 (2) REPORT.—

16 (A) IN GENERAL.—Not later than October
17 1, 2011, subject to subparagraph (B), the In-
18 spector General shall submit to Congress a re-
19 port containing the results of the study con-
20 ducted under paragraph (1), together with rec-
21 ommendations for such legislation and adminis-
22 trative action as the Inspector General deter-
23 mines appropriate.

24 (B) LIMITATION ON INFORMATION CON-
25 TAINED IN REPORT.—The report submitted

1 under subparagraph (A) shall not include any
2 information that the Inspector General deter-
3 mines is proprietary or is likely to negatively
4 impact the ability of a PDP sponsor or a State
5 plan under title XIX to negotiate prices for cov-
6 ered part D drugs or covered outpatient drugs,
7 respectively.

8 (3) DEFINITIONS.—In this section:

9 (A) COVERED PART D DRUG.—The term
10 “covered part D drug” has the meaning given
11 such term in section 1860D–2(e) of the Social
12 Security Act (42 U.S.C. 1395w–102(e)).

13 (B) COVERED OUTPATIENT DRUG.—The
14 term “covered outpatient drug” has the mean-
15 ing given such term in section 1927(k) of such
16 Act (42 U.S.C. 1396r(k)).

17 (C) MA–PD PLAN.—The term “MA–PD
18 plan” has the meaning given such term in sec-
19 tion 1860D–41(a)(9) of such Act (42 U.S.C.
20 1395w–151(a)(9)).

21 (D) MEDICARE ADVANTAGE ORGANIZA-
22 TION.—The term “Medicare Advantage organi-
23 zation” has the meaning given such term in
24 section 1859(a)(1) of such Act (42 U.S.C.
25 1395w–28)(a)(1)).

1 (E) PDP SPONSOR.—The term “PDP
2 sponsor” has the meaning given such term in
3 section 1860D–41(a)(13) of such Act (42
4 U.S.C. 1395w–151(a)(13)).

5 (F) PRESCRIPTION DRUG PLAN.—The
6 term “prescription drug plan” has the meaning
7 given such term in section 1860D–41(a)(14) of
8 such Act (42 U.S.C. 1395w–151(a)(14)).

9 **SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**
10 **SISTANCE PROGRAMS AND INDIAN HEALTH**
11 **SERVICE IN PROVIDING PRESCRIPTION**
12 **DRUGS TOWARD THE ANNUAL OUT-OF-POCK-**
13 **ET THRESHOLD UNDER PART D.**

14 (a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the
15 Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is
16 amended—

17 (1) in clause (i), by striking “and” at the end;

18 (2) in clause (ii)—

19 (A) by striking “such costs shall be treated
20 as incurred only if” and inserting “subject to
21 clause (iii), such costs shall be treated as in-
22 curred only if”;

23 (B) by striking “, under section 1860D–
24 14, or under a State Pharmaceutical Assistance
25 Program”; and

1 (C) by striking the period at the end and
2 inserting “; and”; and

3 (3) by inserting after clause (ii) the following
4 new clause:

5 “(iii) such costs shall be treated as in-
6 curred and shall not be considered to be
7 reimbursed under clause (ii) if such costs
8 are borne or paid—

9 “(I) under section 1860D–14;

10 “(II) under a State Pharma-
11 ceutical Assistance Program;

12 “(III) by the Indian Health Serv-
13 ice, an Indian tribe or tribal organiza-
14 tion, or an urban Indian organization
15 (as defined in section 4 of the Indian
16 Health Care Improvement Act); or

17 “(IV) under an AIDS Drug As-
18 sistance Program under part B of
19 title XXVI of the Public Health Serv-
20 ice Act.”.

21 (b) EFFECTIVE DATE.—The amendments made by
22 subsection (a) shall apply to costs incurred on or after
23 January 1, 2011.

1 **SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN**
2 **2010.**

3 Section 1860D–2(b) of the Social Security Act (42
4 U.S.C. 1395w–102(b)) is amended—

5 (1) in paragraph (3)(A), by striking “paragraph
6 (4)” and inserting “paragraphs (4) and (7)”; and

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

9 “(7) INCREASE IN INITIAL COVERAGE LIMIT IN
10 2010.—

11 “(A) IN GENERAL.—For the plan year be-
12 ginning on January 1, 2010, the initial cov-
13 erage limit described in paragraph (3)(B) other-
14 wise applicable shall be increased by \$500.

15 “(B) APPLICATION.—In applying subpara-
16 graph (A)—

17 “(i) except as otherwise provided in
18 this subparagraph, there shall be no
19 change in the premiums, bids, or any other
20 parameters under this part or part C;

21 “(ii) costs that would be treated as in-
22 curred costs for purposes of applying para-
23 graph (4) but for the application of sub-
24 paragraph (A) shall continue to be treated
25 as incurred costs;

1 “(iii) the Secretary shall establish pro-
2 cedures, which may include a reconciliation
3 process, to fully reimburse PDP sponsors
4 with respect to prescription drug plans and
5 MA organizations with respect to MA–PD
6 plans for the reduction in beneficiary cost
7 sharing associated with the application of
8 subparagraph (A);

9 “(iv) the Secretary shall develop an
10 estimate of the additional increased costs
11 attributable to the application of this para-
12 graph for increased drug utilization and fi-
13 nancing and administrative costs and shall
14 use such estimate to adjust payments to
15 PDP sponsors with respect to prescription
16 drug plans under this part and MA organi-
17 zations with respect to MA–PD plans
18 under part C; and

19 “(v) the Secretary shall establish pro-
20 cedures for retroactive reimbursement of
21 part D eligible individuals who are covered
22 under such a plan for costs which are in-
23 curred before the date of initial implemen-
24 tation of subparagraph (A) and which
25 would be reimbursed under such a plan if

1 such implementation occurred as of Janu-
2 ary 1, 2010.

3 “(C) NO EFFECT ON SUBSEQUENT
4 YEARS.—The increase under subparagraph (A)
5 shall only apply with respect to the plan year
6 beginning on January 1, 2010, and the initial
7 coverage limit for plan years beginning on or
8 after January 1, 2011, shall be determined as
9 if subparagraph (A) had never applied.”.

10 **Subtitle E—Ensuring Medicare** 11 **Sustainability**

12 **SEC. 3401. REVISION OF CERTAIN MARKET BASKET UP-** 13 **DATES AND INCORPORATION OF PRODUC-** 14 **TIVITY IMPROVEMENTS INTO MARKET BAS-** 15 **KET UPDATES THAT DO NOT ALREADY IN-** 16 **CORPORATE SUCH IMPROVEMENTS.**

17 (a) INPATIENT ACUTE HOSPITALS.—Section
18 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
19 1395ww(b)(3)(B)), as amended by section 3001(a)(3), is
20 further amended—

21 (1) in clause (i)(XX), by striking “clause (viii)”
22 and inserting “clauses (viii), (ix), (xi), and (xii)”;

23 (2) in the first sentence of clause (viii), by in-
24 serting “of such applicable percentage increase (de-

1 terminated without regard to clause (ix), (xi), or
2 (xii))” after “one-quarter”;

3 (3) in the first sentence of clause (ix)(I), by in-
4 serting “(determined without regard to clause (viii),
5 (xi), or (xii))” after “clause (i)” the second time it
6 appears; and

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

9 “(xi)(I) For 2012 and each subsequent fiscal year,
10 after determining the applicable percentage increase de-
11 scribed in clause (i) and after application of clauses (viii)
12 and (ix), such percentage increase shall be reduced by the
13 productivity adjustment described in subclause (II).

14 “(II) The productivity adjustment described in this
15 subclause, with respect to a percentage, factor, or update
16 for a fiscal year, year, cost reporting period, or other an-
17 nual period, is a productivity adjustment equal to the 10-
18 year moving average of changes in annual economy-wide
19 private nonfarm business multi-factor productivity (as
20 projected by the Secretary for the 10-year period ending
21 with the applicable fiscal year, year, cost reporting period,
22 or other annual period).

23 “(III) The application of subclause (I) may result in
24 the applicable percentage increase described in clause (i)
25 being less than 0.0 for a fiscal year, and may result in

1 payment rates under this section for a fiscal year being
2 less than such payment rates for the preceding fiscal year.

3 “(xii) After determining the applicable percentage in-
4 crease described in clause (i), and after application of
5 clauses (viii), (ix), and (xi), the Secretary shall reduce
6 such applicable percentage increase—

7 “(I) for each of fiscal years 2010 and 2011, by
8 0.25 percentage point; and

9 “(II) subject to clause (xiii), for each of fiscal
10 years 2012 through 2019, by 0.2 percentage point.

11 The application of this clause may result in the applicable
12 percentage increase described in clause (i) being less than
13 0.0 for a fiscal year, and may result in payment rates
14 under this section for a fiscal year being less than such
15 payment rates for the preceding fiscal year.

16 “(xiii) Clause (xii) shall be applied with respect to
17 any of fiscal years 2014 through 2019 by substituting ‘0.0
18 percentage points’ for ‘0.2 percentage point’, if for such
19 fiscal year—

20 “(I) the excess (if any) of—

21 “(aa) the total percentage of the non-elder-
22 ly insured population for the preceding fiscal
23 year (based on the most recent estimates avail-
24 able from the Director of the Congressional
25 Budget Office before a vote in either House on

1 the Patient Protection and Affordable Care Act
2 that, if determined in the affirmative, would
3 clear such Act for enrollment); over

4 “(bb) the total percentage of the non-elder-
5 ly insured population for such preceding fiscal
6 year (as estimated by the Secretary); exceeds

7 “(II) 5 percentage points.”.

8 (b) SKILLED NURSING FACILITIES.—Section
9 1888(e)(5)(B) of the Social Security Act (42 U.S.C.
10 1395yy(e)(5)(B)) is amended—

11 (1) by striking “PERCENTAGE.—The term” and
12 inserting “PERCENTAGE.—

13 “(i) IN GENERAL.—Subject to clause
14 (ii), the term”; and

15 (2) by adding at the end the following new
16 clause:

17 “(ii) ADJUSTMENT.—For fiscal year
18 2012 and each subsequent fiscal year,
19 after determining the percentage described
20 in clause (i), the Secretary shall reduce
21 such percentage by the productivity adjust-
22 ment described in section
23 1886(b)(3)(B)(xi)(II). The application of
24 the preceding sentence may result in such
25 percentage being less than 0.0 for a fiscal

1 year, and may result in payment rates
2 under this subsection for a fiscal year
3 being less than such payment rates for the
4 preceding fiscal year.”.

5 (c) LONG-TERM CARE HOSPITALS.—Section 1886(m)
6 of the Social Security Act (42 U.S.C. 1395ww(m)) is
7 amended by adding at the end the following new para-
8 graphs:

9 “(3) IMPLEMENTATION FOR RATE YEAR 2010
10 AND SUBSEQUENT YEARS.—

11 “(A) IN GENERAL.—In implementing the
12 system described in paragraph (1) for rate year
13 2010 and each subsequent rate year, any an-
14 nual update to a standard Federal rate for dis-
15 charges for the hospital during the rate year,
16 shall be reduced—

17 “(i) for rate year 2012 and each sub-
18 sequent rate year, by the productivity ad-
19 justment described in section
20 1886(b)(3)(B)(xi)(II); and

21 “(ii) for each of rate years 2010
22 through 2019, by the other adjustment de-
23 scribed in paragraph (4).

24 “(B) SPECIAL RULE.—The application of
25 this paragraph may result in such annual up-

1 date being less than 0.0 for a rate year, and
2 may result in payment rates under the system
3 described in paragraph (1) for a rate year being
4 less than such payment rates for the preceding
5 rate year.

6 “(4) OTHER ADJUSTMENT.—

7 “(A) IN GENERAL.—For purposes of para-
8 graph (3)(A)(ii), the other adjustment described
9 in this paragraph is—

10 “(i) for each of rate years 2010 and
11 2011, 0.25 percentage point; and

12 “(ii) subject to subparagraph (B), for
13 each of rate years 2012 through 2019, 0.2
14 percentage point.

15 “(B) REDUCTION OF OTHER ADJUST-
16 MENT.—Subparagraph (A)(ii) shall be applied
17 with respect to any of rate years 2014 through
18 2019 by substituting ‘0.0 percentage points’ for
19 ‘0.2 percentage point’, if for such rate year—

20 “(i) the excess (if any) of—

21 “(I) the total percentage of the
22 non-elderly insured population for the
23 preceding rate year (based on the
24 most recent estimates available from
25 the Director of the Congressional

1 Budget Office before a vote in either
 2 House on the Patient Protection and
 3 Affordable Care Act that, if deter-
 4 mined in the affirmative, would clear
 5 such Act for enrollment); over

6 “(II) the total percentage of the
 7 non-elderly insured population for
 8 such preceding rate year (as estimated
 9 by the Secretary); exceeds

10 “(ii) 5 percentage points.”.

11 (d) INPATIENT REHABILITATION FACILITIES.—Sec-
 12 tion 1886(j)(3) of the Social Security Act (42 U.S.C.
 13 1395ww(j)(3)) is amended—

14 (1) in subparagraph (C)—

15 (A) by striking “FACTOR.—For purposes”
 16 and inserting “FACTOR.—

17 “(i) IN GENERAL.—For purposes”;

18 (B) by inserting “subject to clause (ii)” be-
 19 fore the period at the end of the first sentence
 20 of clause (i), as added by paragraph (1); and

21 (C) by adding at the end the following new
 22 clause:

23 “(ii) PRODUCTIVITY AND OTHER AD-
 24 JUSTMENT.—After establishing the in-
 25 crease factor described in clause (i) for a

1 fiscal year, the Secretary shall reduce such
2 increase factor—

3 “(I) for fiscal year 2012 and
4 each subsequent fiscal year, by the
5 productivity adjustment described in
6 section 1886(b)(3)(B)(xi)(II); and

7 “(II) for each of fiscal years
8 2010 through 2019, by the other ad-
9 justment described in subparagraph
10 (D).

11 The application of this clause may result in
12 the increase factor under this subpara-
13 graph being less than 0.0 for a fiscal year,
14 and may result in payment rates under
15 this subsection for a fiscal year being less
16 than such payment rates for the preceding
17 fiscal year.”; and

18 (2) by adding at the end the following new sub-
19 paragraph:

20 “(D) OTHER ADJUSTMENT.—

21 “(i) IN GENERAL.—For purposes of
22 subparagraph (C)(ii)(II), the other adjust-
23 ment described in this subparagraph is—

24 “(I) for each of fiscal years 2010
25 and 2011, 0.25 percentage point; and

1 “(II) subject to clause (ii), for
2 each of fiscal years 2012 through
3 2019, 0.2 percentage point.

4 “(ii) REDUCTION OF OTHER ADJUST-
5 MENT.—Clause (i)(II) shall be applied with
6 respect to any of fiscal years 2014 through
7 2019 by substituting ‘0.0 percentage
8 points’ for ‘0.2 percentage point’, if for
9 such fiscal year—

10 “(I) the excess (if any) of—

11 “(aa) the total percentage of
12 the non-elderly insured popu-
13 lation for the preceding fiscal
14 year (based on the most recent
15 estimates available from the Di-
16 rector of the Congressional
17 Budget Office before a vote in ei-
18 ther House on the Patient Pro-
19 tection and Affordable Care Act
20 that, if determined in the affirm-
21 ative, would clear such Act for
22 enrollment); over

23 “(bb) the total percentage of
24 the non-elderly insured popu-
25 lation for such preceding fiscal

1 year (as estimated by the Sec-
2 retary); exceeds

3 “(II) 5 percentage points.”.

4 (e) HOME HEALTH AGENCIES.—Section
5 1895(b)(3)(B) of the Social Security Act (42 U.S.C.
6 1395fff(b)(3)(B)) is amended—

7 (1) in clause (ii)(V), by striking “clause (v)”
8 and inserting “clauses (v) and (vi)”; and

9 (2) by adding at the end the following new
10 clause:

11 “(vi) ADJUSTMENTS.—After deter-
12 mining the home health market basket per-
13 centage increase under clause (iii), and
14 after application of clause (v), the Sec-
15 retary shall reduce such percentage—

16 “(I) for 2015 and each subse-
17 quent year, by the productivity adjust-
18 ment described in section
19 1886(b)(3)(B)(xi)(II); and

20 “(II) for each of 2011 and 2012,
21 by 1 percentage point.

22 The application of this clause may result in
23 the home health market basket percentage
24 increase under clause (iii) being less than
25 0.0 for a year, and may result in payment

1 rates under the system under this sub-
 2 section for a year being less than such pay-
 3 ment rates for the preceding year.”.

4 (f) PSYCHIATRIC HOSPITALS.—Section 1886 of the
 5 Social Security Act, as amended by sections 3001, 3008,
 6 3025, and 3133, is amended by adding at the end the fol-
 7 lowing new subsection:

8 “(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC
 9 HOSPITALS.—

10 “(1) REFERENCE TO ESTABLISHMENT AND IM-
 11 PLEMENTATION OF SYSTEM.—For provisions related
 12 to the establishment and implementation of a pro-
 13 spective payment system for payments under this
 14 title for inpatient hospital services furnished by psy-
 15 chiatric hospitals (as described in clause (i) of sub-
 16 section (d)(1)(B)) and psychiatric units (as de-
 17 scribed in the matter following clause (v) of such
 18 subsection), see section 124 of the Medicare, Med-
 19 icaid, and SCHIP Balanced Budget Refinement Act
 20 of 1999.

21 “(2) IMPLEMENTATION FOR RATE YEAR BEGIN-
 22 NING IN 2010 AND SUBSEQUENT RATE YEARS.—

23 “(A) IN GENERAL.—In implementing the
 24 system described in paragraph (1) for the rate
 25 year beginning in 2010 and any subsequent

1 rate year, any update to a base rate for days
2 during the rate year for a psychiatric hospital
3 or unit, respectively, shall be reduced—

4 “(i) for the rate year beginning in
5 2012 and each subsequent rate year, by
6 the productivity adjustment described in
7 section 1886(b)(3)(B)(xi)(II); and

8 “(ii) for each of the rate years begin-
9 ning in 2010 through 2019, by the other
10 adjustment described in paragraph (3).

11 “(B) SPECIAL RULE.—The application of
12 this paragraph may result in such update being
13 less than 0.0 for a rate year, and may result in
14 payment rates under the system described in
15 paragraph (1) for a rate year being less than
16 such payment rates for the preceding rate year.

17 “(3) OTHER ADJUSTMENT.—

18 “(A) IN GENERAL.—For purposes of para-
19 graph (2)(A)(ii), the other adjustment described
20 in this paragraph is—

21 “(i) for each of the rate years begin-
22 ning in 2010 and 2011, 0.25 percentage
23 point; and

1 “(ii) subject to subparagraph (B), for
2 each of the rate years beginning in 2012
3 through 2019, 0.2 percentage point.

4 “(B) REDUCTION OF OTHER ADJUST-
5 MENT.—Subparagraph (A)(ii) shall be applied
6 with respect to any of rate years 2014 through
7 2019 by substituting ‘0.0 percentage points’ for
8 ‘0.2 percentage point’, if for such rate year—

9 “(i) the excess (if any) of—

10 “(I) the total percentage of the
11 non-elderly insured population for the
12 preceding rate year (based on the
13 most recent estimates available from
14 the Director of the Congressional
15 Budget Office before a vote in either
16 House on the Patient Protection and
17 Affordable Care Act that, if deter-
18 mined in the affirmative, would clear
19 such Act for enrollment); over

20 “(II) the total percentage of the
21 non-elderly insured population for
22 such preceding rate year (as estimated
23 by the Secretary); exceeds

24 “(ii) 5 percentage points.”.

1 (g) HOSPICE CARE.—Section 1814(i)(1)(C) of the
2 Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amend-
3 ed by section 3132, is amended by adding at the end the
4 following new clauses:

5 “(iv) After determining the market basket percentage
6 increase under clause (ii)(VII) or (iii), as applicable, with
7 respect to fiscal year 2013 and each subsequent fiscal
8 year, the Secretary shall reduce such percentage—

9 “(I) for 2013 and each subsequent fiscal year,
10 by the productivity adjustment described in section
11 1886(b)(3)(B)(xi)(II); and

12 “(II) subject to clause (v), for each of fiscal
13 years 2013 through 2019, by 0.5 percentage point.
14 The application of this clause may result in the market
15 basket percentage increase under clause (ii)(VII) or (iii),
16 as applicable, being less than 0.0 for a fiscal year, and
17 may result in payment rates under this subsection for a
18 fiscal year being less than such payment rates for the pre-
19 ceding fiscal year.

20 “(v) Clause (iv)(II) shall be applied with respect to
21 any of fiscal years 2014 through 2019 by substituting ‘0.0
22 percentage points’ for ‘0.5 percentage point’, if for such
23 fiscal year—

24 “(I) the excess (if any) of—

1 “(aa) the total percentage of the non-elder-
 2 ly insured population for the preceding fiscal
 3 year (based on the most recent estimates avail-
 4 able from the Director of the Congressional
 5 Budget Office before a vote in either House on
 6 the Patient Protection and Affordable Care Act
 7 that, if determined in the affirmative, would
 8 clear such Act for enrollment); over

9 “(bb) the total percentage of the non-elder-
 10 ly insured population for such preceding fiscal
 11 year (as estimated by the Secretary); exceeds
 12 “(II) 5 percentage points.”.

13 (h) DIALYSIS.—Section 1881(b)(14)(F) of the Social
 14 Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended—

15 (1) in clause (i)—

16 (A) by inserting “(I)” after “(F)(i)”

17 (B) in subclause (I), as inserted by sub-
 18 paragraph (A)—

19 (i) by striking “clause (ii)” and in-
 20 serting “subclause (II) and clause (ii)”;
 21 and

22 (ii) by striking “minus 1.0 percentage
 23 point”; and

24 (C) by adding at the end the following new
 25 subclause:

1 “(II) For 2012 and each subsequent year, after de-
2 termining the increase factor described in subclause (I),
3 the Secretary shall reduce such increase factor by the pro-
4 ductivity adjustment described in section
5 1886(b)(3)(B)(xi)(II). The application of the preceding
6 sentence may result in such increase factor being less than
7 0.0 for a year, and may result in payment rates under
8 the payment system under this paragraph for a year being
9 less than such payment rates for the preceding year.”; and

10 (2) in clause (ii)(II)—

11 (A) by striking “The” and inserting “Sub-
12 ject to clause (i)(II), the”; and

13 (B) by striking “clause (i) minus 1.0 per-
14 centage point” and inserting “clause (i)(I)”.

15 (i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of
16 the Social Security Act (42 U.S.C. 1395l(t)(3)) is amend-
17 ed—

18 (1) in subparagraph (C)(iv), by inserting “and
19 subparagraph (F) of this paragraph” after “(17)”;
20 and

21 (2) by adding at the end the following new sub-
22 paragraphs:

23 “(F) PRODUCTIVITY AND OTHER ADJUST-
24 MENT.—After determining the OPD fee sched-
25 ule increase factor under subparagraph (C)(iv),

1 the Secretary shall reduce such increase fac-
2 tor—

3 “(i) for 2012 and subsequent years,
4 by the productivity adjustment described in
5 section 1886(b)(3)(B)(xi)(II); and

6 “(ii) for each of 2010 through 2019,
7 by the adjustment described in subpara-
8 graph (G).

9 The application of this subparagraph may re-
10 sult in the increase factor under subparagraph
11 (C)(iv) being less than 0.0 for a year, and may
12 result in payment rates under the payment sys-
13 tem under this subsection for a year being less
14 than such payment rates for the preceding year.

15 “(G) OTHER ADJUSTMENT.—

16 “(i) ADJUSTMENT.—For purposes of
17 subparagraph (F)(ii), the adjustment de-
18 scribed in this subparagraph is—

19 “(I) for each of 2010 and 2011,
20 0.25 percentage point; and

21 “(II) subject to clause (ii), for
22 each of 2012 through 2019, 0.2 per-
23 centage point.

24 “(ii) REDUCTION OF OTHER ADJUST-
25 MENT.—Clause (i)(II) shall be applied with

1 respect to any of 2014 through 2019 by
2 substituting ‘0.0 percentage points’ for ‘0.2
3 percentage point’, if for such year—

4 “(I) the excess (if any) of—

5 “(aa) the total percentage of
6 the non-elderly insured popu-
7 lation for the preceding year
8 (based on the most recent esti-
9 mates available from the Director
10 of the Congressional Budget Of-
11 fice before a vote in either House
12 on the Patient Protection and Af-
13 fordable Care Act that, if deter-
14 mined in the affirmative, would
15 clear such Act for enrollment);
16 over

17 “(bb) the total percentage of
18 the non-elderly insured popu-
19 lation for such preceding year (as
20 estimated by the Secretary); ex-
21 ceeds

22 “(II) 5 percentage points.”.

23 (j) **AMBULANCE SERVICES.**—Section 1834(l)(3) of
24 the Social Security Act (42 U.S.C. 1395m(l)(3)) is amend-
25 ed—

1 (1) in subparagraph (A), by striking “and” at
2 the end;

3 (2) in subparagraph (B)—

4 (A) by inserting “, subject to subpara-
5 graph (C) and the succeeding sentence of this
6 paragraph,” after “increased”; and

7 (B) by striking the period at the end and
8 inserting “; and”;

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(C) for 2011 and each subsequent year,
12 after determining the percentage increase under
13 subparagraph (B) for the year, reduce such per-
14 centage increase by the productivity adjustment
15 described in section 1886(b)(3)(B)(xi)(II).”;

16 and

17 (4) by adding at the end the following flush
18 sentence:

19 “‘The application of subparagraph (C) may result in
20 the percentage increase under subparagraph (B)
21 being less than 0.0 for a year, and may result in
22 payment rates under the fee schedule under this
23 subsection for a year being less than such payment
24 rates for the preceding year.’”.

1 (k) AMBULATORY SURGICAL CENTER SERVICES.—
2 Section 1833(i)(2)(D) of the Social Security Act (42
3 U.S.C. 1395l(i)(2)(D)) is amended—

4 (1) by redesignating clause (v) as clause (vi);
5 and

6 (2) by inserting after clause (iv) the following
7 new clause:

8 “(v) In implementing the system de-
9 scribed in clause (i) for 2011 and each
10 subsequent year, any annual update under
11 such system for the year, after application
12 of clause (iv), shall be reduced by the pro-
13 ductivity adjustment described in section
14 1886(b)(3)(B)(xi)(II). The application of
15 the preceding sentence may result in such
16 update being less than 0.0 for a year, and
17 may result in payment rates under the sys-
18 tem described in clause (i) for a year being
19 less than such payment rates for the pre-
20 ceding year.”.

21 (l) LABORATORY SERVICES.—Section 1833(h)(2)(A)
22 of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is
23 amended—

24 (1) in clause (i)—

1 (A) by inserting “, subject to clause (iv),”
2 after “year) by”; and

3 (B) by striking “through 2013” and in-
4 sserting “and 2010”; and

5 (2) by adding at the end the following new
6 clause:

7 “(iv) After determining the adjust-
8 ment to the fee schedules under clause (i),
9 the Secretary shall reduce such adjust-
10 ment—

11 “(I) for 2011 and each subse-
12 quent year, by the productivity adjust-
13 ment described in section
14 1886(b)(3)(B)(xi)(II); and

15 “(II) for each of 2011 through
16 2015, by 1.75 percentage points.

17 Subclause (I) shall not apply in a year
18 where the adjustment to the fee schedules
19 determined under clause (i) is 0.0 or a per-
20 centage decrease for a year. The applica-
21 tion of the productivity adjustment under
22 subclause (I) shall not result in an adjust-
23 ment to the fee schedules under clause (i)
24 being less than 0.0 for a year. The applica-
25 tion of subclause (II) may result in an ad-

1 justment to the fee schedules under clause
2 (i) being less than 0.0 for a year, and may
3 result in payment rates for a year being
4 less than such payment rates for the pre-
5 ceding year.”.

6 (m) CERTAIN DURABLE MEDICAL EQUIPMENT.—
7 Section 1834(a)(14) of the Social Security Act (42 U.S.C.
8 1395m(a)(14)) is amended—

9 (1) in subparagraph (K)—

10 (A) by striking “2011, 2012, and 2013,”;

11 and

12 (B) by inserting “and” after the semicolon
13 at the end;

14 (2) by striking subparagraphs (L) and (M) and
15 inserting the following new subparagraph:

16 “(L) for 2011 and each subsequent year—

17 “(i) the percentage increase in the
18 consumer price index for all urban con-
19 sumers (United States city average) for
20 the 12-month period ending with June of
21 the previous year, reduced by—

22 “(ii) the productivity adjustment de-
23 scribed in section 1886(b)(3)(B)(xi)(II).”;

24 and

1 (3) by adding at the end the following flush
2 sentence:

3 “The application of subparagraph (L)(ii) may result
4 in the covered item update under this paragraph
5 being less than 0.0 for a year, and may result in
6 payment rates under this subsection for a year being
7 less than such payment rates for the preceding
8 year.”.

9 (n) PROSTHETIC DEVICES, ORTHOTICS, AND PROS-
10 THETICS.—Section 1834(h)(4) of the Social Security Act
11 (42 U.S.C. 1395m(h)(4)) is amended—

12 (1) in subparagraph (A)—

13 (A) in clause (ix), by striking “and” at the
14 end;

15 (B) in clause (x)—

16 (i) by striking “a subsequent year”
17 and inserting “for each of 2007 through
18 2010”; and

19 (ii) by inserting “and” after the semi-
20 colon at the end;

21 (C) by adding at the end the following new
22 clause:

23 “(xi) for 2011 and each subsequent
24 year—

1 “(I) the percentage increase in
2 the consumer price index for all urban
3 consumers (United States city aver-
4 age) for the 12-month period ending
5 with June of the previous year, re-
6 duced by—

7 “(II) the productivity adjustment
8 described in section
9 1886(b)(3)(B)(xi)(II).”; and

10 (D) by adding at the end the following
11 flush sentence:

12 “The application of subparagraph (A)(xi)(II) may
13 result in the applicable percentage increase under
14 subparagraph (A) being less than 0.0 for a year, and
15 may result in payment rates under this subsection
16 for a year being less than such payment rates for
17 the preceding year.”.

18 (o) OTHER ITEMS.—Section 1842(s)(1) of the Social
19 Security Act (42 U.S.C. 1395u(s)(1)) is amended—

20 (1) in the first sentence, by striking “Subject
21 to” and inserting “(A) Subject to”;

22 (2) by striking the second sentence and insert-
23 ing the following new subparagraph:

1 “(B) Any fee schedule established under
2 this paragraph for such item or service shall be
3 updated—

4 “(i) for years before 2011—

5 “(I) subject to subclause (II), by
6 the percentage increase in the con-
7 sumer price index for all urban con-
8 sumers (United States city average)
9 for the 12-month period ending with
10 June of the preceding year; and

11 “(II) for items and services de-
12 scribed in paragraph (2)(D) for 2009,
13 section 1834(a)(14)(J) shall apply
14 under this paragraph instead of the
15 percentage increase otherwise applica-
16 ble; and

17 “(ii) for 2011 and subsequent years—

18 “(I) the percentage increase in
19 the consumer price index for all urban
20 consumers (United States city aver-
21 age) for the 12-month period ending
22 with June of the previous year, re-
23 duced by—

1 “(II) the productivity adjustment
2 described in section
3 1886(b)(3)(B)(xi)(II).”; and

4 (3) by adding at the end the following flush
5 sentence:

6 “The application of subparagraph (B)(ii)(II) may re-
7 sult in the update under this paragraph being less
8 than 0.0 for a year, and may result in payment rates
9 under any fee schedule established under this para-
10 graph for a year being less than such payment rates
11 for the preceding year.”.

12 (p) NO APPLICATION PRIOR TO APRIL 1, 2010.—
13 Notwithstanding the preceding provisions of this section,
14 the amendments made by subsections (a), (c), and (d)
15 shall not apply to discharges occurring before April 1,
16 2010.

17 **SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULA-**
18 **TION OF PART B PREMIUMS.**

19 Section 1839(i) of the Social Security Act (42 U.S.C.
20 1395r(i)) is amended—

21 (1) in paragraph (2), in the matter preceding
22 subparagraph (A), by inserting “subject to para-
23 graph (6),” after “subsection,”;

1 (2) in paragraph (3)(A)(i), by striking “The ap-
2 plicable” and inserting “Subject to paragraph (6),
3 the applicable”;

4 (3) by redesignating paragraph (6) as para-
5 graph (7); and

6 (4) by inserting after paragraph (5) the fol-
7 lowing new paragraph:

8 “(6) TEMPORARY ADJUSTMENT TO INCOME
9 THRESHOLDS.—Notwithstanding any other provision
10 of this subsection, during the period beginning on
11 January 1, 2011, and ending on December 31,
12 2019—

13 “(A) the threshold amount otherwise appli-
14 cable under paragraph (2) shall be equal to
15 such amount for 2010; and

16 “(B) the dollar amounts otherwise applica-
17 ble under paragraph (3)(C)(i) shall be equal to
18 such dollar amounts for 2010.”.

19 **SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.**

20 (a) BOARD.—

21 (1) IN GENERAL.—Title XVIII of the Social Se-
22 curity Act (42 U.S.C. 1395 et seq.), as amended by
23 section 3022, is amended by adding at the end the
24 following new section:

1 “INDEPENDENT MEDICARE ADVISORY BOARD

2 “SEC. 1899A. (a) ESTABLISHMENT.—There is estab-
3 lished an independent board to be known as the ‘Inde-
4 pendent Medicare Advisory Board’.

5 “(b) PURPOSE.—It is the purpose of this section to,
6 in accordance with the following provisions of this section,
7 reduce the per capita rate of growth in Medicare spend-
8 ing—

9 “(1) by requiring the Chief Actuary of the Cen-
10 ters for Medicare & Medicaid Services to determine
11 in each year to which this section applies (in this
12 section referred to as ‘a determination year’) the
13 projected per capita growth rate under Medicare for
14 the second year following the determination year (in
15 this section referred to as ‘an implementation year’);

16 “(2) if the projection for the implementation
17 year exceeds the target growth rate for that year, by
18 requiring the Board to develop and submit during
19 the first year following the determination year (in
20 this section referred to as ‘a proposal year’) a pro-
21 posal containing recommendations to reduce the
22 Medicare per capita growth rate to the extent re-
23 quired by this section; and

1 “(3) by requiring the Secretary to implement
2 such proposals unless Congress enacts legislation
3 pursuant to this section.

4 “(c) BOARD PROPOSALS.—

5 “(1) DEVELOPMENT.—

6 “(A) IN GENERAL.—The Board shall de-
7 velop detailed and specific proposals related to
8 the Medicare program in accordance with the
9 succeeding provisions of this section.

10 “(B) ADVISORY REPORTS.—Beginning
11 January 15, 2014, the Board may develop and
12 submit to Congress advisory reports on matters
13 related to the Medicare program, regardless of
14 whether or not the Board submitted a proposal
15 for such year. Such a report may, for years
16 prior to 2020, include recommendations regard-
17 ing improvements to payment systems for pro-
18 viders of services and suppliers who are not oth-
19 erwise subject to the scope of the Board’s rec-
20 ommendations in a proposal under this section.
21 Any advisory report submitted under this sub-
22 paragraph shall not be subject to the rules for
23 congressional consideration under subsection
24 (d).

25 “(2) PROPOSALS.—

1 “(A) REQUIREMENTS.—Each proposal
2 submitted under this section in a proposal year
3 shall meet each of the following requirements:

4 “(i) If the Chief Actuary of the Cen-
5 ters for Medicare & Medicaid Services has
6 made a determination under paragraph
7 (7)(A) in the determination year, the pro-
8 posal shall include recommendations so
9 that the proposal as a whole (after taking
10 into account recommendations under
11 clause (v)) will result in a net reduction in
12 total Medicare program spending in the
13 implementation year that is at least equal
14 to the applicable savings target established
15 under paragraph (7)(B) for such imple-
16 mentation year. In determining whether a
17 proposal meets the requirement of the pre-
18 ceding sentence, reductions in Medicare
19 program spending during the 3-month pe-
20 riod immediately preceding the implemen-
21 tation year shall be counted to the extent
22 that such reductions are a result of the im-
23 plementation of recommendations con-
24 tained in the proposal for a change in the
25 payment rate for an item or service that

1 was effective during such period pursuant
2 to subsection (e)(2)(A).

3 “(ii) The proposal shall not include
4 any recommendation to ration health care,
5 raise revenues or Medicare beneficiary pre-
6 miums under section 1818, 1818A, or
7 1839, increase Medicare beneficiary cost-
8 sharing (including deductibles, coinsur-
9 ance, and copayments), or otherwise re-
10 strict benefits or modify eligibility criteria.

11 “(iii) In the case of proposals sub-
12 mitted prior to December 31, 2018, the
13 proposal shall not include any rec-
14 ommendation that would reduce payment
15 rates for items and services furnished,
16 prior to December 31, 2019, by providers
17 of services (as defined in section 1861(u))
18 and suppliers (as defined in section
19 1861(d)) scheduled, pursuant to the
20 amendments made by section 3401 of the
21 Patient Protection and Affordable Care
22 Act, to receive a reduction to the infla-
23 tionary payment updates of such providers
24 of services and suppliers in excess of a re-
25 duction due to productivity in a year in

1 which such recommendations would take
2 effect.

3 “(iv) As appropriate, the proposal
4 shall include recommendations to reduce
5 Medicare payments under parts C and D,
6 such as reductions in direct subsidy pay-
7 ments to Medicare Advantage and pre-
8 scription drug plans specified under para-
9 graph (1) and (2) of section 1860D–15(a)
10 that are related to administrative expenses
11 (including profits) for basic coverage, deny-
12 ing high bids or removing high bids for
13 prescription drug coverage from the cal-
14 culation of the national average monthly
15 bid amount under section 1860D–13(a)(4),
16 and reductions in payments to Medicare
17 Advantage plans under clauses (i) and (ii)
18 of section 1853(a)(1)(B) that are related
19 to administrative expenses (including prof-
20 its) and performance bonuses for Medicare
21 Advantage plans under section 1853(n).
22 Any such recommendation shall not affect
23 the base beneficiary premium percentage
24 specified under 1860D–13(a).

1 “(v) The proposal shall include rec-
2 ommendations with respect to administra-
3 tive funding for the Secretary to carry out
4 the recommendations contained in the pro-
5 posal.

6 “(vi) The proposal shall only include
7 recommendations related to the Medicare
8 program.

9 “(B) ADDITIONAL CONSIDERATIONS.—In
10 developing and submitting each proposal under
11 this section in a proposal year, the Board shall,
12 to the extent feasible—

13 “(i) give priority to recommendations
14 that extend Medicare solvency;

15 “(ii) include recommendations that—

16 “(I) improve the health care de-
17 livery system and health outcomes, in-
18 cluding by promoting integrated care,
19 care coordination, prevention and
20 wellness, and quality and efficiency
21 improvement; and

22 “(II) protect and improve Medi-
23 care beneficiaries’ access to necessary
24 and evidence-based items and services,
25 including in rural and frontier areas;

1 “(iii) include recommendations that
2 target reductions in Medicare program
3 spending to sources of excess cost growth;

4 “(iv) consider the effects on Medicare
5 beneficiaries of changes in payments to
6 providers of services (as defined in section
7 1861(u)) and suppliers (as defined in sec-
8 tion 1861(d));

9 “(v) consider the effects of the rec-
10 ommendations on providers of services and
11 suppliers with actual or projected negative
12 cost margins or payment updates; and

13 “(vi) consider the unique needs of
14 Medicare beneficiaries who are dually eligi-
15 ble for Medicare and the Medicaid program
16 under title XIX.

17 “(C) NO INCREASE IN TOTAL MEDICARE
18 PROGRAM SPENDING.—Each proposal submitted
19 under this section shall be designed in such a
20 manner that implementation of the rec-
21 ommendations contained in the proposal would
22 not be expected to result, over the 10-year pe-
23 riod starting with the implementation year, in
24 any increase in the total amount of net Medi-
25 care program spending relative to the total

1 amount of net Medicare program spending that
2 would have occurred absent such implementa-
3 tion.

4 “(D) CONSULTATION WITH MEDPAC.—The
5 Board shall submit a draft copy of each pro-
6 posal to be submitted under this section to the
7 Medicare Payment Advisory Commission estab-
8 lished under section 1805 for its review. The
9 Board shall submit such draft copy by not later
10 than September 1 of the determination year.

11 “(E) REVIEW AND COMMENT BY THE SEC-
12 RETARY.—The Board shall submit a draft copy
13 of each proposal to be submitted to Congress
14 under this section to the Secretary for the Sec-
15 retary’s review and comment. The Board shall
16 submit such draft copy by not later than Sep-
17 tember 1 of the determination year. Not later
18 than March 1 of the submission year, the Sec-
19 retary shall submit a report to Congress on the
20 results of such review, unless the Secretary sub-
21 mits a proposal under paragraph (5)(A) in that
22 year.

23 “(F) CONSULTATIONS.—In carrying out
24 its duties under this section, the Board shall
25 engage in regular consultations with the Med-

1 icaid and CHIP Payment and Access Commis-
2 sion under section 1900.

3 “(3) TRANSMISSION OF BOARD PROPOSAL TO
4 PRESIDENT.—

5 “(A) IN GENERAL.—

6 “(i) IN GENERAL.—Except as pro-
7 vided in clause (ii) and subsection
8 (f)(3)(B), the Board shall transmit a pro-
9 posal under this section to the President
10 on January 15 of each year (beginning
11 with 2014).

12 “(ii) EXCEPTION.—The Board shall
13 not submit a proposal under clause (i) in
14 a proposal year if the year is—

15 “(I) a year for which the Chief
16 Actuary of the Centers for Medicare &
17 Medicaid Services makes a determina-
18 tion in the determination year under
19 paragraph (6)(A) that the growth rate
20 described in clause (i) of such para-
21 graph does not exceed the growth rate
22 described in clause (ii) of such para-
23 graph;

24 “(II) a year in which the Chief
25 Actuary of the Centers for Medicare &

1 Medicaid Services makes a determina-
2 tion in the determination year that
3 the projected percentage increase (if
4 any) for the medical care expenditure
5 category of the Consumer Price Index
6 for All Urban Consumers (United
7 States city average) for the implemen-
8 tation year is less than the projected
9 percentage increase (if any) in the
10 Consumer Price Index for All Urban
11 Consumers (all items; United States
12 city average) for such implementation
13 year; or

14 “(III) for proposal year 2019 and
15 subsequent proposal years, a year in
16 which the Chief Actuary of the Cen-
17 ters for Medicare & Medicaid Services
18 makes a determination in the deter-
19 mination year that the growth rate
20 described in paragraph (8) exceeds
21 the growth rate described in para-
22 graph (6)(A)(i).

23 “(iii) START-UP PERIOD.—The Board
24 may not submit a proposal under clause (i)
25 prior to January 15, 2014.

1 “(B) REQUIRED INFORMATION.—Each
2 proposal submitted by the Board under sub-
3 paragraph (A)(i) shall include—

4 “(i) the recommendations described in
5 paragraph (2)(A)(i);

6 “(ii) an explanation of each rec-
7 ommendation contained in the proposal
8 and the reasons for including such rec-
9 ommendation;

10 “(iii) an actuarial opinion by the
11 Chief Actuary of the Centers for Medicare
12 & Medicaid Services certifying that the
13 proposal meets the requirements of sub-
14 paragraphs (A)(i) and (C) of paragraph
15 (2);

16 “(iv) a legislative proposal that imple-
17 ments the recommendations; and

18 “(v) other information determined ap-
19 propriate by the Board.

20 “(4) PRESIDENTIAL SUBMISSION TO CON-
21 GRESS.—Upon receiving a proposal from the Board
22 under paragraph (3)(A)(i) or the Secretary under
23 paragraph (5), the President shall immediately sub-
24 mit such proposal to Congress.

1 “(5) CONTINGENT SECRETARIAL DEVELOP-
2 MENT OF PROPOSAL.—If, with respect to a proposal
3 year, the Board is required, to but fails, to submit
4 a proposal to the President by the deadline applica-
5 ble under paragraph (3)(A)(i), the Secretary shall
6 develop a detailed and specific proposal that satisfies
7 the requirements of subparagraphs (A) and (C)
8 (and, to the extent feasible, subparagraph (B)) of
9 paragraph (2) and contains the information required
10 paragraph (3)(B)). By not later than January 25 of
11 the year, the Secretary shall transmit—

12 “(A) such proposal to the President; and

13 “(B) a copy of such proposal to the Medi-
14 care Payment Advisory Commission for its re-
15 view.

16 “(6) PER CAPITA GROWTH RATE PROJECTIONS
17 BY CHIEF ACTUARY.—

18 “(A) IN GENERAL.—Subject to subsection
19 (f)(3)(A), not later than April 30, 2013, and
20 annually thereafter, the Chief Actuary of the
21 Centers for Medicare & Medicaid Services shall
22 determine in each such year whether—

23 “(i) the projected Medicare per capita
24 growth rate for the implementation year

1 (as determined under subparagraph (B));
2 exceeds

3 “(ii) the projected Medicare per capita
4 target growth rate for the implementation
5 year (as determined under subparagraph
6 (C)).

7 “(B) MEDICARE PER CAPITA GROWTH
8 RATE.—

9 “(i) IN GENERAL.—For purposes of
10 this section, the Medicare per capita
11 growth rate for an implementation year
12 shall be calculated as the projected 5-year
13 average (ending with such year) of the
14 growth in Medicare program spending per
15 unduplicated enrollee.

16 “(ii) REQUIREMENT.—The projection
17 under clause (i) shall—

18 “(I) to the extent that there is
19 projected to be a negative update to
20 the single conversion factor applicable
21 to payments for physicians’ services
22 under section 1848(d) furnished in
23 the proposal year or the implementa-
24 tion year, assume that such update
25 for such services is 0 percent rather

1 than the negative percent that would
2 otherwise apply; and

3 “(II) take into account any deliv-
4 ery system reforms or other payment
5 changes that have been enacted or
6 published in final rules but not yet
7 implemented as of the making of such
8 calculation.

9 “(C) MEDICARE PER CAPITA TARGET
10 GROWTH RATE.—For purposes of this section,
11 the Medicare per capita target growth rate for
12 an implementation year shall be calculated as
13 the projected 5-year average (ending with such
14 year) percentage increase in—

15 “(i) with respect to a determination
16 year that is prior to 2018, the average of
17 the projected percentage increase (if any)
18 in—

19 “(I) the Consumer Price Index
20 for All Urban Consumers (all items;
21 United States city average); and

22 “(II) the medical care expendi-
23 ture category of the Consumer Price
24 Index for All Urban Consumers
25 (United States city average); and

1 “(ii) with respect to a determination
2 year that is after 2017, the nominal gross
3 domestic product per capita plus 1.0 per-
4 centage point.

5 “(7) SAVINGS REQUIREMENT.—

6 “(A) IN GENERAL.—If, with respect to a
7 determination year, the Chief Actuary of the
8 Centers for Medicare & Medicaid Services
9 makes a determination under paragraph (6)(A)
10 that the growth rate described in clause (i) of
11 such paragraph exceeds the growth rate de-
12 scribed in clause (ii) of such paragraph, the
13 Chief Actuary shall establish an applicable sav-
14 ings target for the implementation year.

15 “(B) APPLICABLE SAVINGS TARGET.—For
16 purposes of this section, the applicable savings
17 target for an implementation year shall be an
18 amount equal to the product of—

19 “(i) the total amount of projected
20 Medicare program spending for the pro-
21 posal year; and

22 “(ii) the applicable percent for the im-
23 plementation year.

24 “(C) APPLICABLE PERCENT.—For pur-
25 poses of subparagraph (B), the applicable per-

1 cent for an implementation year is the lesser
2 of—

3 “(i) in the case of—

4 “(I) implementation year 2015,
5 0.5 percent;

6 “(II) implementation year 2016,
7 1.0 percent;

8 “(III) implementation year 2017,
9 1.25 percent; and

10 “(IV) implementation year 2018
11 or any subsequent implementation
12 year, 1.5 percent; and

13 “(ii) the projected excess for the im-
14 plementation year (expressed as a percent)
15 determined under subparagraph (A).

16 “(8) PER CAPITA RATE OF GROWTH IN NA-
17 TIONAL HEALTH EXPENDITURES.—In each deter-
18 mination year (beginning in 2018), the Chief Actu-
19 ary of the Centers for Medicare & Medicaid Services
20 shall project the per capita rate of growth in na-
21 tional health expenditures for the implementation
22 year. Such rate of growth for an implementation
23 year shall be calculated as the projected 5-year aver-
24 age (ending with such year) percentage increase in
25 national health care expenditures.

1 “(d) CONGRESSIONAL CONSIDERATION.—

2 “(1) INTRODUCTION.—

3 “(A) IN GENERAL.—On the day on which
4 a proposal is submitted by the President to the
5 House of Representatives and the Senate under
6 subsection (c)(4), the legislative proposal (de-
7 scribed in subsection (c)(3)(B)(iv)) contained in
8 the proposal shall be introduced (by request) in
9 the Senate by the majority leader of the Senate
10 or by Members of the Senate designated by the
11 majority leader of the Senate and shall be in-
12 troduced (by request) in the House by the ma-
13 jority leader of the House or by Members of the
14 House designated by the majority leader of the
15 House.

16 “(B) NOT IN SESSION.—If either House is
17 not in session on the day on which such legisla-
18 tive proposal is submitted, the legislative pro-
19 posal shall be introduced in that House, as pro-
20 vided in subparagraph (A), on the first day
21 thereafter on which that House is in session.

22 “(C) ANY MEMBER.—If the legislative pro-
23 posal is not introduced in either House within
24 5 days on which that House is in session after
25 the day on which the legislative proposal is sub-

1 mitted, then any Member of that House may
2 introduce the legislative proposal.

3 “(D) REFERRAL.—The legislation intro-
4 duced under this paragraph shall be referred by
5 the Presiding Officers of the respective Houses
6 to the Committee on Finance in the Senate and
7 to the Committee on Energy and Commerce
8 and the Committee on Ways and Means in the
9 House of Representatives.

10 “(2) COMMITTEE CONSIDERATION OF PRO-
11 POSAL.—

12 “(A) REPORTING BILL.—Not later than
13 April 1 of any proposal year in which a pro-
14 posal is submitted by the President to Congress
15 under this section, the Committee on Ways and
16 Means and the Committee on Energy and Com-
17 merce of the House of Representatives and the
18 Committee on Finance of the Senate may re-
19 port the bill referred to the Committee under
20 paragraph (1)(D) with committee amendments
21 related to the Medicare program.

22 “(B) CALCULATIONS.—In determining
23 whether a committee amendment meets the re-
24 quirement of subparagraph (A), the reductions
25 in Medicare program spending during the 3-

1 month period immediately preceding the imple-
2 mentation year shall be counted to the extent
3 that such reductions are a result of the imple-
4 mentation provisions in the committee amend-
5 ment for a change in the payment rate for an
6 item or service that was effective during such
7 period pursuant to such amendment.

8 “(C) COMMITTEE JURISDICTION.—Not-
9 withstanding rule XV of the Standing Rules of
10 the Senate, a committee amendment described
11 in subparagraph (A) may include matter not
12 within the jurisdiction of the Committee on Fi-
13 nance if that matter is relevant to a proposal
14 contained in the bill submitted under subsection
15 (c)(3).

16 “(D) DISCHARGE.—If, with respect to the
17 House involved, the committee has not reported
18 the bill by the date required by subparagraph
19 (A), the committee shall be discharged from
20 further consideration of the proposal.

21 “(3) LIMITATION ON CHANGES TO THE BOARD
22 RECOMMENDATIONS.—

23 “(A) IN GENERAL.—It shall not be in
24 order in the Senate or the House of Represent-
25 atives to consider any bill, resolution, or amend-

1 ment, pursuant to this subsection or conference
2 report thereon, that fails to satisfy the require-
3 ments of subparagraphs (A)(i) and (C) of sub-
4 section (c)(2).

5 “(B) LIMITATION ON CHANGES TO THE
6 BOARD RECOMMENDATIONS IN OTHER LEGISLA-
7 TION.—It shall not be in order in the Senate or
8 the House of Representatives to consider any
9 bill, resolution, amendment, or conference re-
10 port (other than pursuant to this section) that
11 would repeal or otherwise change the rec-
12 ommendations of the Board if that change
13 would fail to satisfy the requirements of sub-
14 paragraphs (A)(i) and (C) of subsection (c)(2).

15 “(C) LIMITATION ON CHANGES TO THIS
16 SUBSECTION.—It shall not be in order in the
17 Senate or the House of Representatives to con-
18 sider any bill, resolution, amendment, or con-
19 ference report that would repeal or otherwise
20 change this subsection.

21 “(D) WAIVER.—This paragraph may be
22 waived or suspended in the Senate only by the
23 affirmative vote of three-fifths of the Members,
24 duly chosen and sworn.

1 “(E) APPEALS.—An affirmative vote of
2 three-fifths of the Members of the Senate, duly
3 chosen and sworn, shall be required in the Sen-
4 ate to sustain an appeal of the ruling of the
5 Chair on a point of order raised under this
6 paragraph.

7 “(4) EXPEDITED PROCEDURE.—

8 “(A) CONSIDERATION.—A motion to pro-
9 ceed to the consideration of the bill in the Sen-
10 ate is not debatable.

11 “(B) AMENDMENT.—

12 “(i) TIME LIMITATION.—Debate in
13 the Senate on any amendment to a bill
14 under this section shall be limited to 1
15 hour, to be equally divided between, and
16 controlled by, the mover and the manager
17 of the bill, and debate on any amendment
18 to an amendment, debatable motion, or ap-
19 peal shall be limited to 30 minutes, to be
20 equally divided between, and controlled by,
21 the mover and the manager of the bill, ex-
22 cept that in the event the manager of the
23 bill is in favor of any such amendment,
24 motion, or appeal, the time in opposition

1 thereto shall be controlled by the minority
2 leader or such leader's designee.

3 “(ii) GERMANE.—No amendment that
4 is not germane to the provisions of such
5 bill shall be received.

6 “(iii) ADDITIONAL TIME.—The lead-
7 ers, or either of them, may, from the time
8 under their control on the passage of the
9 bill, allot additional time to any Senator
10 during the consideration of any amend-
11 ment, debatable motion, or appeal.

12 “(iv) AMENDMENT NOT IN ORDER.—
13 It shall not be in order to consider an
14 amendment that would cause the bill to re-
15 sult in a net reduction in total Medicare
16 program spending in the implementation
17 year that is less than the applicable sav-
18 ings target established under subsection
19 (c)(7)(B) for such implementation year.

20 “(v) WAIVER AND APPEALS.—This
21 paragraph may be waived or suspended in
22 the Senate only by the affirmative vote of
23 three-fifths of the Members, duly chosen
24 and sworn. An affirmative vote of three-
25 fifths of the Members of the Senate, duly

1 chosen and sworn, shall be required in the
2 Senate to sustain an appeal of the ruling
3 of the Chair on a point of order raised
4 under this section.

5 “(C) CONSIDERATION BY THE OTHER
6 HOUSE.—

7 “(i) IN GENERAL.—The expedited
8 procedures provided in this subsection for
9 the consideration of a bill introduced pur-
10 suant to paragraph (1) shall not apply to
11 such a bill that is received by one House
12 from the other House if such a bill was not
13 introduced in the receiving House.

14 “(ii) BEFORE PASSAGE.—If a bill that
15 is introduced pursuant to paragraph (1) is
16 received by one House from the other
17 House, after introduction but before dis-
18 position of such a bill in the receiving
19 House, then the following shall apply:

20 “(I) The receiving House shall
21 consider the bill introduced in that
22 House through all stages of consider-
23 ation up to, but not including, pas-
24 sage.

1 “(II) The question on passage
2 shall be put on the bill of the other
3 House as amended by the language of
4 the receiving House.

5 “(iii) AFTER PASSAGE.—If a bill in-
6 troduced pursuant to paragraph (1) is re-
7 ceived by one House from the other House,
8 after such a bill is passed by the receiving
9 House, then the vote on passage of the bill
10 that originates in the receiving House shall
11 be considered to be the vote on passage of
12 the bill received from the other House as
13 amended by the language of the receiving
14 House.

15 “(iv) DISPOSITION.—Upon disposition
16 of a bill introduced pursuant to paragraph
17 (1) that is received by one House from the
18 other House, it shall no longer be in order
19 to consider the bill that originates in the
20 receiving House.

21 “(v) LIMITATION.—Clauses (ii), (iii),
22 and (iv) shall apply only to a bill received
23 by one House from the other House if the
24 bill—

1 “(I) is related only to the pro-
2 gram under this title; and

3 “(II) satisfies the requirements
4 of subparagraphs (A)(i) and (C) of
5 subsection (c)(2).

6 “(D) SENATE LIMITS ON DEBATE.—

7 “(i) IN GENERAL.—In the Senate,
8 consideration of the bill and on all debat-
9 able motions and appeals in connection
10 therewith shall not exceed a total of 30
11 hours, which shall be divided equally be-
12 tween the majority and minority leaders or
13 their designees.

14 “(ii) MOTION TO FURTHER LIMIT DE-
15 BATE.—A motion to further limit debate
16 on the bill is in order and is not debatable.

17 “(iii) MOTION OR APPEAL.—Any de-
18 batable motion or appeal is debatable for
19 not to exceed 1 hour, to be divided equally
20 between those favoring and those opposing
21 the motion or appeal.

22 “(iv) FINAL DISPOSITION.—After 30
23 hours of consideration, the Senate shall
24 proceed, without any further debate on any
25 question, to vote on the final disposition

1 thereof to the exclusion of all amendments
2 not then pending before the Senate at that
3 time and to the exclusion of all motions,
4 except a motion to table, or to reconsider
5 and one quorum call on demand to estab-
6 lish the presence of a quorum (and mo-
7 tions required to establish a quorum) im-
8 mediately before the final vote begins.

9 “(E) CONSIDERATION IN CONFERENCE.—

10 “(i) IN GENERAL.—Consideration in
11 the Senate and the House of Representa-
12 tives on the conference report or any mes-
13 sages between Houses shall be limited to
14 10 hours, equally divided and controlled by
15 the majority and minority leaders of the
16 Senate or their designees and the Speaker
17 of the House of Representatives and the
18 minority leader of the House of Represent-
19 atives or their designees.

20 “(ii) TIME LIMITATION.—Debate in
21 the Senate on any amendment under this
22 subparagraph shall be limited to 1 hour, to
23 be equally divided between, and controlled
24 by, the mover and the manager of the bill,
25 and debate on any amendment to an

1 amendment, debatable motion, or appeal
2 shall be limited to 30 minutes, to be equal-
3 ly divided between, and controlled by, the
4 mover and the manager of the bill, except
5 that in the event the manager of the bill
6 is in favor of any such amendment, mo-
7 tion, or appeal, the time in opposition
8 thereto shall be controlled by the minority
9 leader or such leader's designee.

10 “(iii) FINAL DISPOSITION.—After 10
11 hours of consideration, the Senate shall
12 proceed, without any further debate on any
13 question, to vote on the final disposition
14 thereof to the exclusion of all motions not
15 then pending before the Senate at that
16 time or necessary to resolve the differences
17 between the Houses and to the exclusion of
18 all other motions, except a motion to table,
19 or to reconsider and one quorum call on
20 demand to establish the presence of a
21 quorum (and motions required to establish
22 a quorum) immediately before the final
23 vote begins.

24 “(iv) LIMITATION.—Clauses (i)
25 through (iii) shall only apply to a con-

1 ference report, message or the amendments
2 thereto if the conference report, message,
3 or an amendment thereto—

4 “(I) is related only to the pro-
5 gram under this title; and

6 “(II) satisfies the requirements
7 of subparagraphs (A)(i) and (C) of
8 subsection (c)(2).

9 “(F) VETO.—If the President vetoes the
10 bill debate on a veto message in the Senate
11 under this subsection shall be 1 hour equally di-
12 vided between the majority and minority leaders
13 or their designees.

14 “(5) RULES OF THE SENATE AND HOUSE OF
15 REPRESENTATIVES.—This subsection and subsection
16 (f)(2) are enacted by Congress—

17 “(A) as an exercise of the rulemaking
18 power of the Senate and the House of Rep-
19 resentatives, respectively, and is deemed to be
20 part of the rules of each House, respectively,
21 but applicable only with respect to the proce-
22 dure to be followed in that House in the case
23 of bill under this section, and it supersedes
24 other rules only to the extent that it is incon-
25 sistent with such rules; and

1 “(B) with full recognition of the constitu-
2 tional right of either House to change the rules
3 (so far as they relate to the procedure of that
4 House) at any time, in the same manner, and
5 to the same extent as in the case of any other
6 rule of that House.

7 “(e) IMPLEMENTATION OF PROPOSAL.—

8 “(1) IN GENERAL.—Notwithstanding any other
9 provision of law, the Secretary shall, except as pro-
10 vided in paragraph (3), implement the recommenda-
11 tions contained in a proposal submitted by the Presi-
12 dent to Congress pursuant to this section on August
13 15 of the year in which the proposal is so submitted.

14 “(2) APPLICATION.—

15 “(A) IN GENERAL.—A recommendation de-
16 scribed in paragraph (1) shall apply as follows:

17 “(i) In the case of a recommendation
18 that is a change in the payment rate for
19 an item or service under Medicare in which
20 payment rates change on a fiscal year
21 basis (or a cost reporting period basis that
22 relates to a fiscal year), on a calendar year
23 basis (or a cost reporting period basis that
24 relates to a calendar year), or on a rate
25 year basis (or a cost reporting period basis

1 that relates to a rate year), such rec-
2 ommendation shall apply to items and
3 services furnished on the first day of the
4 first fiscal year, calendar year, or rate year
5 (as the case may be) that begins after such
6 August 15.

7 “(ii) In the case of a recommendation
8 relating to payments to plans under parts
9 C and D, such recommendation shall apply
10 to plan years beginning on the first day of
11 the first calendar year that begins after
12 such August 15.

13 “(iii) In the case of any other rec-
14 ommendation, such recommendation shall
15 be addressed in the regular regulatory
16 process timeframe and shall apply as soon
17 as practicable.

18 “(B) INTERIM FINAL RULEMAKING.—The
19 Secretary may use interim final rulemaking to
20 implement any recommendation described in
21 paragraph (1).

22 “(3) EXCEPTION.—The Secretary shall not be
23 required to implement the recommendations con-
24 tained in a proposal submitted in a proposal year by

1 the President to Congress pursuant to this section
2 if—

3 “(A) prior to August 15 of the proposal
4 year, Federal legislation is enacted that in-
5 cludes the following provision: ‘This Act
6 supercedes the recommendations of the Board
7 contained in the proposal submitted, in the year
8 which includes the date of enactment of this
9 Act, to Congress under section 1899A of the
10 Social Security Act.’; and

11 “(B) in the case of implementation year
12 2020 and subsequent implementation years, a
13 joint resolution described in subsection (f)(1) is
14 enacted not later than August 15, 2017.

15 “(4) NO AFFECT ON AUTHORITY TO IMPLE-
16 MENT CERTAIN PROVISIONS.—Nothing in paragraph
17 (3) shall be construed to affect the authority of the
18 Secretary to implement any recommendation con-
19 tained in a proposal or advisory report under this
20 section to the extent that the Secretary otherwise
21 has the authority to implement such recommenda-
22 tion administratively.

23 “(5) LIMITATION ON REVIEW.—There shall be
24 no administrative or judicial review under section
25 1869, section 1878, or otherwise of the implementa-

1 tion by the Secretary under this subsection of the
2 recommendations contained in a proposal.

3 “(f) JOINT RESOLUTION REQUIRED TO DIS-
4 CONTINUE THE BOARD.—

5 “(1) IN GENERAL.—For purposes of subsection
6 (e)(3)(B), a joint resolution described in this para-
7 graph means only a joint resolution—

8 “(A) that is introduced in 2017 by not
9 later than February 1 of such year;

10 “(B) which does not have a preamble;

11 “(C) the title of which is as follows: ‘Joint
12 resolution approving the discontinuation of the
13 process for consideration and automatic imple-
14 mentation of the annual proposal of the Inde-
15 pendent Medicare Advisory Board under section
16 1899A of the Social Security Act’; and

17 “(D) the matter after the resolving clause
18 of which is as follows: ‘That Congress approves
19 the discontinuation of the process for consider-
20 ation and automatic implementation of the an-
21 nual proposal of the Independent Medicare Ad-
22 visory Board under section 1899A of the Social
23 Security Act.’.

24 “(2) PROCEDURE.—

1 “(A) REFERRAL.—A joint resolution de-
2 scribed in paragraph (1) shall be referred to the
3 Committee on Ways and Means and the Com-
4 mittee on Energy and Commerce of the House
5 of Representatives and the Committee on Fi-
6 nance of the Senate.

7 “(B) DISCHARGE.—In the Senate, if the
8 committee to which is referred a joint resolution
9 described in paragraph (1) has not reported
10 such joint resolution (or an identical joint reso-
11 lution) at the end of 20 days after the joint res-
12 olution described in paragraph (1) is intro-
13 duced, such committee may be discharged from
14 further consideration of such joint resolution
15 upon a petition supported in writing by 30
16 Members of the Senate, and such joint resolu-
17 tion shall be placed on the calendar.

18 “(C) CONSIDERATION.—

19 “(i) IN GENERAL.—In the Senate,
20 when the committee to which a joint reso-
21 lution is referred has reported, or when a
22 committee is discharged (under subpara-
23 graph (C)) from further consideration of a
24 joint resolution described in paragraph (1),
25 it is at any time thereafter in order (even

1 though a previous motion to the same ef-
2 fect has been disagreed to) for a motion to
3 proceed to the consideration of the joint
4 resolution to be made, and all points of
5 order against the joint resolution (and
6 against consideration of the joint resolu-
7 tion) are waived, except for points of order
8 under the Congressional Budget act of
9 1974 or under budget resolutions pursuant
10 to that Act. The motion is not debatable.
11 A motion to reconsider the vote by which
12 the motion is agreed to or disagreed to
13 shall not be in order. If a motion to pro-
14 ceed to the consideration of the joint reso-
15 lution is agreed to, the joint resolution
16 shall remain the unfinished business of the
17 Senate until disposed of.

18 “(ii) DEBATE LIMITATION.—In the
19 Senate, consideration of the joint resolu-
20 tion, and on all debatable motions and ap-
21 peals in connection therewith, shall be lim-
22 ited to not more than 10 hours, which
23 shall be divided equally between the major-
24 ity leader and the minority leader, or their
25 designees. A motion further to limit debate

1 is in order and not debatable. An amend-
2 ment to, or a motion to postpone, or a mo-
3 tion to proceed to the consideration of
4 other business, or a motion to recommit
5 the joint resolution is not in order.

6 “(iii) *PASSAGE*.—In the Senate, im-
7 mediately following the conclusion of the
8 debate on a joint resolution described in
9 paragraph (1), and a single quorum call at
10 the conclusion of the debate if requested in
11 accordance with the rules of the Senate,
12 the vote on passage of the joint resolution
13 shall occur.

14 “(iv) *APPEALS*.—Appeals from the de-
15 cisions of the Chair relating to the applica-
16 tion of the rules of the Senate to the pro-
17 cedure relating to a joint resolution de-
18 scribed in paragraph (1) shall be decided
19 without debate.

20 “(D) *OTHER HOUSE ACTS FIRST*.—If, be-
21 fore the passage by 1 House of a joint resolu-
22 tion of that House described in paragraph (1),
23 that House receives from the other House a
24 joint resolution described in paragraph (1),
25 then the following procedures shall apply:

1 “(i) The joint resolution of the other
2 House shall not be referred to a com-
3 mittee.

4 “(ii) With respect to a joint resolution
5 described in paragraph (1) of the House
6 receiving the joint resolution—

7 “(I) the procedure in that House
8 shall be the same as if no joint resolu-
9 tion had been received from the other
10 House; but

11 “(II) the vote on final passage
12 shall be on the joint resolution of the
13 other House.

14 “(E) EXCLUDED DAYS.—For purposes of
15 determining the period specified in subpara-
16 graph (B), there shall be excluded any days ei-
17 ther House of Congress is adjourned for more
18 than 3 days during a session of Congress.

19 “(F) MAJORITY REQUIRED FOR ADOPT-
20 TION.—A joint resolution considered under this
21 subsection shall require an affirmative vote of
22 three-fifths of the Members, duly chosen and
23 sworn, for adoption.

1 “(3) TERMINATION.—If a joint resolution de-
 2 scribed in paragraph (1) is enacted not later than
 3 August 15, 2017—

4 “(A) the Chief Actuary of the Medicare &
 5 Medicaid Services shall not—

6 “(i) make any determinations under
 7 subsection (c)(6) after May 1, 2017; or

8 “(ii) provide any opinion pursuant to
 9 subsection (c)(3)(B)(iii) after January 16,
 10 2018;

11 “(B) the Board shall not submit any pro-
 12 posals or advisory reports to Congress under
 13 this section after January 16, 2018; and

14 “(C) the Board and the consumer advisory
 15 council under subsection (k) shall terminate on
 16 August 16, 2018.

17 “(g) BOARD MEMBERSHIP; TERMS OF OFFICE;
 18 CHAIRPERSON; REMOVAL.—

19 “(1) MEMBERSHIP.—

20 “(A) IN GENERAL.—The Board shall be
 21 composed of—

22 “(i) 15 members appointed by the
 23 President, by and with the advice and con-
 24 sent of the Senate; and

1 “(ii) the Secretary, the Administrator
2 of the Center for Medicare & Medicaid
3 Services, and the Administrator of the
4 Health Resources and Services Administra-
5 tion, all of whom shall serve ex officio as
6 nonvoting members of the Board.

7 “(B) QUALIFICATIONS.—

8 “(i) IN GENERAL.—The appointed
9 membership of the Board shall include in-
10 dividuals with national recognition for
11 their expertise in health finance and eco-
12 nomics, actuarial science, health facility
13 management, health plans and integrated
14 delivery systems, reimbursement of health
15 facilities, allopathic and osteopathic physi-
16 cians, and other providers of health serv-
17 ices, and other related fields, who provide
18 a mix of different professionals, broad geo-
19 graphic representation, and a balance be-
20 tween urban and rural representatives.

21 “(ii) INCLUSION.—The appointed
22 membership of the Board shall include
23 (but not be limited to) physicians and
24 other health professionals, experts in the
25 area of pharmaco-economics or prescrip-

1 tion drug benefit programs, employers,
2 third-party payers, individuals skilled in
3 the conduct and interpretation of bio-
4 medical, health services, and health eco-
5 nomics research and expertise in outcomes
6 and effectiveness research and technology
7 assessment. Such membership shall also
8 include representatives of consumers and
9 the elderly.

10 “(iii) MAJORITY NONPROVIDERS.—In-
11 dividuals who are directly involved in the
12 provision or management of the delivery of
13 items and services covered under this title
14 shall not constitute a majority of the ap-
15 pointed membership of the Board.

16 “(C) ETHICAL DISCLOSURE.—The Presi-
17 dent shall establish a system for public disclo-
18 sure by appointed members of the Board of fi-
19 nancial and other potential conflicts of interest
20 relating to such members. Appointed members
21 of the Board shall be treated as officers in the
22 executive branch for purposes of applying title
23 I of the Ethics in Government Act of 1978
24 (Public Law 95–521).

1 “(D) CONFLICTS OF INTEREST.—No indi-
2 vidual may serve as an appointed member if
3 that individual engages in any other business,
4 vocation, or employment.

5 “(E) CONSULTATION WITH CONGRESS.—In
6 selecting individuals for nominations for ap-
7 pointments to the Board, the President shall
8 consult with—

9 “(i) the majority leader of the Senate
10 concerning the appointment of 3 members;

11 “(ii) the Speaker of the House of
12 Representatives concerning the appoint-
13 ment of 3 members;

14 “(iii) the minority leader of the Sen-
15 ate concerning the appointment of 3 mem-
16 bers; and

17 “(iv) the minority leader of the House
18 of Representatives concerning the appoint-
19 ment of 3 members.

20 “(2) TERM OF OFFICE.—Each appointed mem-
21 ber shall hold office for a term of 6 years except
22 that—

23 “(A) a member may not serve more than
24 2 full consecutive terms (but may be re-

1 appointed to 2 full consecutive terms after
2 being appointed to fill a vacancy on the Board);

3 “(B) a member appointed to fill a vacancy
4 occurring prior to the expiration of the term for
5 which that member’s predecessor was appointed
6 shall be appointed for the remainder of such
7 term;

8 “(C) a member may continue to serve after
9 the expiration of the member’s term until a suc-
10 cessor has taken office; and

11 “(D) of the members first appointed under
12 this section, 5 shall be appointed for a term of
13 1 year, 5 shall be appointed for a term of 3
14 years, and 5 shall be appointed for a term of
15 6 years, the term of each to be designated by
16 the President at the time of nomination.

17 “(3) CHAIRPERSON.—

18 “(A) IN GENERAL.—The Chairperson shall
19 be appointed by the President, by and with the
20 advice and consent of the Senate, from among
21 the members of the Board.

22 “(B) DUTIES.—The Chairperson shall be
23 the principal executive officer of the Board, and
24 shall exercise all of the executive and adminis-

1 trative functions of the Board, including func-
2 tions of the Board with respect to—

3 “(i) the appointment and supervision
4 of personnel employed by the Board;

5 “(ii) the distribution of business
6 among personnel appointed and supervised
7 by the Chairperson and among administra-
8 tive units of the Board; and

9 “(iii) the use and expenditure of
10 funds.

11 “(C) GOVERNANCE.—In carrying out any
12 of the functions under subparagraph (B), the
13 Chairperson shall be governed by the general
14 policies established by the Board and by the de-
15 cisions, findings, and determinations the Board
16 shall by law be authorized to make.

17 “(D) REQUESTS FOR APPROPRIATIONS.—
18 Requests or estimates for regular, supple-
19 mental, or deficiency appropriations on behalf
20 of the Board may not be submitted by the
21 Chairperson without the prior approval of a ma-
22 jority vote of the Board.

23 “(4) REMOVAL.—Any appointed member may
24 be removed by the President for neglect of duty or
25 malfeasance in office, but for no other cause.

1 “(h) VACANCIES; QUORUM; SEAL; VICE CHAIR-
2 PERSON; VOTING ON REPORTS.—

3 “(1) VACANCIES.—No vacancy on the Board
4 shall impair the right of the remaining members to
5 exercise all the powers of the Board.

6 “(2) QUORUM.—A majority of the appointed
7 members of the Board shall constitute a quorum for
8 the transaction of business, but a lesser number of
9 members may hold hearings.

10 “(3) SEAL.—The Board shall have an official
11 seal, of which judicial notice shall be taken.

12 “(4) VICE CHAIRPERSON.—The Board shall an-
13 nually elect a Vice Chairperson to act in the absence
14 or disability of the Chairperson or in case of a va-
15 cancy in the office of the Chairperson.

16 “(5) VOTING ON PROPOSALS.—Any proposal of
17 the Board must be approved by the majority of ap-
18 pointed members present.

19 “(i) POWERS OF THE BOARD.—

20 “(1) HEARINGS.—The Board may hold such
21 hearings, sit and act at such times and places, take
22 such testimony, and receive such evidence as the
23 Board considers advisable to carry out this section.

24 “(2) AUTHORITY TO INFORM RESEARCH PRIOR-
25 ITIES FOR DATA COLLECTION.—The Board may ad-

1 vise the Secretary on priorities for health services re-
2 search, particularly as such priorities pertain to nec-
3 essary changes and issues regarding payment re-
4 forms under Medicare.

5 “(3) OBTAINING OFFICIAL DATA.—The Board
6 may secure directly from any department or agency
7 of the United States information necessary to enable
8 it to carry out this section. Upon request of the
9 Chairperson, the head of that department or agency
10 shall furnish that information to the Board on an
11 agreed upon schedule.

12 “(4) POSTAL SERVICES.—The Board may use
13 the United States mails in the same manner and
14 under the same conditions as other departments and
15 agencies of the Federal Government.

16 “(5) GIFTS.—The Board may accept, use, and
17 dispose of gifts or donations of services or property.

18 “(6) OFFICES.—The Board shall maintain a
19 principal office and such field offices as it deter-
20 mines necessary, and may meet and exercise any of
21 its powers at any other place.

22 “(j) PERSONNEL MATTERS.—

23 “(1) COMPENSATION OF MEMBERS AND CHAIR-
24 PERSON.—Each appointed member, other than the
25 Chairperson, shall be compensated at a rate equal to

1 the annual rate of basic pay prescribed for level III
2 of the Executive Schedule under section 5315 of title
3 5, United States Code. The Chairperson shall be
4 compensated at a rate equal to the daily equivalent
5 of the annual rate of basic pay prescribed for level
6 II of the Executive Schedule under section 5315 of
7 title 5, United States Code.

8 “(2) TRAVEL EXPENSES.—The appointed mem-
9 bers shall be allowed travel expenses, including per
10 diem in lieu of subsistence, at rates authorized for
11 employees of agencies under subchapter I of chapter
12 57 of title 5, United States Code, while away from
13 their homes or regular places of business in the per-
14 formance of services for the Board.

15 “(3) STAFF.—

16 “(A) IN GENERAL.—The Chairperson may,
17 without regard to the civil service laws and reg-
18 ulations, appoint and terminate an executive di-
19 rector and such other additional personnel as
20 may be necessary to enable the Board to per-
21 form its duties. The employment of an executive
22 director shall be subject to confirmation by the
23 Board.

24 “(B) COMPENSATION.—The Chairperson
25 may fix the compensation of the executive direc-

1 tor and other personnel without regard to chap-
2 ter 51 and subchapter III of chapter 53 of title
3 5, United States Code, relating to classification
4 of positions and General Schedule pay rates, ex-
5 cept that the rate of pay for the executive direc-
6 tor and other personnel may not exceed the rate
7 payable for level V of the Executive Schedule
8 under section 5316 of such title.

9 “(4) DETAIL OF GOVERNMENT EMPLOYEES.—

10 Any Federal Government employee may be detailed
11 to the Board without reimbursement, and such de-
12 tail shall be without interruption or loss of civil serv-
13 ice status or privilege.

14 “(5) PROCUREMENT OF TEMPORARY AND
15 INTERMITTENT SERVICES.—The Chairperson may
16 procure temporary and intermittent services under
17 section 3109(b) of title 5, United States Code, at
18 rates for individuals which do not exceed the daily
19 equivalent of the annual rate of basic pay prescribed
20 for level V of the Executive Schedule under section
21 5316 of such title.

22 “(k) CONSUMER ADVISORY COUNCIL.—

23 “(1) IN GENERAL.—There is established a con-
24 sumer advisory council to advise the Board on the

1 impact of payment policies under this title on con-
2 sumers.

3 “(2) MEMBERSHIP.—

4 “(A) NUMBER AND APPOINTMENT.—The
5 consumer advisory council shall be composed of
6 10 consumer representatives appointed by the
7 Comptroller General of the United States, 1
8 from among each of the 10 regions established
9 by the Secretary as of the date of enactment of
10 this section.

11 “(B) QUALIFICATIONS.—The membership
12 of the council shall represent the interests of
13 consumers and particular communities.

14 “(3) DUTIES.—The consumer advisory council
15 shall, subject to the call of the Board, meet not less
16 frequently than 2 times each year in the District of
17 Columbia.

18 “(4) OPEN MEETINGS.—Meetings of the con-
19 sumer advisory council shall be open to the public.

20 “(5) ELECTION OF OFFICERS.—Members of the
21 consumer advisory council shall elect their own offi-
22 cers.

23 “(6) APPLICATION OF FACa.—The Federal Ad-
24 visory Committee Act (5 U.S.C. App.) shall apply to

1 the consumer advisory council except that section 14
2 of such Act shall not apply.

3 “(l) DEFINITIONS.—In this section:

4 “(1) BOARD; CHAIRPERSON; MEMBER.—The
5 terms ‘Board’, ‘Chairperson’, and ‘Member’ mean
6 the Independent Medicare Advisory Board estab-
7 lished under subsection (a) and the Chairperson and
8 any Member thereof, respectively.

9 “(2) MEDICARE.—The term ‘Medicare’ means
10 the program established under this title, including
11 parts A, B, C, and D.

12 “(3) MEDICARE BENEFICIARY.—The term
13 ‘Medicare beneficiary’ means an individual who is
14 entitled to, or enrolled for, benefits under part A or
15 enrolled for benefits under part B.

16 “(4) MEDICARE PROGRAM SPENDING.—The
17 term ‘Medicare program spending’ means program
18 spending under parts A, B, and D net of premiums.

19 “(m) FUNDING.—

20 “(1) IN GENERAL.—There are appropriated to
21 the Board to carry out its duties and functions—

22 “(A) for fiscal year 2012, \$15,000,000;
23 and

24 “(B) for each subsequent fiscal year, the
25 amount appropriated under this paragraph for

1 the previous fiscal year increased by the annual
2 percentage increase in the Consumer Price
3 Index for All Urban Consumers (all items;
4 United States city average) as of June of the
5 previous fiscal year.

6 “(2) FROM TRUST FUNDS.—Sixty percent of
7 amounts appropriated under paragraph (1) shall be
8 derived by transfer from the Federal Hospital Insur-
9 ance Trust Fund under section 1817 and 40 percent
10 of amounts appropriated under such paragraph shall
11 be derived by transfer from the Federal Supple-
12 mentary Medical Insurance Trust Fund under sec-
13 tion 1841.”.

14 (2) LOBBYING COOLING-OFF PERIOD FOR MEM-
15 BERS OF THE INDEPENDENT MEDICARE ADVISORY
16 BOARD.—Section 207(c) of title 18, United States
17 Code, is amended by inserting at the end the fol-
18 lowing:

19 “(3) MEMBERS OF THE INDEPENDENT MEDI-
20 CARE ADVISORY BOARD.—

21 “(A) IN GENERAL.—Paragraph (1) shall
22 apply to a member of the Independent Medicare
23 Advisory Board under section 1899A.

24 “(B) AGENCIES AND CONGRESS.—For pur-
25 poses of paragraph (1), the agency in which the

1 individual described in subparagraph (A) served
2 shall be considered to be the Independent Medi-
3 care Advisory Board, the Department of Health
4 and Human Services, and the relevant commit-
5 tees of jurisdiction of Congress, including the
6 Committee on Ways and Means and the Com-
7 mittee on Energy and Commerce of the House
8 of Representatives and the Committee on Fi-
9 nance of the Senate.”.

10 (b) GAO STUDY AND REPORT ON DETERMINATION
11 AND IMPLEMENTATION OF PAYMENT AND COVERAGE
12 POLICIES UNDER THE MEDICARE PROGRAM.—

13 (1) INITIAL STUDY AND REPORT.—

14 (A) STUDY.—The Comptroller General of
15 the United States (in this section referred to as
16 the “Comptroller General”) shall conduct a
17 study on changes to payment policies, meth-
18 odologies, and rates and coverage policies and
19 methodologies under the Medicare program
20 under title XVIII of the Social Security Act as
21 a result of the recommendations contained in
22 the proposals made by the Independent Medi-
23 care Advisory Board under section 1899A of
24 such Act (as added by subsection (a)), including

1 an analysis of the effect of such recommenda-
2 tions on—

3 (i) Medicare beneficiary access to pro-
4 viders and items and services;

5 (ii) the affordability of Medicare pre-
6 miums and cost-sharing (including
7 deductibles, coinsurance, and copayments);

8 (iii) the potential impact of changes
9 on other government or private-sector pur-
10 chasers and payers of care; and

11 (iv) quality of patient care, including
12 patient experience, outcomes, and other
13 measures of care.

14 (B) REPORT.—Not later than July 1,
15 2015, the Comptroller General shall submit to
16 Congress a report containing the results of the
17 study conducted under subparagraph (A), to-
18 gether with recommendations for such legisla-
19 tion and administrative action as the Comp-
20 troller General determines appropriate.

21 (2) SUBSEQUENT STUDIES AND REPORTS.—The
22 Comptroller General shall periodically conduct such
23 additional studies and submit reports to Congress on
24 changes to Medicare payments policies, methodolo-
25 gies, and rates and coverage policies and methodolo-

1 gies as the Comptroller General determines appro-
2 priate, in consultation with the Committee on Ways
3 and Means and the Committee on Energy and Com-
4 merce of the House of Representatives and the Com-
5 mittee on Finance of the Senate.

6 (c) CONFORMING AMENDMENTS.—Section 1805(b)
7 of the Social Security Act (42 U.S.C. 1395b–6(b)) is
8 amended—

9 (1) by redesignating paragraphs (4) through
10 (8) as paragraphs (5) through (9), respectively; and

11 (2) by inserting after paragraph (3) the fol-
12 lowing:

13 “(4) REVIEW AND COMMENT ON THE INDE-
14 PENDENT MEDICARE ADVISORY BOARD OR SECRE-
15 TARIAL PROPOSAL.—If the Independent Medicare
16 Advisory Board (as established under subsection (a)
17 of section 1899A) or the Secretary submits a pro-
18 posal to the Commission under such section in a
19 year, the Commission shall review the proposal and,
20 not later than March 1 of that year, submit to the
21 Committee on Ways and Means and the Committee
22 on Energy and Commerce of the House of Rep-
23 resentatives and the Committee on Finance of the
24 Senate written comments on such proposal. Such

1 comments may include such recommendations as the
 2 Commission deems appropriate.”.

3 **Subtitle F—Health Care Quality**
 4 **Improvements**

5 **SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH;**
 6 **QUALITY IMPROVEMENT TECHNICAL ASSIST-**
 7 **ANCE.**

8 Part D of title IX of the Public Health Service Act,
 9 as amended by section 3013, is further amended by adding
 10 at the end the following:

11 **“Subpart II—Health Care Quality Improvement**
 12 **Programs**

13 **“SEC. 933. HEALTH CARE DELIVERY SYSTEM RESEARCH.**

14 “(a) PURPOSE.—The purposes of this section are
 15 to—

16 “(1) enable the Director to identify, develop,
 17 evaluate, disseminate, and provide training in inno-
 18 vative methodologies and strategies for quality im-
 19 provement practices in the delivery of health care
 20 services that represent best practices (referred to as
 21 ‘best practices’) in health care quality, safety, and
 22 value; and

23 “(2) ensure that the Director is accountable for
 24 implementing a model to pursue such research in a

1 collaborative manner with other related Federal
2 agencies.

3 “(b) GENERAL FUNCTIONS OF THE CENTER.—The
4 Center for Quality Improvement and Patient Safety of the
5 Agency for Healthcare Research and Quality (referred to
6 in this section as the ‘Center’), or any other relevant agen-
7 cy or department designated by the Director, shall—

8 “(1) carry out its functions using research from
9 a variety of disciplines, which may include epidemi-
10 ology, health services, sociology, psychology, human
11 factors engineering, biostatistics, health economics,
12 clinical research, and health informatics;

13 “(2) conduct or support activities consistent
14 with the purposes described in subsection (a), and
15 for—

16 “(A) best practices for quality improve-
17 ment practices in the delivery of health care
18 services; and

19 “(B) that include changes in processes of
20 care and the redesign of systems used by pro-
21 viders that will reliably result in intended health
22 outcomes, improve patient safety, and reduce
23 medical errors (such as skill development for
24 health care providers in team-based health care

1 delivery and rapid cycle process improvement)
2 and facilitate adoption of improved workflow;

3 “(3) identify health care providers, including
4 health care systems, single institutions, and indi-
5 vidual providers, that—

6 “(A) deliver consistently high-quality, effi-
7 cient health care services (as determined by the
8 Secretary); and

9 “(B) employ best practices that are adapt-
10 able and scalable to diverse health care settings
11 or effective in improving care across diverse set-
12 tings;

13 “(4) assess research, evidence, and knowledge
14 about what strategies and methodologies are most
15 effective in improving health care delivery;

16 “(5) find ways to translate such information
17 rapidly and effectively into practice, and document
18 the sustainability of those improvements;

19 “(6) create strategies for quality improvement
20 through the development of tools, methodologies,
21 and interventions that can successfully reduce vari-
22 ations in the delivery of health care;

23 “(7) identify, measure, and improve organiza-
24 tional, human, or other causative factors, including
25 those related to the culture and system design of a

1 health care organization, that contribute to the suc-
2 cess and sustainability of specific quality improve-
3 ment and patient safety strategies;

4 “(8) provide for the development of best prac-
5 tices in the delivery of health care services that—

6 “(A) have a high likelihood of success,
7 based on structured review of empirical evi-
8 dence;

9 “(B) are specified with sufficient detail of
10 the individual processes, steps, training, skills,
11 and knowledge required for implementation and
12 incorporation into workflow of health care prac-
13 titioners in a variety of settings;

14 “(C) are designed to be readily adapted by
15 health care providers in a variety of settings;
16 and

17 “(D) where applicable, assist health care
18 providers in working with other health care pro-
19 viders across the continuum of care and in en-
20 gaging patients and their families in improving
21 the care and patient health outcomes;

22 “(9) provide for the funding of the activities of
23 organizations with recognized expertise and excel-
24 lence in improving the delivery of health care serv-
25 ices, including children’s health care, by involving

1 multiple disciplines, managers of health care entities,
2 broad development and training, patients, caregivers
3 and families, and frontline health care workers, in-
4 cluding activities for the examination of strategies to
5 share best quality improvement practices and to pro-
6 mote excellence in the delivery of health care serv-
7 ices; and

8 “(10) build capacity at the State and commu-
9 nity level to lead quality and safety efforts through
10 education, training, and mentoring programs to
11 carry out the activities under paragraphs (1)
12 through (9).

13 “(c) RESEARCH FUNCTIONS OF CENTER.—

14 “(1) IN GENERAL.—The Center shall support,
15 such as through a contract or other mechanism, re-
16 search on health care delivery system improvement
17 and the development of tools to facilitate adoption of
18 best practices that improve the quality, safety, and
19 efficiency of health care delivery services. Such sup-
20 port may include establishing a Quality Improve-
21 ment Network Research Program for the purpose of
22 testing, scaling, and disseminating of interventions
23 to improve quality and efficiency in health care. Re-
24 cipients of funding under the Program may include

1 national, State, multi-State, or multi-site quality im-
2 provement networks.

3 “(2) RESEARCH REQUIREMENTS.—The re-
4 search conducted pursuant to paragraph (1) shall—

5 “(A) address the priorities identified by
6 the Secretary in the national strategic plan es-
7 tablished under section 399HH;

8 “(B) identify areas in which evidence is in-
9 sufficient to identify strategies and methodolo-
10 gies, taking into consideration areas of insuffi-
11 cient evidence identified by the entity with a
12 contract under section 1890(a) of the Social Se-
13 curity Act in the report required under section
14 399JJ;

15 “(C) address concerns identified by health
16 care institutions and providers and commu-
17 nicated through the Center pursuant to sub-
18 section (d);

19 “(D) reduce preventable morbidity, mor-
20 tality, and associated costs of morbidity and
21 mortality by building capacity for patient safety
22 research;

23 “(E) support the discovery of processes for
24 the reliable, safe, efficient, and responsive deliv-
25 ery of health care, taking into account discov-

1 eries from clinical research and comparative ef-
2 fectiveness research;

3 “(F) allow communication of research find-
4 ings and translate evidence into practice rec-
5 ommendations that are adaptable to a variety
6 of settings, and which, as soon as practicable
7 after the establishment of the Center, shall in-
8 clude—

9 “(i) the implementation of a national
10 application of Intensive Care Unit improve-
11 ment projects relating to the adult (includ-
12 ing geriatric), pediatric, and neonatal pa-
13 tient populations;

14 “(ii) practical methods for addressing
15 health care associated infections, including
16 Methicillin-Resistant Staphylococcus
17 Aureus and Vancomycin-Resistant
18 Enterococcus infections and other emerging
19 infections; and

20 “(iii) practical methods for reducing
21 preventable hospital admissions and re-
22 admissions;

23 “(G) expand demonstration projects for
24 improving the quality of children’s health care
25 and the use of health information technology,

1 such as through Pediatric Quality Improvement
2 Collaboratives and Learning Networks, con-
3 sistent with provisions of section 1139A of the
4 Social Security Act for assessing and improving
5 quality, where applicable;

6 “(H) identify and mitigate hazards by—

7 “(i) analyzing events reported to pa-
8 tient safety reporting systems and patient
9 safety organizations; and

10 “(ii) using the results of such analyses
11 to develop scientific methods of response to
12 such events;

13 “(I) include the conduct of systematic re-
14 views of existing practices that improve the
15 quality, safety, and efficiency of health care de-
16 livery, as well as new research on improving
17 such practices; and

18 “(J) include the examination of how to
19 measure and evaluate the progress of quality
20 and patient safety activities.

21 “(d) DISSEMINATION OF RESEARCH FINDINGS.—

22 “(1) PUBLIC AVAILABILITY.—The Director
23 shall make the research findings of the Center avail-
24 able to the public through multiple media and appro-
25 priate formats to reflect the varying needs of health

1 care providers and consumers and diverse levels of
2 health literacy.

3 “(2) LINKAGE TO HEALTH INFORMATION TECH-
4 NOLOGY.—The Secretary shall ensure that research
5 findings and results generated by the Center are
6 shared with the Office of the National Coordinator
7 of Health Information Technology and used to in-
8 form the activities of the health information tech-
9 nology extension program under section 3012, as
10 well as any relevant standards, certification criteria,
11 or implementation specifications.

12 “(e) PRIORITIZATION.—The Director shall identify
13 and regularly update a list of processes or systems on
14 which to focus research and dissemination activities of the
15 Center, taking into account—

16 “(1) the cost to Federal health programs;

17 “(2) consumer assessment of health care experi-
18 ence;

19 “(3) provider assessment of such processes or
20 systems and opportunities to minimize distress and
21 injury to the health care workforce;

22 “(4) the potential impact of such processes or
23 systems on health status and function of patients,
24 including vulnerable populations including children;

1 viders of services and suppliers for which there are
2 disparities in care among subgroups of patients) so
3 that such institutions and providers understand,
4 adapt, and implement the models and practices iden-
5 tified in the research conducted by the Center, in-
6 cluding the Quality Improvement Networks Research
7 Program; and

8 “(2) implementation grants or contracts to eli-
9 gible entities to implement the models and practices
10 described under paragraph (1).

11 “(b) ELIGIBLE ENTITIES.—

12 “(1) TECHNICAL ASSISTANCE AWARD.—To be
13 eligible to receive a technical assistance grant or
14 contract under subsection (a)(1), an entity—

15 “(A) may be a health care provider, health
16 care provider association, professional society,
17 health care worker organization, Indian health
18 organization, quality improvement organization,
19 patient safety organization, local quality im-
20 provement collaborative, the Joint Commission,
21 academic health center, university, physician-
22 based research network, primary care extension
23 program established under section 399W, a
24 Federal Indian Health Service program or a
25 health program operated by an Indian tribe (as

1 defined in section 4 of the Indian Health Care
2 Improvement Act), or any other entity identi-
3 fied by the Secretary; and

4 “(B) shall have demonstrated expertise in
5 providing information and technical support
6 and assistance to health care providers regard-
7 ing quality improvement.

8 “(2) IMPLEMENTATION AWARD.—To be eligible
9 to receive an implementation grant or contract
10 under subsection (a)(2), an entity—

11 “(A) may be a hospital or other health
12 care provider or consortium or providers, as de-
13 termined by the Secretary; and

14 “(B) shall have demonstrated expertise in
15 providing information and technical support
16 and assistance to health care providers regard-
17 ing quality improvement.

18 “(c) APPLICATION.—

19 “(1) TECHNICAL ASSISTANCE AWARD.—To re-
20 ceive a technical assistance grant or contract under
21 subsection (a)(1), an eligible entity shall submit an
22 application to the Secretary at such time, in such
23 manner, and containing—

24 “(A) a plan for a sustainable business
25 model that may include a system of—

1 “(i) charging fees to institutions and
2 providers that receive technical support
3 from the entity; and

4 “(ii) reducing or eliminating such fees
5 for such institutions and providers that
6 serve low-income populations; and

7 “(B) such other information as the Direc-
8 tor may require.

9 “(2) IMPLEMENTATION AWARD.—To receive a
10 grant or contract under subsection (a)(2), an eligible
11 entity shall submit an application to the Secretary at
12 such time, in such manner, and containing—

13 “(A) a plan for implementation of a model
14 or practice identified in the research conducted
15 by the Center including—

16 “(i) financial cost, staffing require-
17 ments, and timeline for implementation;
18 and

19 “(ii) pre- and projected post-imple-
20 mentation quality measure performance
21 data in targeted improvement areas identi-
22 fied by the Secretary; and

23 “(B) such other information as the Direc-
24 tor may require.

1 “(d) MATCHING FUNDS.—The Director may not
2 award a grant or contract under this section to an entity
3 unless the entity agrees that it will make available (di-
4 rectly or through contributions from other public or pri-
5 vate entities) non-Federal contributions toward the activi-
6 ties to be carried out under the grant or contract in an
7 amount equal to \$1 for each \$5 of Federal funds provided
8 under the grant or contract. Such non-Federal matching
9 funds may be provided directly or through donations from
10 public or private entities and may be in cash or in-kind,
11 fairly evaluated, including plant, equipment, or services.

12 “(e) EVALUATION.—

13 “(1) IN GENERAL.—The Director shall evaluate
14 the performance of each entity that receives a grant
15 or contract under this section. The evaluation of an
16 entity shall include a study of—

17 “(A) the success of such entity in achiev-
18 ing the implementation, by the health care in-
19 stitutions and providers assisted by such entity,
20 of the models and practices identified in the re-
21 search conducted by the Center under section
22 933;

23 “(B) the perception of the health care in-
24 stitutions and providers assisted by such entity
25 regarding the value of the entity; and

1 “(C) where practicable, better patient
2 health outcomes and lower cost resulting from
3 the assistance provided by such entity.

4 “(2) EFFECT OF EVALUATION.—Based on the
5 outcome of the evaluation of the entity under para-
6 graph (1), the Director shall determine whether to
7 renew a grant or contract with such entity under
8 this section.

9 “(f) COORDINATION.—The entities that receive a
10 grant or contract under this section shall coordinate with
11 health information technology regional extension centers
12 under section 3012(c) and the primary care extension pro-
13 gram established under section 399W regarding the dis-
14 semination of quality improvement, system delivery re-
15 form, and best practices information.”.

16 **SEC. 3502. ESTABLISHING COMMUNITY HEALTH TEAMS TO**
17 **SUPPORT THE PATIENT-CENTERED MEDICAL**
18 **HOME.**

19 (a) IN GENERAL.—The Secretary of Health and
20 Human Services (referred to in this section as the “Sec-
21 retary”) shall establish a program to provide grants to or
22 enter into contracts with eligible entities to establish com-
23 munity-based interdisciplinary, interprofessional teams
24 (referred to in this section as “health teams”) to support
25 primary care practices, including obstetrics and gyne-

1 cology practices, within the hospital service areas served
2 by the eligible entities. Grants or contracts shall be used
3 to—

4 (1) establish health teams to provide support
5 services to primary care providers; and

6 (2) provide capitated payments to primary care
7 providers as determined by the Secretary.

8 (b) ELIGIBLE ENTITIES.—To be eligible to receive a
9 grant or contract under subsection (a), an entity shall—

10 (1)(A) be a State or State-designated entity; or

11 (B) be an Indian tribe or tribal organization, as
12 defined in section 4 of the Indian Health Care Im-
13 provement Act;

14 (2) submit a plan for achieving long-term finan-
15 cial sustainability within 3 years;

16 (3) submit a plan for incorporating prevention
17 initiatives and patient education and care manage-
18 ment resources into the delivery of health care that
19 is integrated with community-based prevention and
20 treatment resources, where available;

21 (4) ensure that the health team established by
22 the entity includes an interdisciplinary, interprofes-
23 sional team of health care providers, as determined
24 by the Secretary; such team may include medical
25 specialists, nurses, pharmacists, nutritionists, dieti-

1 cians, social workers, behavioral and mental health
2 providers (including substance use disorder preven-
3 tion and treatment providers), doctors of chiro-
4 practice, licensed complementary and alternative med-
5 icine practitioners, and physicians' assistants;

6 (5) agree to provide services to eligible individ-
7 uals with chronic conditions, as described in section
8 1945 of the Social Security Act (as added by section
9 2703), in accordance with the payment methodology
10 established under subsection (c) of such section; and

11 (6) submit to the Secretary an application at
12 such time, in such manner, and containing such in-
13 formation as the Secretary may require.

14 (c) REQUIREMENTS FOR HEALTH TEAMS.—A health
15 team established pursuant to a grant or contract under
16 subsection (a) shall—

17 (1) establish contractual agreements with pri-
18 mary care providers to provide support services;

19 (2) support patient-centered medical homes, de-
20 fined as a mode of care that includes—

21 (A) personal physicians;

22 (B) whole person orientation;

23 (C) coordinated and integrated care;

24 (D) safe and high-quality care through evi-
25 dence-informed medicine, appropriate use of

1 health information technology, and continuous
2 quality improvements;

3 (E) expanded access to care; and

4 (F) payment that recognizes added value
5 from additional components of patient-centered
6 care;

7 (3) collaborate with local primary care providers
8 and existing State and community based resources
9 to coordinate disease prevention, chronic disease
10 management, transitioning between health care pro-
11 viders and settings and case management for pa-
12 tients, including children, with priority given to
13 those amenable to prevention and with chronic dis-
14 eases or conditions identified by the Secretary;

15 (4) in collaboration with local health care pro-
16 viders, develop and implement interdisciplinary,
17 interprofessional care plans that integrate clinical
18 and community preventive and health promotion
19 services for patients, including children, with a pri-
20 ority given to those amenable to prevention and with
21 chronic diseases or conditions identified by the Sec-
22 retary;

23 (5) incorporate health care providers, patients,
24 caregivers, and authorized representatives in pro-
25 gram design and oversight;

1 (6) provide support necessary for local primary
2 care providers to—

3 (A) coordinate and provide access to high-
4 quality health care services;

5 (B) coordinate and provide access to pre-
6 ventive and health promotion services;

7 (C) provide access to appropriate specialty
8 care and inpatient services;

9 (D) provide quality-driven, cost-effective,
10 culturally appropriate, and patient- and family-
11 centered health care;

12 (E) provide access to pharmacist-delivered
13 medication management services, including
14 medication reconciliation;

15 (F) provide coordination of the appropriate
16 use of complementary and alternative (CAM)
17 services to those who request such services;

18 (G) promote effective strategies for treat-
19 ment planning, monitoring health outcomes and
20 resource use, sharing information, treatment
21 decision support, and organizing care to avoid
22 duplication of service and other medical man-
23 agement approaches intended to improve qual-
24 ity and value of health care services;

1 (H) provide local access to the continuum
2 of health care services in the most appropriate
3 setting, including access to individuals that im-
4 plement the care plans of patients and coordi-
5 nate care, such as integrative health care prac-
6 titioners;

7 (I) collect and report data that permits
8 evaluation of the success of the collaborative ef-
9 fort on patient outcomes, including collection of
10 data on patient experience of care, and identi-
11 fication of areas for improvement; and

12 (J) establish a coordinated system of early
13 identification and referral for children at risk
14 for developmental or behavioral problems such
15 as through the use of infolines, health informa-
16 tion technology, or other means as determined
17 by the Secretary;

18 (7) provide 24-hour care management and sup-
19 port during transitions in care settings including—

20 (A) a transitional care program that pro-
21 vides onsite visits from the care coordinator, as-
22 sists with the development of discharge plans
23 and medication reconciliation upon admission to
24 and discharge from the hospitals, nursing home,
25 or other institution setting;

1 (B) discharge planning and counseling
2 support to providers, patients, caregivers, and
3 authorized representatives;

4 (C) assuring that post-discharge care plans
5 include medication management, as appro-
6 priate;

7 (D) referrals for mental and behavioral
8 health services, which may include the use of
9 infolines; and

10 (E) transitional health care needs from
11 adolescence to adulthood;

12 (8) serve as a liaison to community prevention
13 and treatment programs;

14 (9) demonstrate a capacity to implement and
15 maintain health information technology that meets
16 the requirements of certified EHR technology (as
17 defined in section 3000 of the Public Health Service
18 Act (42 U.S.C. 300jj)) to facilitate coordination
19 among members of the applicable care team and af-
20 filiated primary care practices; and

21 (10) where applicable, report to the Secretary
22 information on quality measures used under section
23 399JJ of the Public Health Service Act.

1 (d) REQUIREMENT FOR PRIMARY CARE PRO-
2 VIDERS.—A provider who contracts with a care team
3 shall—

4 (1) provide a care plan to the care team for
5 each patient participant;

6 (2) provide access to participant health records;
7 and

8 (3) meet regularly with the care team to ensure
9 integration of care.

10 (e) REPORTING TO SECRETARY.—An entity that re-
11 ceives a grant or contract under subsection (a) shall sub-
12 mit to the Secretary a report that describes and evaluates,
13 as requested by the Secretary, the activities carried out
14 by the entity under subsection (c).

15 (f) DEFINITION OF PRIMARY CARE.—In this section,
16 the term “primary care” means the provision of inte-
17 grated, accessible health care services by clinicians who
18 are accountable for addressing a large majority of personal
19 health care needs, developing a sustained partnership with
20 patients, and practicing in the context of family and com-
21 munity.

1 **SEC. 3503. MEDICATION MANAGEMENT SERVICES IN**
2 **TREATMENT OF CHRONIC DISEASE.**

3 Title IX of the Public Health Service Act (42 U.S.C.
4 299 et seq.), as amended by section 3501, is further
5 amended by inserting after section 934 the following:

6 **“SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDI-**
7 **CATION MANAGEMENT SERVICES IN TREAT-**
8 **MENT OF CHRONIC DISEASES.**

9 “(a) IN GENERAL.—The Secretary, acting through
10 the Patient Safety Research Center established in section
11 933 (referred to in this section as the ‘Center’), shall es-
12 tablish a program to provide grants or contracts to eligible
13 entities to implement medication management (referred to
14 in this section as ‘MTM’) services provided by licensed
15 pharmacists, as a collaborative, multidisciplinary, inter-
16 professional approach to the treatment of chronic diseases
17 for targeted individuals, to improve the quality of care and
18 reduce overall cost in the treatment of such diseases. The
19 Secretary shall commence the program under this section
20 not later than May 1, 2010.

21 “(b) ELIGIBLE ENTITIES.—To be eligible to receive
22 a grant or contract under subsection (a), an entity shall—

23 “(1) provide a setting appropriate for MTM
24 services, as recommended by the experts described in
25 subsection (e);

1 “(2) submit to the Secretary a plan for achiev-
2 ing long-term financial sustainability;

3 “(3) where applicable, submit a plan for coordi-
4 nating MTM services through local community
5 health teams established in section 3502 of the Pa-
6 tient Protection and Affordable Care Act or in col-
7 laboration with primary care extension programs es-
8 tablished in section 399W;

9 “(4) submit a plan for meeting the require-
10 ments under subsection (c); and

11 “(5) submit to the Secretary such other infor-
12 mation as the Secretary may require.

13 “(c) MTM SERVICES TO TARGETED INDIVIDUALS.—
14 The MTM services provided with the assistance of a grant
15 or contract awarded under subsection (a) shall, as allowed
16 by State law including applicable collaborative pharmacy
17 practice agreements, include—

18 “(1) performing or obtaining necessary assess-
19 ments of the health and functional status of each
20 patient receiving such MTM services;

21 “(2) formulating a medication treatment plan
22 according to therapeutic goals agreed upon by the
23 prescriber and the patient or caregiver or authorized
24 representative of the patient;

1 “(3) selecting, initiating, modifying, recom-
2 mending changes to, or administering medication
3 therapy;

4 “(4) monitoring, which may include access to,
5 ordering, or performing laboratory assessments, and
6 evaluating the response of the patient to therapy, in-
7 cluding safety and effectiveness;

8 “(5) performing an initial comprehensive medi-
9 cation review to identify, resolve, and prevent medi-
10 cation-related problems, including adverse drug
11 events, quarterly targeted medication reviews for on-
12 going monitoring, and additional followup interven-
13 tions on a schedule developed collaboratively with
14 the prescriber;

15 “(6) documenting the care delivered and com-
16 municating essential information about such care,
17 including a summary of the medication review, and
18 the recommendations of the pharmacist to other ap-
19 propriate health care providers of the patient in a
20 timely fashion;

21 “(7) providing education and training designed
22 to enhance the understanding and appropriate use of
23 the medications by the patient, caregiver, and other
24 authorized representative;

1 “(8) providing information, support services,
2 and resources and strategies designed to enhance
3 patient adherence with therapeutic regimens;

4 “(9) coordinating and integrating MTM serv-
5 ices within the broader health care management
6 services provided to the patient; and

7 “(10) such other patient care services allowed
8 under pharmacist scopes of practice in use in other
9 Federal programs that have implemented MTM
10 services.

11 “(d) TARGETED INDIVIDUALS.—MTM services pro-
12 vided by licensed pharmacists under a grant or contract
13 awarded under subsection (a) shall be offered to targeted
14 individuals who—

15 “(1) take 4 or more prescribed medications (in-
16 cluding over-the-counter medications and dietary
17 supplements);

18 “(2) take any ‘high risk’ medications;

19 “(3) have 2 or more chronic diseases, as identi-
20 fied by the Secretary; or

21 “(4) have undergone a transition of care, or
22 other factors, as determined by the Secretary, that
23 are likely to create a high risk of medication-related
24 problems.

1 “(e) CONSULTATION WITH EXPERTS.—In designing
2 and implementing MTM services provided under grants or
3 contracts awarded under subsection (a), the Secretary
4 shall consult with Federal, State, private, public-private,
5 and academic entities, pharmacy and pharmacist organi-
6 zations, health care organizations, consumer advocates,
7 chronic disease groups, and other stakeholders involved
8 with the research, dissemination, and implementation of
9 pharmacist-delivered MTM services, as the Secretary de-
10 termines appropriate. The Secretary, in collaboration with
11 this group, shall determine whether it is possible to incor-
12 porate rapid cycle process improvement concepts in use
13 in other Federal programs that have implemented MTM
14 services.

15 “(f) REPORTING TO THE SECRETARY.—An entity
16 that receives a grant or contract under subsection (a) shall
17 submit to the Secretary a report that describes and evalu-
18 ates, as requested by the Secretary, the activities carried
19 out under subsection (e), including quality measures en-
20 dorsed by the entity with a contract under section 1890
21 of the Social Security Act, as determined by the Secretary.

22 “(g) EVALUATION AND REPORT.—The Secretary
23 shall submit to the relevant committees of Congress a re-
24 port which shall—

1 “(1) assess the clinical effectiveness of phar-
2 macist-provided services under the MTM services
3 program, as compared to usual care, including an
4 evaluation of whether enrollees maintained better
5 health with fewer hospitalizations and emergency
6 room visits than similar patients not enrolled in the
7 program;

8 “(2) assess changes in overall health care re-
9 source use by targeted individuals;

10 “(3) assess patient and prescriber satisfaction
11 with MTM services;

12 “(4) assess the impact of patient-cost sharing
13 requirements on medication adherence and rec-
14 ommendations for modifications;

15 “(5) identify and evaluate other factors that
16 may impact clinical and economic outcomes, includ-
17 ing demographic characteristics, clinical characteris-
18 tics, and health services use of the patient, as well
19 as characteristics of the regimen, pharmacy benefit,
20 and MTM services provided; and

21 “(6) evaluate the extent to which participating
22 pharmacists who maintain a dispensing role have a
23 conflict of interest in the provision of MTM services,
24 and if such conflict is found, provide recommenda-

1 tions on how such a conflict might be appropriately
2 addressed.

3 “(h) GRANTS OR CONTRACTS TO FUND DEVELOP-
4 MENT OF PERFORMANCE MEASURES.—The Secretary
5 may, through the quality measure development program
6 under section 931 of the Public Health Service Act, award
7 grants or contracts to eligible entities for the purpose of
8 funding the development of performance measures that as-
9 sess the use and effectiveness of medication therapy man-
10 agement services.”.

11 **SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONAL-**
12 **IZED SYSTEMS FOR EMERGENCY CARE.**

13 (a) IN GENERAL.—Title XII of the Public Health
14 Service Act (42 U.S.C. 300d et seq.) is amended—

15 (1) in section 1203—

16 (A) in the section heading, by inserting
17 “**FOR TRAUMA SYSTEMS**” after “**GRANTS**”;
18 and

19 (B) in subsection (a), by striking “Admin-
20 istrator of the Health Resources and Services
21 Administration” and inserting “Assistant Sec-
22 retary for Preparedness and Response”;

23 (2) by inserting after section 1203 the fol-
24 lowing:

1 **“SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYS-**
2 **TEMS FOR EMERGENCY CARE RESPONSE.**

3 “(a) IN GENERAL.—The Secretary, acting through
4 the Assistant Secretary for Preparedness and Response,
5 shall award not fewer than 4 multiyear contracts or com-
6 petitive grants to eligible entities to support pilot projects
7 that design, implement, and evaluate innovative models of
8 regionalized, comprehensive, and accountable emergency
9 care and trauma systems.

10 “(b) ELIGIBLE ENTITY; REGION.—In this section:

11 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
12 tity’ means—

13 “(A) a State or a partnership of 1 or more
14 States and 1 or more local governments; or

15 “(B) an Indian tribe (as defined in section
16 4 of the Indian Health Care Improvement Act)
17 or a partnership of 1 or more Indian tribes.

18 “(2) REGION.—The term ‘region’ means an
19 area within a State, an area that lies within multiple
20 States, or a similar area (such as a multicounty
21 area), as determined by the Secretary.

22 “(3) EMERGENCY SERVICES.—The term ‘emer-
23 gency services’ includes acute, prehospital, and trau-
24 ma care.

25 “(c) PILOT PROJECTS.—The Secretary shall award
26 a contract or grant under subsection (a) to an eligible enti-

1 ty that proposes a pilot project to design, implement, and
2 evaluate an emergency medical and trauma system that—

3 “(1) coordinates with public health and safety
4 services, emergency medical services, medical facili-
5 ties, trauma centers, and other entities in a region
6 to develop an approach to emergency medical and
7 trauma system access throughout the region, includ-
8 ing 9–1–1 Public Safety Answering Points and
9 emergency medical dispatch;

10 “(2) includes a mechanism, such as a regional
11 medical direction or transport communications sys-
12 tem, that operates throughout the region to ensure
13 that the patient is taken to the medically appro-
14 priate facility (whether an initial facility or a higher-
15 level facility) in a timely fashion;

16 “(3) allows for the tracking of prehospital and
17 hospital resources, including inpatient bed capacity,
18 emergency department capacity, trauma center ca-
19 pacity, on-call specialist coverage, ambulance diver-
20 sion status, and the coordination of such tracking
21 with regional communications and hospital destina-
22 tion decisions; and

23 “(4) includes a consistent region-wide
24 prehospital, hospital, and interfacility data manage-
25 ment system that—

1 “(A) submits data to the National EMS
2 Information System, the National Trauma Data
3 Bank, and others;

4 “(B) reports data to appropriate Federal
5 and State databanks and registries; and

6 “(C) contains information sufficient to
7 evaluate key elements of prehospital care, hos-
8 pital destination decisions, including initial hos-
9 pital and interfacility decisions, and relevant
10 health outcomes of hospital care.

11 “(d) APPLICATION.—

12 “(1) IN GENERAL.—An eligible entity that
13 seeks a contract or grant described in subsection (a)
14 shall submit to the Secretary an application at such
15 time and in such manner as the Secretary may re-
16 quire.

17 “(2) APPLICATION INFORMATION.—Each appli-
18 cation shall include—

19 “(A) an assurance from the eligible entity
20 that the proposed system—

21 “(i) has been coordinated with the ap-
22 plicable State Office of Emergency Medical
23 Services (or equivalent State office);

24 “(ii) includes consistent indirect and
25 direct medical oversight of prehospital,

1 hospital, and interfacility transport
2 throughout the region;

3 “(iii) coordinates prehospital treat-
4 ment and triage, hospital destination, and
5 interfacility transport throughout the re-
6 gion;

7 “(iv) includes a categorization or des-
8 ignation system for special medical facili-
9 ties throughout the region that is inte-
10 grated with transport and destination pro-
11 tocols;

12 “(v) includes a regional medical direc-
13 tion, patient tracking, and resource alloca-
14 tion system that supports day-to-day emer-
15 gency care and surge capacity and is inte-
16 grated with other components of the na-
17 tional and State emergency preparedness
18 system; and

19 “(vi) addresses pediatric concerns re-
20 lated to integration, planning, prepared-
21 ness, and coordination of emergency med-
22 ical services for infants, children and ado-
23 lescents; and

24 “(B) such other information as the Sec-
25 retary may require.

1 “(e) REQUIREMENT OF MATCHING FUNDS.—

2 “(1) IN GENERAL.—The Secretary may not
3 make a grant under this section unless the State (or
4 consortia of States) involved agrees, with respect to
5 the costs to be incurred by the State (or consortia)
6 in carrying out the purpose for which such grant
7 was made, to make available non-Federal contribu-
8 tions (in cash or in kind under paragraph (2)) to-
9 ward such costs in an amount equal to not less than
10 \$1 for each \$3 of Federal funds provided in the
11 grant. Such contributions may be made directly or
12 through donations from public or private entities.

13 “(2) NON-FEDERAL CONTRIBUTIONS.—Non-
14 Federal contributions required in paragraph (1) may
15 be in cash or in kind, fairly evaluated, including
16 equipment or services (and excluding indirect or
17 overhead costs). Amounts provided by the Federal
18 Government, or services assisted or subsidized to
19 any significant extent by the Federal Government,
20 may not be included in determining the amount of
21 such non-Federal contributions.

22 “(f) PRIORITY.—The Secretary shall give priority for
23 the award of the contracts or grants described in sub-
24 section (a) to any eligible entity that serves a population

1 in a medically underserved area (as defined in section
2 330(b)(3)).

3 “(g) REPORT.—Not later than 90 days after the com-
4 pletion of a pilot project under subsection (a), the recipi-
5 ent of such contract or grant described in shall submit
6 to the Secretary a report containing the results of an eval-
7 uation of the program, including an identification of—

8 “(1) the impact of the regional, accountable
9 emergency care and trauma system on patient health
10 outcomes for various critical care categories, such as
11 trauma, stroke, cardiac emergencies, neurological
12 emergencies, and pediatric emergencies;

13 “(2) the system characteristics that contribute
14 to the effectiveness and efficiency of the program (or
15 lack thereof);

16 “(3) methods of assuring the long-term finan-
17 cial sustainability of the emergency care and trauma
18 system;

19 “(4) the State and local legislation necessary to
20 implement and to maintain the system;

21 “(5) the barriers to developing regionalized, ac-
22 countable emergency care and trauma systems, as
23 well as the methods to overcome such barriers; and

24 “(6) recommendations on the utilization of
25 available funding for future regionalization efforts.

1 “(h) DISSEMINATION OF FINDINGS.—The Secretary
2 shall, as appropriate, disseminate to the public and to the
3 appropriate Committees of the Congress, the information
4 contained in a report made under subsection (g).”; and

5 (3) in section 1232—

6 (A) in subsection (a), by striking “appro-
7 priated” and all that follows through the period
8 at the end and inserting “appropriated
9 \$24,000,000 for each of fiscal years 2010
10 through 2014.”; and

11 (B) by inserting after subsection (c) the
12 following:

13 “(d) AUTHORITY.—For the purpose of carrying out
14 parts A through C, beginning on the date of enactment
15 of the Patient Protection and Affordable Care Act, the
16 Secretary shall transfer authority in administering grants
17 and related authorities under such parts from the Admin-
18 istrator of the Health Resources and Services Administra-
19 tion to the Assistant Secretary for Preparedness and Re-
20 sponse.”.

21 (b) SUPPORT FOR EMERGENCY MEDICINE RE-
22 SEARCH.—Part H of title IV of the Public Health Service
23 Act (42 U.S.C. 289 et seq.) is amended by inserting after
24 the section 498C the following:

1 **“SEC. 498D. SUPPORT FOR EMERGENCY MEDICINE RE-**
2 **SEARCH.**

3 “(a) EMERGENCY MEDICAL RESEARCH.—The Sec-
4 retary shall support Federal programs administered by the
5 National Institutes of Health, the Agency for Healthcare
6 Research and Quality, the Health Resources and Services
7 Administration, the Centers for Disease Control and Pre-
8 vention, and other agencies involved in improving the
9 emergency care system to expand and accelerate research
10 in emergency medical care systems and emergency medi-
11 cine, including—

12 “(1) the basic science of emergency medicine;

13 “(2) the model of service delivery and the com-
14 ponents of such models that contribute to enhanced
15 patient health outcomes;

16 “(3) the translation of basic scientific research
17 into improved practice; and

18 “(4) the development of timely and efficient de-
19 livery of health services.

20 “(b) PEDIATRIC EMERGENCY MEDICAL RE-
21 SEARCH.—The Secretary shall support Federal programs
22 administered by the National Institutes of Health, the
23 Agency for Healthcare Research and Quality, the Health
24 Resources and Services Administration, the Centers for
25 Disease Control and Prevention, and other agencies to co-
26 ordinate and expand research in pediatric emergency med-

1 ical care systems and pediatric emergency medicine, in-
2 cluding—

3 “(1) an examination of the gaps and opportuni-
4 ties in pediatric emergency care research and a
5 strategy for the optimal organization and funding of
6 such research;

7 “(2) the role of pediatric emergency services as
8 an integrated component of the overall health sys-
9 tem;

10 “(3) system-wide pediatric emergency care plan-
11 ning, preparedness, coordination, and funding;

12 “(4) pediatric training in professional edu-
13 cation; and

14 “(5) research in pediatric emergency care, spe-
15 cifically on the efficacy, safety, and health outcomes
16 of medications used for infants, children, and adoles-
17 cents in emergency care settings in order to improve
18 patient safety.

19 “(c) IMPACT RESEARCH.—The Secretary shall sup-
20 port research to determine the estimated economic impact
21 of, and savings that result from, the implementation of
22 coordinated emergency care systems.

23 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
24 are authorized to be appropriated to carry out this section

1 such sums as may be necessary for each of fiscal years
2 2010 through 2014.”.

3 **SEC. 3505. TRAUMA CARE CENTERS AND SERVICE AVAIL-**
4 **ABILITY.**

5 (a) TRAUMA CARE CENTERS.—

6 (1) GRANTS FOR TRAUMA CARE CENTERS.—

7 Section 1241 of the Public Health Service Act (42
8 U.S.C. 300d–41) is amended by striking subsections
9 (a) and (b) and inserting the following:

10 “(a) IN GENERAL.—The Secretary shall establish 3
11 programs to award grants to qualified public, nonprofit
12 Indian Health Service, Indian tribal, and urban Indian
13 trauma centers—

14 “(1) to assist in defraying substantial uncom-
15 pensated care costs;

16 “(2) to further the core missions of such trau-
17 ma centers, including by addressing costs associated
18 with patient stabilization and transfer, trauma edu-
19 cation and outreach, coordination with local and re-
20 gional trauma systems, essential personnel and other
21 fixed costs, and expenses associated with employee
22 and non-employee physician services; and

23 “(3) to provide emergency relief to ensure the
24 continued and future availability of trauma services.

1 “(b) MINIMUM QUALIFICATIONS OF TRAUMA CEN-
2 TERS.—

3 “(1) PARTICIPATION IN TRAUMA CARE SYSTEM
4 OPERATING UNDER CERTAIN PROFESSIONAL GUIDE-
5 LINES.—Except as provided in paragraph (2), the
6 Secretary may not award a grant to a trauma center
7 under subsection (a) unless the trauma center is a
8 participant in a trauma system that substantially
9 complies with section 1213.

10 “(2) EXEMPTION.—Paragraph (1) shall not
11 apply to trauma centers that are located in States
12 with no existing trauma care system.

13 “(3) QUALIFICATION FOR SUBSTANTIAL UN-
14 COMPENSATED CARE COSTS.—The Secretary shall
15 award substantial uncompensated care grants under
16 subsection (a)(1) only to trauma centers meeting at
17 least 1 of the criteria in 1 of the following 3 cat-
18 egories:

19 “(A) CATEGORY A.—The criteria for cat-
20 egory A are as follows:

21 “(i) At least 40 percent of the visits
22 in the emergency department of the hos-
23 pital in which the trauma center is located
24 were charity or self-pay patients.

1 “(ii) At least 50 percent of the visits
2 in such emergency department were Med-
3 icaid (under title XIX of the Social Secu-
4 rity Act (42 U.S.C. 1396 et seq.)) and
5 charity and self-pay patients combined.

6 “(B) CATEGORY B.—The criteria for cat-
7 egory B are as follows:

8 “(i) At least 35 percent of the visits
9 in the emergency department were charity
10 or self-pay patients.

11 “(ii) At least 50 percent of the visits
12 in the emergency department were Med-
13 icaid and charity and self-pay patients
14 combined.

15 “(C) CATEGORY C.—The criteria for cat-
16 egory C are as follows:

17 “(i) At least 20 percent of the visits
18 in the emergency department were charity
19 or self-pay patients.

20 “(ii) At least 30 percent of the visits
21 in the emergency department were Med-
22 icaid and charity and self-pay patients
23 combined.

24 “(4) TRAUMA CENTERS IN 1115 WAIVER
25 STATES.—Notwithstanding paragraph (3), the Sec-

1 retary may award a substantial uncompensated care
2 grant to a trauma center under subsection (a)(1) if
3 the trauma center qualifies for funds under a Low
4 Income Pool or Safety Net Care Pool established
5 through a waiver approved under section 1115 of the
6 Social Security Act (42 U.S.C. 1315).

7 “(5) DESIGNATION.—The Secretary may not
8 award a grant to a trauma center unless such trauma
9 center is verified by the American College of
10 Surgeons or designated by an equivalent State or
11 local agency.

12 “(c) ADDITIONAL REQUIREMENTS.—The Secretary
13 may not award a grant to a trauma center under sub-
14 section (a)(1) unless such trauma center—

15 “(1) submits to the Secretary a plan satisfac-
16 tory to the Secretary that demonstrates a continued
17 commitment to serving trauma patients regardless of
18 their ability to pay; and

19 “(2) has policies in place to assist patients who
20 cannot pay for part or all of the care they receive,
21 including a sliding fee scale, and to ensure fair bill-
22 ing and collection practices.”.

23 “(2) CONSIDERATIONS IN MAKING GRANTS.—
24 Section 1242 of the Public Health Service Act (42

1 U.S.C. 300d-42) is amended by striking subsections
2 (a) and (b) and inserting the following:

3 “(a) SUBSTANTIAL UNCOMPENSATED CARE
4 AWARDS.—

5 “(1) IN GENERAL.—The Secretary shall estab-
6 lish an award basis for each eligible trauma center
7 for grants under section 1241(a)(1) according to the
8 percentage described in paragraph (2), subject to the
9 requirements of section 1241(b)(3).

10 “(2) PERCENTAGES.—The applicable percent-
11 ages are as follows:

12 “(A) With respect to a category A trauma
13 center, 100 percent of the uncompensated care
14 costs.

15 “(B) With respect to a category B trauma
16 center, not more than 75 percent of the uncom-
17 pensated care costs.

18 “(C) With respect to a category C trauma
19 center, not more than 50 percent of the uncom-
20 pensated care costs.

21 “(b) CORE MISSION AWARDS.—

22 “(1) IN GENERAL.—In awarding grants under
23 section 1241(a)(2), the Secretary shall—

1 “(A) reserve 25 percent of the amount al-
2 located for core mission awards for Level III
3 and Level IV trauma centers; and

4 “(B) reserve 25 percent of the amount al-
5 located for core mission awards for large urban
6 Level I and II trauma centers—

7 “(i) that have at least 1 graduate
8 medical education fellowship in trauma or
9 trauma related specialties for which de-
10 mand is exceeding supply;

11 “(ii) for which—

12 “(I) annual uncompensated care
13 costs exceed \$10,000,000; or

14 “(II) at least 20 percent of emer-
15 gency department visits are charity or
16 self-pay or Medicaid patients; and

17 “(iii) that are not eligible for substan-
18 tial uncompensated care awards under sec-
19 tion 1241(a)(1).

20 “(c) EMERGENCY AWARDS.—In awarding grants
21 under section 1241(a)(3), the Secretary shall—

22 “(1) give preference to any application sub-
23 mitted by a trauma center that provides trauma care
24 in a geographic area in which the availability of
25 trauma care has significantly decreased or will sig-

1 significantly decrease if the center is forced to close or
2 downgrade service or growth in demand for trauma
3 services exceeds capacity; and

4 “(2) reallocate any emergency awards funds not
5 obligated due to insufficient, or a lack of qualified,
6 applications to the significant uncompensated care
7 award program.”.

8 (3) CERTAIN AGREEMENTS.—Section 1243 of
9 the Public Health Service Act (42 U.S.C. 300d–43)
10 is amended by striking subsections (a), (b), and (c)
11 and inserting the following:

12 “(a) MAINTENANCE OF FINANCIAL SUPPORT.—The
13 Secretary may require a trauma center receiving a grant
14 under section 1241(a) to maintain access to trauma serv-
15 ices at comparable levels to the prior year during the grant
16 period.

17 “(b) TRAUMA CARE REGISTRY.—The Secretary may
18 require the trauma center receiving a grant under section
19 1241(a) to provide data to a national and centralized reg-
20 istry of trauma cases, in accordance with guidelines devel-
21 oped by the American College of Surgeons, and as the Sec-
22 retary may otherwise require.”.

23 (4) GENERAL PROVISIONS.—Section 1244 of
24 the Public Health Service Act (42 U.S.C. 300d–44)

1 is amended by striking subsections (a), (b), and (c)
2 and inserting the following:

3 “(a) APPLICATION.—The Secretary may not award
4 a grant to a trauma center under section 1241(a) unless
5 such center submits an application for the grant to the
6 Secretary and the application is in such form, is made in
7 such manner, and contains such agreements, assurances,
8 and information as the Secretary determines to be nec-
9 essary to carry out this part.

10 “(b) LIMITATION ON DURATION OF SUPPORT.—The
11 period during which a trauma center receives payments
12 under a grant under section 1241(a)(3) shall be for 3 fis-
13 cal years, except that the Secretary may waive such re-
14 quirement for a center and authorize such center to re-
15 ceive such payments for 1 additional fiscal year.

16 “(c) LIMITATION ON AMOUNT OF GRANT.—Notwith-
17 standing section 1242(a), a grant under section 1241 may
18 not be made in an amount exceeding \$2,000,000 for each
19 fiscal year.

20 “(d) ELIGIBILITY.—Except as provided in section
21 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant
22 under section 1241(a) shall not preclude a trauma center
23 from being eligible for other grants described in such sec-
24 tion.

1 “(e) FUNDING DISTRIBUTION.—Of the total amount
2 appropriated for a fiscal year under section 1245, 70 per-
3 cent shall be used for substantial uncompensated care
4 awards under section 1241(a)(1), 20 percent shall be used
5 for core mission awards under section 1241(a)(2), and 10
6 percent shall be used for emergency awards under section
7 1241(a)(3).

8 “(f) MINIMUM ALLOWANCE.—Notwithstanding sub-
9 section (e), if the amount appropriated for a fiscal year
10 under section 1245 is less than \$25,000,000, all available
11 funding for such fiscal year shall be used for substantial
12 uncompensated care awards under section 1241(a)(1).

13 “(g) SUBSTANTIAL UNCOMPENSATED CARE AWARD
14 DISTRIBUTION AND PROPORTIONAL SHARE.—Notwith-
15 standing section 1242(a), of the amount appropriated for
16 substantial uncompensated care grants for a fiscal year,
17 the Secretary shall—

18 “(1) make available—

19 “(A) 50 percent of such funds for category
20 A trauma center grantees;

21 “(B) 35 percent of such funds for category
22 B trauma center grantees; and

23 “(C) 15 percent of such funds for category
24 C trauma center grantees; and

1 “(2) provide available funds within each cat-
2 egory in a manner proportional to the award basis
3 specified in section 1242(a)(2) to each eligible trau-
4 ma center.

5 “(h) REPORT.—Beginning 2 years after the date of
6 enactment of the Patient Protection and Affordable Care
7 Act, and every 2 years thereafter, the Secretary shall bien-
8 nially report to Congress regarding the status of the
9 grants made under section 1241 and on the overall finan-
10 cial stability of trauma centers.”.

11 (5) AUTHORIZATION OF APPROPRIATIONS.—

12 Section 1245 of the Public Health Service Act (42
13 U.S.C. 300d–45) is amended to read as follows:

14 **“SEC. 1245. AUTHORIZATION OF APPROPRIATIONS.**

15 “For the purpose of carrying out this part, there are
16 authorized to be appropriated \$100,000,000 for fiscal year
17 2009, and such sums as may be necessary for each of fis-
18 cal years 2010 through 2015. Such authorization of ap-
19 propriations is in addition to any other authorization of
20 appropriations or amounts that are available for such pur-
21 pose.”.

22 (6) DEFINITION.—Part D of title XII of the
23 Public Health Service Act (42 U.S.C. 300d–41 et
24 seq.) is amended by adding at the end the following:

1 **“SEC. 1246. DEFINITION.**

2 “In this part, the term ‘uncompensated care costs’
 3 means unreimbursed costs from serving self-pay, charity,
 4 or Medicaid patients, without regard to payment under
 5 section 1923 of the Social Security Act, all of which are
 6 attributable to emergency care and trauma care, including
 7 costs related to subsequent inpatient admissions to the
 8 hospital.”.

9 (b) **TRAUMA SERVICE AVAILABILITY.**—Title XII of
 10 the Public Health Service Act (42 U.S.C. 300d et seq.)
 11 is amended by adding at the end the following:

12 **“PART H—TRAUMA SERVICE AVAILABILITY**13 **“SEC. 1281. GRANTS TO STATES.**

14 “(a) **ESTABLISHMENT.**—To promote universal access
 15 to trauma care services provided by trauma centers and
 16 trauma-related physician specialties, the Secretary shall
 17 provide funding to States to enable such States to award
 18 grants to eligible entities for the purposes described in this
 19 section.

20 “(b) **AWARDING OF GRANTS BY STATES.**—Each
 21 State may award grants to eligible entities within the
 22 State for the purposes described in subparagraph (d).

23 “(c) **ELIGIBILITY.**—

24 “(1) **IN GENERAL.**—To be eligible to receive a
 25 grant under subsection (b) an entity shall—

26 “(A) be—

1 “(i) a public or nonprofit trauma cen-
2 ter or consortium thereof that meets that
3 requirements of paragraphs (1), (2), and
4 (5) of section 1241(b);

5 “(ii) a safety net public or nonprofit
6 trauma center that meets the requirements
7 of paragraphs (1) through (5) of section
8 1241(b); or

9 “(iii) a hospital in an underserved
10 area (as defined by the State) that seeks
11 to establish new trauma services; and

12 “(B) submit to the State an application at
13 such time, in such manner, and containing such
14 information as the State may require.

15 “(2) LIMITATION.—A State shall use at least
16 40 percent of the amount available to the State
17 under this part for a fiscal year to award grants to
18 safety net trauma centers described in paragraph
19 (1)(A)(ii).

20 “(d) USE OF FUNDS.—The recipient of a grant under
21 subsection (b) shall carry out 1 or more of the following
22 activities consistent with subsection (b):

23 “(1) Providing trauma centers with funding to
24 support physician compensation in trauma-related
25 physician specialties where shortages exist in the re-

1 gion involved, with priority provided to safety net
2 trauma centers described in subsection (c)(1)(A)(ii).

3 “(2) Providing for individual safety net trauma
4 center fiscal stability and costs related to having
5 service that is available 24 hours a day, 7 days a
6 week, with priority provided to safety net trauma
7 centers described in subsection (c)(1)(A)(ii) located
8 in urban, border, and rural areas.

9 “(3) Reducing trauma center overcrowding at
10 specific trauma centers related to throughput of
11 trauma patients.

12 “(4) Establishing new trauma services in un-
13 derserved areas as defined by the State.

14 “(5) Enhancing collaboration between trauma
15 centers and other hospitals and emergency medical
16 services personnel related to trauma service avail-
17 ability.

18 “(6) Making capital improvements to enhance
19 access and expedite trauma care, including providing
20 helipads and associated safety infrastructure.

21 “(7) Enhancing trauma surge capacity at spe-
22 cific trauma centers.

23 “(8) Ensuring expedient receipt of trauma pa-
24 tients transported by ground or air to the appro-
25 priate trauma center.

1 “(9) Enhancing interstate trauma center col-
2 laboration.

3 “(e) LIMITATION.—

4 “(1) IN GENERAL.—A State may use not more
5 than 20 percent of the amount available to the State
6 under this part for a fiscal year for administrative
7 costs associated with awarding grants and related
8 costs.

9 “(2) MAINTENANCE OF EFFORT.—The Sec-
10 retary may not provide funding to a State under this
11 part unless the State agrees that such funds will be
12 used to supplement and not supplant State funding
13 otherwise available for the activities and costs de-
14 scribed in this part.

15 “(f) DISTRIBUTION OF FUNDS.—The following shall
16 apply with respect to grants provided in this part:

17 “(1) LESS THAN \$10,000,000.—If the amount of
18 appropriations for this part in a fiscal year is less
19 than \$10,000,000, the Secretary shall divide such
20 funding evenly among only those States that have 1
21 or more trauma centers eligible for funding under
22 section 1241(b)(3)(A).

23 “(2) LESS THAN \$20,000,000.—If the amount of
24 appropriations in a fiscal year is less than
25 \$20,000,000, the Secretary shall divide such funding

1 evenly among only those States that have 1 or more
2 trauma centers eligible for funding under subpara-
3 graphs (A) and (B) of section 1241(b)(3).

4 “(3) LESS THAN \$30,000,000.—If the amount of
5 appropriations for this part in a fiscal year is less
6 than \$30,000,000, the Secretary shall divide such
7 funding evenly among only those States that have 1
8 or more trauma centers eligible for funding under
9 section 1241(b)(3).

10 “(4) \$30,000,000 OR MORE.—If the amount of
11 appropriations for this part in a fiscal year is
12 \$30,000,000 or more, the Secretary shall divide such
13 funding evenly among all States.

14 **“SEC. 1282. AUTHORIZATION OF APPROPRIATIONS.**

15 “For the purpose of carrying out this part, there is
16 authorized to be appropriated \$100,000,000 for each of
17 fiscal years 2010 through 2015.”.

18 **SEC. 3506. PROGRAM TO FACILITATE SHARED DECISION-**
19 **MAKING.**

20 Part D of title IX of the Public Health Service Act,
21 as amended by section 3503, is further amended by adding
22 at the end the following:

1 **“SEC. 936. PROGRAM TO FACILITATE SHARED DECISION-**
2 **MAKING.**

3 “(a) PURPOSE.—The purpose of this section is to fa-
4 cilitate collaborative processes between patients, caregivers
5 or authorized representatives, and clinicians that engages
6 the patient, caregiver or authorized representative in deci-
7 sionmaking, provides patients, caregivers or authorized
8 representatives with information about trade-offs among
9 treatment options, and facilitates the incorporation of pa-
10 tient preferences and values into the medical plan.

11 “(b) DEFINITIONS.—In this section:

12 “(1) PATIENT DECISION AID.—The term ‘pa-
13 tient decision aid’ means an educational tool that
14 helps patients, caregivers or authorized representa-
15 tives understand and communicate their beliefs and
16 preferences related to their treatment options, and
17 to decide with their health care provider what treat-
18 ments are best for them based on their treatment
19 options, scientific evidence, circumstances, beliefs,
20 and preferences.

21 “(2) PREFERENCE SENSITIVE CARE.—The term
22 ‘preference sensitive care’ means medical care for
23 which the clinical evidence does not clearly support
24 one treatment option such that the appropriate
25 course of treatment depends on the values of the pa-
26 tient or the preferences of the patient, caregivers or

1 authorized representatives regarding the benefits,
2 harms and scientific evidence for each treatment op-
3 tion, the use of such care should depend on the in-
4 formed patient choice among clinically appropriate
5 treatment options.

6 “(c) ESTABLISHMENT OF INDEPENDENT STANDARDS
7 FOR PATIENT DECISION AIDS FOR PREFERENCE SEN-
8 SITIVE CARE.—

9 “(1) CONTRACT WITH ENTITY TO ESTABLISH
10 STANDARDS AND CERTIFY PATIENT DECISION
11 AIDS.—

12 “(A) IN GENERAL.—For purposes of sup-
13 porting consensus-based standards for patient
14 decision aids for preference sensitive care and a
15 certification process for patient decision aids for
16 use in the Federal health programs and by
17 other interested parties, the Secretary shall
18 have in effect a contract with the entity with a
19 contract under section 1890 of the Social Secu-
20 rity Act. Such contract shall provide that the
21 entity perform the duties described in para-
22 graph (2).

23 “(B) TIMING FOR FIRST CONTRACT.—As
24 soon as practicable after the date of the enact-

1 ment of this section, the Secretary shall enter
2 into the first contract under subparagraph (A).

3 “(C) PERIOD OF CONTRACT.—A contract
4 under subparagraph (A) shall be for a period of
5 18 months (except such contract may be re-
6 newed after a subsequent bidding process).

7 “(2) DUTIES.—The following duties are de-
8 scribed in this paragraph:

9 “(A) DEVELOP AND IDENTIFY STANDARDS
10 FOR PATIENT DECISION AIDS.—The entity shall
11 synthesize evidence and convene a broad range
12 of experts and key stakeholders to develop and
13 identify consensus-based standards to evaluate
14 patient decision aids for preference sensitive
15 care.

16 “(B) ENDORSE PATIENT DECISION AIDS.—
17 The entity shall review patient decision aids
18 and develop a certification process whether pa-
19 tient decision aids meet the standards developed
20 and identified under subparagraph (A). The en-
21 tity shall give priority to the review and certifi-
22 cation of patient decision aids for preference
23 sensitive care.

1 “(d) PROGRAM TO DEVELOP, UPDATE AND PATIENT
2 DECISION AIDS TO ASSIST HEALTH CARE PROVIDERS
3 AND PATIENTS.—

4 “(1) IN GENERAL.—The Secretary, acting
5 through the Director, and in coordination with heads
6 of other relevant agencies, such as the Director of
7 the Centers for Disease Control and Prevention and
8 the Director of the National Institutes of Health,
9 shall establish a program to award grants or con-
10 tracts—

11 “(A) to develop, update, and produce pa-
12 tient decision aids for preference sensitive care
13 to assist health care providers in educating pa-
14 tients, caregivers, and authorized representa-
15 tives concerning the relative safety, relative ef-
16 fectiveness (including possible health outcomes
17 and impact on functional status), and relative
18 cost of treatment or, where appropriate, pallia-
19 tive care options;

20 “(B) to test such materials to ensure such
21 materials are balanced and evidence based in
22 aiding health care providers and patients, care-
23 givers, and authorized representatives to make
24 informed decisions about patient care and can

1 be easily incorporated into a broad array of
2 practice settings; and

3 “(C) to educate providers on the use of
4 such materials, including through academic cur-
5 ricula.

6 “(2) REQUIREMENTS FOR PATIENT DECISION
7 AIDS.—Patient decision aids developed and produced
8 pursuant to a grant or contract under paragraph
9 (1)—

10 “(A) shall be designed to engage patients,
11 caregivers, and authorized representatives in in-
12 formed decisionmaking with health care pro-
13 viders;

14 “(B) shall present up-to-date clinical evi-
15 dence about the risks and benefits of treatment
16 options in a form and manner that is age-ap-
17 propriate and can be adapted for patients, care-
18 givers, and authorized representatives from a
19 variety of cultural and educational backgrounds
20 to reflect the varying needs of consumers and
21 diverse levels of health literacy;

22 “(C) shall, where appropriate, explain why
23 there is a lack of evidence to support one treat-
24 ment option over another; and

1 “(D) shall address health care decisions
2 across the age span, including those affecting
3 vulnerable populations including children.

4 “(3) DISTRIBUTION.—The Director shall ensure
5 that patient decision aids produced with grants or
6 contracts under this section are available to the pub-
7 lic.

8 “(4) NONDUPLICATION OF EFFORTS.—The Di-
9 rector shall ensure that the activities under this sec-
10 tion of the Agency and other agencies, including the
11 Centers for Disease Control and Prevention and the
12 National Institutes of Health, are free of unneces-
13 sary duplication of effort.

14 “(e) GRANTS TO SUPPORT SHARED DECISION-
15 MAKING IMPLEMENTATION.—

16 “(1) IN GENERAL.—The Secretary shall estab-
17 lish a program to provide for the phased-in develop-
18 ment, implementation, and evaluation of shared deci-
19 sionmaking using patient decision aids to meet the
20 objective of improving the understanding of patients
21 of their medical treatment options.

22 “(2) SHARED DECISIONMAKING RESOURCE CEN-
23 TERS.—

24 “(A) IN GENERAL.—The Secretary shall
25 provide grants for the establishment and sup-

1 port of Shared Decisionmaking Resource Cen-
2 ters (referred to in this subsection as ‘Centers’)
3 to provide technical assistance to providers and
4 to develop and disseminate best practices and
5 other information to support and accelerate
6 adoption, implementation, and effective use of
7 patient decision aids and shared decisionmaking
8 by providers.

9 “(B) OBJECTIVES.—The objective of a
10 Center is to enhance and promote the adoption
11 of patient decision aids and shared decision-
12 making through—

13 “(i) providing assistance to eligible
14 providers with the implementation and ef-
15 fective use of, and training on, patient de-
16 cision aids; and

17 “(ii) the dissemination of best prac-
18 tices and research on the implementation
19 and effective use of patient decision aids.

20 “(3) SHARED DECISIONMAKING PARTICIPATION
21 GRANTS.—

22 “(A) IN GENERAL.—The Secretary shall
23 provide grants to health care providers for the
24 development and implementation of shared deci-

1 sionmaking techniques and to assess the use of
2 such techniques.

3 “(B) PREFERENCE.—In order to facilitate
4 the use of best practices, the Secretary shall
5 provide a preference in making grants under
6 this subsection to health care providers who
7 participate in training by Shared Decision-
8 making Resource Centers or comparable train-
9 ing.

10 “(C) LIMITATION.—Funds under this
11 paragraph shall not be used to purchase or im-
12 plement use of patient decision aids other than
13 those certified under the process identified in
14 subsection (c).

15 “(4) GUIDANCE.—The Secretary may issue
16 guidance to eligible grantees under this subsection
17 on the use of patient decision aids.

18 “(f) FUNDING.—For purposes of carrying out this
19 section there are authorized to be appropriated such sums
20 as may be necessary for fiscal year 2010 and each subse-
21 quent fiscal year.”.

22 **SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BEN-**
23 **EFIT AND RISK INFORMATION.**

24 (a) IN GENERAL.—The Secretary of Health and
25 Human Services (referred to in this section as the “Sec-

1 retary”), acting through the Commissioner of Food and
2 Drugs, shall determine whether the addition of quan-
3 titative summaries of the benefits and risks of prescription
4 drugs in a standardized format (such as a table or drug
5 facts box) to the promotional labeling or print advertising
6 of such drugs would improve health care decisionmaking
7 by clinicians and patients and consumers.

8 (b) REVIEW AND CONSULTATION.—In making the
9 determination under subsection (a), the Secretary shall re-
10 view all available scientific evidence and research on deci-
11 sionmaking and social and cognitive psychology and con-
12 sult with drug manufacturers, clinicians, patients and con-
13 sumers, experts in health literacy, representatives of racial
14 and ethnic minorities, and experts in women’s and pedi-
15 atric health.

16 (c) REPORT.—Not later than 1 year after the date
17 of enactment of this Act, the Secretary shall submit to
18 Congress a report that provides—

19 (1) the determination by the Secretary under
20 subsection (a); and

21 (2) the reasoning and analysis underlying that
22 determination.

23 (d) AUTHORITY.—If the Secretary determines under
24 subsection (a) that the addition of quantitative summaries
25 of the benefits and risks of prescription drugs in a stand-

1 ardized format (such as a table or drug facts box) to the
2 promotional labeling or print advertising of such drugs
3 would improve health care decisionmaking by clinicians
4 and patients and consumers, then the Secretary, not later
5 than 3 years after the date of submission of the report
6 under subsection (c), shall promulgate proposed regula-
7 tions as necessary to implement such format.

8 (e) CLARIFICATION.—Nothing in this section shall be
9 construed to restrict the existing authorities of the Sec-
10 retary with respect to benefit and risk information.

11 **SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE**
12 **QUALITY IMPROVEMENT AND PATIENT SAFE-**
13 **TY TRAINING INTO CLINICAL EDUCATION OF**
14 **HEALTH PROFESSIONALS.**

15 (a) IN GENERAL.—The Secretary may award grants
16 to eligible entities or consortia under this section to carry
17 out demonstration projects to develop and implement aca-
18 demic curricula that integrates quality improvement and
19 patient safety in the clinical education of health profes-
20 sionals. Such awards shall be made on a competitive basis
21 and pursuant to peer review.

22 (b) ELIGIBILITY.—To be eligible to receive a grant
23 under subsection (a), an entity or consortium shall—

1 (1) submit to the Secretary an application at
2 such time, in such manner, and containing such in-
3 formation as the Secretary may require;

4 (2) be or include—

5 (A) a health professions school;

6 (B) a school of public health;

7 (C) a school of social work;

8 (D) a school of nursing;

9 (E) a school of pharmacy;

10 (F) an institution with a graduate medical

11 education program; or

12 (G) a school of health care administration;

13 (3) collaborate in the development of curricula
14 described in subsection (a) with an organization that
15 accredits such school or institution;

16 (4) provide for the collection of data regarding
17 the effectiveness of the demonstration project; and

18 (5) provide matching funds in accordance with
19 subsection (c).

20 (c) MATCHING FUNDS.—

21 (1) IN GENERAL.—The Secretary may award a
22 grant to an entity or consortium under this section
23 only if the entity or consortium agrees to make
24 available non-Federal contributions toward the costs
25 of the program to be funded under the grant in an

1 amount that is not less than \$1 for each \$5 of Fed-
2 eral funds provided under the grant.

3 (2) DETERMINATION OF AMOUNT CONTRIB-
4 UTED.—Non-Federal contributions under paragraph
5 (1) may be in cash or in-kind, fairly evaluated, in-
6 cluding equipment or services. Amounts provided by
7 the Federal Government, or services assisted or sub-
8 sidized to any significant extent by the Federal Gov-
9 ernment, may not be included in determining the
10 amount of such contributions.

11 (d) EVALUATION.—The Secretary shall take such ac-
12 tion as may be necessary to evaluate the projects funded
13 under this section and publish, make publicly available,
14 and disseminate the results of such evaluations on as wide
15 a basis as is practicable.

16 (e) REPORTS.—Not later than 2 years after the date
17 of enactment of this section, and annually thereafter, the
18 Secretary shall submit to the Committee on Health, Edu-
19 cation, Labor, and Pensions and the Committee on Fi-
20 nance of the Senate and the Committee on Energy and
21 Commerce and the Committee on Ways and Means of the
22 House of Representatives a report that—

23 (1) describes the specific projects supported
24 under this section; and

1 (2) contains recommendations for Congress
2 based on the evaluation conducted under subsection
3 (d).

4 **SEC. 3509. IMPROVING WOMEN'S HEALTH.**

5 (a) HEALTH AND HUMAN SERVICES OFFICE ON
6 WOMEN'S HEALTH.—

7 (1) ESTABLISHMENT.—Part A of title II of the
8 Public Health Service Act (42 U.S.C. 202 et seq.)
9 is amended by adding at the end the following:

10 **“SEC. 229. HEALTH AND HUMAN SERVICES OFFICE ON**
11 **WOMEN'S HEALTH.**

12 “(a) ESTABLISHMENT OF OFFICE.—There is estab-
13 lished within the Office of the Secretary, an Office on
14 Women's Health (referred to in this section as the ‘Of-
15 fice’). The Office shall be headed by a Deputy Assistant
16 Secretary for Women's Health who may report to the Sec-
17 retary.

18 “(b) DUTIES.—The Secretary, acting through the Of-
19 fice, with respect to the health concerns of women, shall—

20 “(1) establish short-range and long-range goals
21 and objectives within the Department of Health and
22 Human Services and, as relevant and appropriate,
23 coordinate with other appropriate offices on activi-
24 ties within the Department that relate to disease
25 prevention, health promotion, service delivery, re-

1 search, and public and health care professional edu-
2 cation, for issues of particular concern to women
3 throughout their lifespan;

4 “(2) provide expert advice and consultation to
5 the Secretary concerning scientific, legal, ethical,
6 and policy issues relating to women’s health;

7 “(3) monitor the Department of Health and
8 Human Services’ offices, agencies, and regional ac-
9 tivities regarding women’s health and identify needs
10 regarding the coordination of activities, including in-
11 tramural and extramural multidisciplinary activities;

12 “(4) establish a Department of Health and
13 Human Services Coordinating Committee on Wom-
14 en’s Health, which shall be chaired by the Deputy
15 Assistant Secretary for Women’s Health and com-
16 posed of senior level representatives from each of the
17 agencies and offices of the Department of Health
18 and Human Services;

19 “(5) establish a National Women’s Health In-
20 formation Center to—

21 “(A) facilitate the exchange of information
22 regarding matters relating to health informa-
23 tion, health promotion, preventive health serv-
24 ices, research advances, and education in the
25 appropriate use of health care;

1 “(B) facilitate access to such information;

2 “(C) assist in the analysis of issues and
3 problems relating to the matters described in
4 this paragraph; and

5 “(D) provide technical assistance with re-
6 spect to the exchange of information (including
7 facilitating the development of materials for
8 such technical assistance);

9 “(6) coordinate efforts to promote women’s
10 health programs and policies with the private sector;
11 and

12 “(7) through publications and any other means
13 appropriate, provide for the exchange of information
14 between the Office and recipients of grants, con-
15 tracts, and agreements under subsection (c), and be-
16 tween the Office and health professionals and the
17 general public.

18 “(c) GRANTS AND CONTRACTS REGARDING DU-
19 TIES.—

20 “(1) AUTHORITY.—In carrying out subsection
21 (b), the Secretary may make grants to, and enter
22 into cooperative agreements, contracts, and inter-
23 agency agreements with, public and private entities,
24 agencies, and organizations.

1 “(2) EVALUATION AND DISSEMINATION.—The
2 Secretary shall directly or through contracts with
3 public and private entities, agencies, and organiza-
4 tions, provide for evaluations of projects carried out
5 with financial assistance provided under paragraph
6 (1) and for the dissemination of information devel-
7 oped as a result of such projects.

8 “(d) REPORTS.—Not later than 1 year after the date
9 of enactment of this section, and every second year there-
10 after, the Secretary shall prepare and submit to the appro-
11 priate committees of Congress a report describing the ac-
12 tivities carried out under this section during the period
13 for which the report is being prepared.

14 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated such sums as may be necessary for
17 each of the fiscal years 2010 through 2014.”.

18 (2) TRANSFER OF FUNCTIONS.—There are
19 transferred to the Office on Women’s Health (estab-
20 lished under section 229 of the Public Health Serv-
21 ice Act, as added by this section), all functions exer-
22 cised by the Office on Women’s Health of the Public
23 Health Service prior to the date of enactment of this
24 section, including all personnel and compensation
25 authority, all delegation and assignment authority,

1 and all remaining appropriations. All orders, deter-
2 minations, rules, regulations, permits, agreements,
3 grants, contracts, certificates, licenses, registrations,
4 privileges, and other administrative actions that—

5 (A) have been issued, made, granted, or al-
6 lowed to become effective by the President, any
7 Federal agency or official thereof, or by a court
8 of competent jurisdiction, in the performance of
9 functions transferred under this paragraph; and

10 (B) are in effect at the time this section
11 takes effect, or were final before the date of en-
12 actment of this section and are to become effec-
13 tive on or after such date,

14 shall continue in effect according to their terms until
15 modified, terminated, superseded, set aside, or re-
16 voked in accordance with law by the President, the
17 Secretary, or other authorized official, a court of
18 competent jurisdiction, or by operation of law.

19 (b) CENTERS FOR DISEASE CONTROL AND PREVEN-
20 TION OFFICE OF WOMEN'S HEALTH.—Part A of title III
21 of the Public Health Service Act (42 U.S.C. 241 et seq.)
22 is amended by adding at the end the following:

1 **“SEC. 310A. CENTERS FOR DISEASE CONTROL AND PREVEN-**
2 **TION OFFICE OF WOMEN’S HEALTH.**

3 “(a) **ESTABLISHMENT.**—There is established within
4 the Office of the Director of the Centers for Disease Con-
5 trol and Prevention, an office to be known as the Office
6 of Women’s Health (referred to in this section as the ‘Of-
7 fice’). The Office shall be headed by a director who shall
8 be appointed by the Director of such Centers.

9 “(b) **PURPOSE.**—The Director of the Office shall—

10 “(1) report to the Director of the Centers for
11 Disease Control and Prevention on the current level
12 of the Centers’ activity regarding women’s health
13 conditions across, where appropriate, age, biological,
14 and sociocultural contexts, in all aspects of the Cen-
15 ters’ work, including prevention programs, public
16 and professional education, services, and treatment;

17 “(2) establish short-range and long-range goals
18 and objectives within the Centers for women’s health
19 and, as relevant and appropriate, coordinate with
20 other appropriate offices on activities within the
21 Centers that relate to prevention, research, edu-
22 cation and training, service delivery, and policy de-
23 velopment, for issues of particular concern to
24 women;

25 “(3) identify projects in women’s health that
26 should be conducted or supported by the Centers;

1 “(4) consult with health professionals, non-
2 governmental organizations, consumer organizations,
3 women’s health professionals, and other individuals
4 and groups, as appropriate, on the policy of the Cen-
5 ters with regard to women; and

6 “(5) serve as a member of the Department of
7 Health and Human Services Coordinating Com-
8 mittee on Women’s Health (established under sec-
9 tion 229(b)(4)).

10 “(c) DEFINITION.—As used in this section, the term
11 ‘women’s health conditions’, with respect to women of all
12 age, ethnic, and racial groups, means diseases, disorders,
13 and conditions—

14 “(1) unique to, significantly more serious for,
15 or significantly more prevalent in women; and

16 “(2) for which the factors of medical risk or
17 type of medical intervention are different for women,
18 or for which there is reasonable evidence that indi-
19 cates that such factors or types may be different for
20 women.

21 “(d) AUTHORIZATION OF APPROPRIATIONS.—For the
22 purpose of carrying out this section, there are authorized
23 to be appropriated such sums as may be necessary for
24 each of the fiscal years 2010 through 2014.”.

1 (c) OFFICE OF WOMEN'S HEALTH RESEARCH.—Sec-
2 tion 486(a) of the Public Health Service Act (42 U.S.C.
3 287d(a)) is amended by inserting “and who shall report
4 directly to the Director” before the period at the end
5 thereof.

6 (d) SUBSTANCE ABUSE AND MENTAL HEALTH
7 SERVICES ADMINISTRATION.—Section 501(f) of the Pub-
8 lic Health Service Act (42 U.S.C. 290aa(f)) is amended—

9 (1) in paragraph (1), by inserting “who shall
10 report directly to the Administrator” before the pe-
11 riod;

12 (2) by redesignating paragraph (4) as para-
13 graph (5); and

14 (3) by inserting after paragraph (3), the fol-
15 lowing:

16 “(4) OFFICE.—Nothing in this subsection shall
17 be construed to preclude the Secretary from estab-
18 lishing within the Substance Abuse and Mental
19 Health Administration an Office of Women's
20 Health.”.

21 (e) AGENCY FOR HEALTHCARE RESEARCH AND
22 QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—
23 Part C of title IX of the Public Health Service Act (42
24 U.S.C. 299c et seq.) is amended—

1 (1) by redesignating sections 925 and 926 as
2 sections 926 and 927, respectively; and

3 (2) by inserting after section 924 the following:

4 **“SEC. 925. ACTIVITIES REGARDING WOMEN’S HEALTH.**

5 “(a) ESTABLISHMENT.—There is established within
6 the Office of the Director, an Office of Women’s Health
7 and Gender-Based Research (referred to in this section
8 as the ‘Office’). The Office shall be headed by a director
9 who shall be appointed by the Director of Healthcare and
10 Research Quality.

11 “(b) PURPOSE.—The official designated under sub-
12 section (a) shall—

13 “(1) report to the Director on the current
14 Agency level of activity regarding women’s health,
15 across, where appropriate, age, biological, and
16 sociocultural contexts, in all aspects of Agency work,
17 including the development of evidence reports and
18 clinical practice protocols and the conduct of re-
19 search into patient outcomes, delivery of health care
20 services, quality of care, and access to health care;

21 “(2) establish short-range and long-range goals
22 and objectives within the Agency for research impor-
23 tant to women’s health and, as relevant and appro-
24 priate, coordinate with other appropriate offices on
25 activities within the Agency that relate to health

1 services and medical effectiveness research, for
2 issues of particular concern to women;

3 “(3) identify projects in women’s health that
4 should be conducted or supported by the Agency;

5 “(4) consult with health professionals, non-
6 governmental organizations, consumer organizations,
7 women’s health professionals, and other individuals
8 and groups, as appropriate, on Agency policy with
9 regard to women; and

10 “(5) serve as a member of the Department of
11 Health and Human Services Coordinating Com-
12 mittee on Women’s Health (established under sec-
13 tion 229(b)(4)).”.

14 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the
15 purpose of carrying out this section, there are authorized
16 to be appropriated such sums as may be necessary for
17 each of the fiscal years 2010 through 2014.”.

18 (f) HEALTH RESOURCES AND SERVICES ADMINIS-
19 TRATION OFFICE OF WOMEN’S HEALTH.—Title VII of
20 the Social Security Act (42 U.S.C. 901 et seq.) is amended
21 by adding at the end the following:

22 **“SEC. 713. OFFICE OF WOMEN’S HEALTH.**

23 “(a) ESTABLISHMENT.—The Secretary shall estab-
24 lish within the Office of the Administrator of the Health
25 Resources and Services Administration, an office to be

1 known as the Office of Women’s Health. The Office shall
2 be headed by a director who shall be appointed by the Ad-
3 ministrator.

4 “(b) PURPOSE.—The Director of the Office shall—

5 “(1) report to the Administrator on the current
6 Administration level of activity regarding women’s
7 health across, where appropriate, age, biological, and
8 sociocultural contexts;

9 “(2) establish short-range and long-range goals
10 and objectives within the Health Resources and
11 Services Administration for women’s health and, as
12 relevant and appropriate, coordinate with other ap-
13 propriate offices on activities within the Administra-
14 tion that relate to health care provider training,
15 health service delivery, research, and demonstration
16 projects, for issues of particular concern to women;

17 “(3) identify projects in women’s health that
18 should be conducted or supported by the bureaus of
19 the Administration;

20 “(4) consult with health professionals, non-
21 governmental organizations, consumer organizations,
22 women’s health professionals, and other individuals
23 and groups, as appropriate, on Administration policy
24 with regard to women; and

1 “(5) serve as a member of the Department of
2 Health and Human Services Coordinating Com-
3 mittee on Women’s Health (established under sec-
4 tion 229(b)(4) of the Public Health Service Act).

5 “(c) CONTINUED ADMINISTRATION OF EXISTING
6 PROGRAMS.—The Director of the Office shall assume the
7 authority for the development, implementation, adminis-
8 tration, and evaluation of any projects carried out through
9 the Health Resources and Services Administration relat-
10 ing to women’s health on the date of enactment of this
11 section.

12 “(d) DEFINITIONS.—For purposes of this section:

13 “(1) ADMINISTRATION.—The term ‘Administra-
14 tion’ means the Health Resources and Services Ad-
15 ministration.

16 “(2) ADMINISTRATOR.—The term ‘Adminis-
17 trator’ means the Administrator of the Health Re-
18 sources and Services Administration.

19 “(3) OFFICE.—The term ‘Office’ means the Of-
20 fice of Women’s Health established under this sec-
21 tion in the Administration.

22 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
23 purpose of carrying out this section, there are authorized
24 to be appropriated such sums as may be necessary for
25 each of the fiscal years 2010 through 2014.”.

1 (g) FOOD AND DRUG ADMINISTRATION OFFICE OF
2 WOMEN'S HEALTH.—Chapter X of the Federal Food,
3 Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amend-
4 ed by adding at the end the following:

5 **“SEC. 1011. OFFICE OF WOMEN'S HEALTH.**

6 “(a) ESTABLISHMENT.—There is established within
7 the Office of the Commissioner, an office to be known as
8 the Office of Women's Health (referred to in this section
9 as the ‘Office’). The Office shall be headed by a director
10 who shall be appointed by the Commissioner of Food and
11 Drugs.

12 “(b) PURPOSE.—The Director of the Office shall—

13 “(1) report to the Commissioner of Food and
14 Drugs on current Food and Drug Administration
15 (referred to in this section as the ‘Administration’)
16 levels of activity regarding women's participation in
17 clinical trials and the analysis of data by sex in the
18 testing of drugs, medical devices, and biological
19 products across, where appropriate, age, biological,
20 and sociocultural contexts;

21 “(2) establish short-range and long-range goals
22 and objectives within the Administration for issues
23 of particular concern to women's health within the
24 jurisdiction of the Administration, including, where
25 relevant and appropriate, adequate inclusion of

1 women and analysis of data by sex in Administration
2 protocols and policies;

3 “(3) provide information to women and health
4 care providers on those areas in which differences
5 between men and women exist;

6 “(4) consult with pharmaceutical, biologics, and
7 device manufacturers, health professionals with ex-
8 pertise in women’s issues, consumer organizations,
9 and women’s health professionals on Administration
10 policy with regard to women;

11 “(5) make annual estimates of funds needed to
12 monitor clinical trials and analysis of data by sex in
13 accordance with needs that are identified; and

14 “(6) serve as a member of the Department of
15 Health and Human Services Coordinating Com-
16 mittee on Women’s Health (established under sec-
17 tion 229(b)(4) of the Public Health Service Act).

18 “(c) AUTHORIZATION OF APPROPRIATIONS.—For the
19 purpose of carrying out this section, there are authorized
20 to be appropriated such sums as may be necessary for
21 each of the fiscal years 2010 through 2014.”.

22 (h) NO NEW REGULATORY AUTHORITY.—Nothing in
23 this section and the amendments made by this section may
24 be construed as establishing regulatory authority or modi-
25 fying any existing regulatory authority.

1 (i) LIMITATION ON TERMINATION.—Notwithstanding
2 any other provision of law, a Federal office of women’s
3 health (including the Office of Research on Women’s
4 Health of the National Institutes of Health) or Federal
5 appointive position with primary responsibility over wom-
6 en’s health issues (including the Associate Administrator
7 for Women’s Services under the Substance Abuse and
8 Mental Health Services Administration) that is in exist-
9 ence on the date of enactment of this section shall not
10 be terminated, reorganized, or have any of its powers or
11 duties transferred unless such termination, reorganization,
12 or transfer is approved by Congress through the adoption
13 of a concurrent resolution of approval.

14 (j) RULE OF CONSTRUCTION.—Nothing in this sec-
15 tion (or the amendments made by this section) shall be
16 construed to limit the authority of the Secretary of Health
17 and Human Services with respect to women’s health, or
18 with respect to activities carried out through the Depart-
19 ment of Health and Human Services on the date of enact-
20 ment of this section.

21 **SEC. 3510. PATIENT NAVIGATOR PROGRAM.**

22 Section 340A of the Public Health Service Act (42
23 U.S.C. 256a) is amended—

24 (1) by striking subsection (d)(3) and inserting
25 the following:

1 “(3) LIMITATIONS ON GRANT PERIOD.—In car-
2 rying out this section, the Secretary shall ensure
3 that the total period of a grant does not exceed 4
4 years.”;

5 (2) in subsection (e), by adding at the end the
6 following:

7 “(3) MINIMUM CORE PROFICIENCIES.—The
8 Secretary shall not award a grant to an entity under
9 this section unless such entity provides assurances
10 that patient navigators recruited, assigned, trained,
11 or employed using grant funds meet minimum core
12 proficiencies, as defined by the entity that submits
13 the application, that are tailored for the main focus
14 or intervention of the navigator involved.”; and

15 (3) in subsection (m)—

16 (A) in paragraph (1), by striking “and
17 \$3,500,000 for fiscal year 2010.” and inserting
18 “\$3,500,000 for fiscal year 2010, and such
19 sums as may be necessary for each of fiscal
20 years 2011 through 2015.”; and

21 (B) in paragraph (2), by striking “2010”
22 and inserting “2015”.

23 **SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.**

24 Except where otherwise provided in this subtitle (or
25 an amendment made by this subtitle), there is authorized

1 to be appropriated such sums as may be necessary to carry
2 out this subtitle (and such amendments made by this sub-
3 title).

4 **TITLE IV—PREVENTION OF**
5 **CHRONIC DISEASE AND IM-**
6 **PROVING PUBLIC HEALTH**

7 **Subtitle A—Modernizing Disease**
8 **Prevention and Public Health**
9 **Systems**

10 **SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION**
11 **AND PUBLIC HEALTH COUNCIL.**

12 (a) **ESTABLISHMENT.**—The President shall establish,
13 within the Department of Health and Human Services,
14 a council to be known as the “National Prevention, Health
15 Promotion and Public Health Council” (referred to in this
16 section as the “Council”).

17 (b) **CHAIRPERSON.**—The President shall appoint the
18 Surgeon General to serve as the chairperson of the Coun-
19 cil.

20 (c) **COMPOSITION.**—The Council shall be composed
21 of—

22 (1) the Secretary of Health and Human Serv-
23 ices;

24 (2) the Secretary of Agriculture;

25 (3) the Secretary of Education;

1 (4) the Chairman of the Federal Trade Com-
2 mission;

3 (5) the Secretary of Transportation;

4 (6) the Secretary of Labor;

5 (7) the Secretary of Homeland Security;

6 (8) the Administrator of the Environmental
7 Protection Agency;

8 (9) the Director of the Office of National Drug
9 Control Policy;

10 (10) the Director of the Domestic Policy Coun-
11 cil;

12 (11) the Assistant Secretary for Indian Affairs;

13 (12) the Chairman of the Corporation for Na-
14 tional and Community Service; and

15 (13) the head of any other Federal agency that
16 the chairperson determines is appropriate.

17 (d) PURPOSES AND DUTIES.—The Council shall—

18 (1) provide coordination and leadership at the
19 Federal level, and among all Federal departments
20 and agencies, with respect to prevention, wellness
21 and health promotion practices, the public health
22 system, and integrative health care in the United
23 States;

24 (2) after obtaining input from relevant stake-
25 holders, develop a national prevention, health pro-

1 motion, public health, and integrative health care
2 strategy that incorporates the most effective and
3 achievable means of improving the health status of
4 Americans and reducing the incidence of preventable
5 illness and disability in the United States;

6 (3) provide recommendations to the President
7 and Congress concerning the most pressing health
8 issues confronting the United States and changes in
9 Federal policy to achieve national wellness, health
10 promotion, and public health goals, including the re-
11 duction of tobacco use, sedentary behavior, and poor
12 nutrition;

13 (4) consider and propose evidence-based models,
14 policies, and innovative approaches for the pro-
15 motion of transformative models of prevention, inte-
16 grative health, and public health on individual and
17 community levels across the United States;

18 (5) establish processes for continual public
19 input, including input from State, regional, and local
20 leadership communities and other relevant stake-
21 holders, including Indian tribes and tribal organiza-
22 tions;

23 (6) submit the reports required under sub-
24 section (g); and

1 (7) carry out other activities determined appro-
2 priate by the President.

3 (e) MEETINGS.—The Council shall meet at the call
4 of the Chairperson.

5 (f) ADVISORY GROUP.—

6 (1) IN GENERAL.—The President shall establish
7 an Advisory Group to the Council to be known as
8 the “Advisory Group on Prevention, Health Pro-
9 motion, and Integrative and Public Health” (here-
10 after referred to in this section as the “Advisory
11 Group”). The Advisory Group shall be within the
12 Department of Health and Human Services and re-
13 port to the Surgeon General.

14 (2) COMPOSITION.—

15 (A) IN GENERAL.—The Advisory Group
16 shall be composed of not more than 25 non-
17 Federal members to be appointed by the Presi-
18 dent.

19 (B) REPRESENTATION.—In appointing
20 members under subparagraph (A), the Presi-
21 dent shall ensure that the Advisory Group in-
22 cludes a diverse group of licensed health profes-
23 sionals, including integrative health practi-
24 tioners who have expertise in—

25 (i) worksite health promotion;

- 1 (ii) community services, including
2 community health centers;
3 (iii) preventive medicine;
4 (iv) health coaching;
5 (v) public health education;
6 (vi) geriatrics; and
7 (vii) rehabilitation medicine.

8 (3) PURPOSES AND DUTIES.—The Advisory
9 Group shall develop policy and program rec-
10 ommendations and advise the Council on lifestyle-
11 based chronic disease prevention and management,
12 integrative health care practices, and health pro-
13 motion.

14 (g) NATIONAL PREVENTION AND HEALTH PRO-
15 MOTION STRATEGY.—Not later than 1 year after the date
16 of enactment of this Act, the Chairperson, in consultation
17 with the Council, shall develop and make public a national
18 prevention, health promotion and public health strategy,
19 and shall review and revise such strategy periodically.
20 Such strategy shall—

- 21 (1) set specific goals and objectives for improv-
22 ing the health of the United States through feder-
23 ally-supported prevention, health promotion, and
24 public health programs, consistent with ongoing goal
25 setting efforts conducted by specific agencies;

1 (2) establish specific and measurable actions
2 and timelines to carry out the strategy, and deter-
3 mine accountability for meeting those timelines,
4 within and across Federal departments and agencies;
5 and

6 (3) make recommendations to improve Federal
7 efforts relating to prevention, health promotion, pub-
8 lic health, and integrative health care practices to
9 ensure Federal efforts are consistent with available
10 standards and evidence.

11 (h) REPORT.—Not later than July 1, 2010, and an-
12 nually thereafter through January 1, 2015, the Council
13 shall submit to the President and the relevant committees
14 of Congress, a report that—

15 (1) describes the activities and efforts on pre-
16 vention, health promotion, and public health and ac-
17 tivities to develop a national strategy conducted by
18 the Council during the period for which the report
19 is prepared;

20 (2) describes the national progress in meeting
21 specific prevention, health promotion, and public
22 health goals defined in the strategy and further de-
23 scribes corrective actions recommended by the Coun-
24 cil and taken by relevant agencies and organizations
25 to meet these goals;

1 (3) contains a list of national priorities on
2 health promotion and disease prevention to address
3 lifestyle behavior modification (smoking cessation,
4 proper nutrition, appropriate exercise, mental health,
5 behavioral health, substance use disorder, and do-
6 mestic violence screenings) and the prevention meas-
7 ures for the 5 leading disease killers in the United
8 States;

9 (4) contains specific science-based initiatives to
10 achieve the measurable goals of Healthy People
11 2010 regarding nutrition, exercise, and smoking ces-
12 sation, and targeting the 5 leading disease killers in
13 the United States;

14 (5) contains specific plans for consolidating
15 Federal health programs and Centers that exist to
16 promote healthy behavior and reduce disease risk
17 (including eliminating programs and offices deter-
18 mined to be ineffective in meeting the priority goals
19 of Healthy People 2010);

20 (6) contains specific plans to ensure that all
21 Federal health care programs are fully coordinated
22 with science-based prevention recommendations by
23 the Director of the Centers for Disease Control and
24 Prevention; and

1 (7) contains specific plans to ensure that all
2 non-Department of Health and Human Services pre-
3 vention programs are based on the science-based
4 guidelines developed by the Centers for Disease Con-
5 trol and Prevention under paragraph (4).

6 (i) PERIODIC REVIEWS.—The Secretary and the
7 Comptroller General of the United States shall jointly con-
8 duct periodic reviews, not less than every 5 years, and
9 evaluations of every Federal disease prevention and health
10 promotion initiative, program, and agency. Such reviews
11 shall be evaluated based on effectiveness in meeting
12 metrics-based goals with an analysis posted on such agen-
13 cies' public Internet websites.

14 **SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.**

15 (a) PURPOSE.—It is the purpose of this section to
16 establish a Prevention and Public Health Fund (referred
17 to in this section as the “Fund”), to be administered
18 through the Department of Health and Human Services,
19 Office of the Secretary, to provide for expanded and sus-
20 tained national investment in prevention and public health
21 programs to improve health and help restrain the rate of
22 growth in private and public sector health care costs.

23 (b) FUNDING.—There are hereby authorized to be
24 appropriated, and appropriated, to the Fund, out of any
25 monies in the Treasury not otherwise appropriated—

- 1 (1) for fiscal year 2010, \$500,000,000;
2 (2) for fiscal year 2011, \$750,000,000;
3 (3) for fiscal year 2012, \$1,000,000,000;
4 (4) for fiscal year 2013, \$1,250,000,000;
5 (5) for fiscal year 2014, \$1,500,000,000; and
6 (6) for fiscal year 2015, and each fiscal year
7 thereafter, \$2,000,000,000.

8 (c) USE OF FUND.—The Secretary shall transfer
9 amounts in the Fund to accounts within the Department
10 of Health and Human Services to increase funding, over
11 the fiscal year 2008 level, for programs authorized by the
12 Public Health Service Act, for prevention, wellness, and
13 public health activities including prevention research and
14 health screenings, such as the Community Transformation
15 grant program, the Education and Outreach Campaign for
16 Preventive Benefits, and immunization programs.

17 (d) TRANSFER AUTHORITY .—The Committee on Ap-
18 propriations of the Senate and the Committee on Appro-
19 priations of the House of Representatives may provide for
20 the transfer of funds in the Fund to eligible activities
21 under this section, subject to subsection (c).

22 **SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERV-**
23 **ICES.**

24 (a) PREVENTIVE SERVICES TASK FORCE.—Section
25 915 of the Public Health Service Act (42 U.S.C. 299b-

1 4) is amended by striking subsection (a) and inserting the
2 following:

3 “(a) PREVENTIVE SERVICES TASK FORCE.—

4 “(1) ESTABLISHMENT AND PURPOSE.—The Di-
5 rector shall convene an independent Preventive Serv-
6 ices Task Force (referred to in this subsection as the
7 ‘Task Force’) to be composed of individuals with ap-
8 propriate expertise. Such Task Force shall review
9 the scientific evidence related to the effectiveness,
10 appropriateness, and cost-effectiveness of clinical
11 preventive services for the purpose of developing rec-
12 ommendations for the health care community, and
13 updating previous clinical preventive recommenda-
14 tions, to be published in the Guide to Clinical Pre-
15 ventive Services (referred to in this section as the
16 ‘Guide’), for individuals and organizations delivering
17 clinical services, including primary care profes-
18 sionals, health care systems, professional societies,
19 employers, community organizations, non-profit or-
20 ganizations, Congress and other policy-makers, gov-
21 ernmental public health agencies, health care quality
22 organizations, and organizations developing national
23 health objectives. Such recommendations shall con-
24 sider clinical preventive best practice recommenda-
25 tions from the Agency for Healthcare Research and

1 Quality, the National Institutes of Health, the Cen-
2 ters for Disease Control and Prevention, the Insti-
3 tute of Medicine, specialty medical associations, pa-
4 tient groups, and scientific societies.

5 “(2) DUTIES.—The duties of the Task Force
6 shall include—

7 “(A) the development of additional topic
8 areas for new recommendations and interven-
9 tions related to those topic areas, including
10 those related to specific sub-populations and
11 age groups;

12 “(B) at least once during every 5-year pe-
13 riod, review interventions and update rec-
14 ommendations related to existing topic areas,
15 including new or improved techniques to assess
16 the health effects of interventions;

17 “(C) improved integration with Federal
18 Government health objectives and related target
19 setting for health improvement;

20 “(D) the enhanced dissemination of rec-
21 ommendations;

22 “(E) the provision of technical assistance
23 to those health care professionals, agencies and
24 organizations that request help in implementing
25 the Guide recommendations; and

1 “(F) the submission of yearly reports to
2 Congress and related agencies identifying gaps
3 in research, such as preventive services that re-
4 ceive an insufficient evidence statement, and
5 recommending priority areas that deserve fur-
6 ther examination, including areas related to
7 populations and age groups not adequately ad-
8 dressed by current recommendations.

9 “(3) ROLE OF AGENCY.—The Agency shall pro-
10 vide ongoing administrative, research, and technical
11 support for the operations of the Task Force, includ-
12 ing coordinating and supporting the dissemination of
13 the recommendations of the Task Force, ensuring
14 adequate staff resources, and assistance to those or-
15 ganizations requesting it for implementation of the
16 Guide’s recommendations.

17 “(4) COORDINATION WITH COMMUNITY PRE-
18 VENTIVE SERVICES TASK FORCE.—The Task Force
19 shall take appropriate steps to coordinate its work
20 with the Community Preventive Services Task Force
21 and the Advisory Committee on Immunization Prac-
22 tices, including the examination of how each task
23 force’s recommendations interact at the nexus of
24 clinic and community.

1 “(5) OPERATION.—Operation. In carrying out
2 the duties under paragraph (2), the Task Force is
3 not subject to the provisions of Appendix 2 of title
4 5, United States Code.

5 “(6) INDEPENDENCE.—All members of the
6 Task Force convened under this subsection, and any
7 recommendations made by such members, shall be
8 independent and, to the extent practicable, not sub-
9 ject to political pressure.

10 “(7) AUTHORIZATION OF APPROPRIATIONS.—
11 There are authorized to be appropriated such sums
12 as may be necessary for each fiscal year to carry out
13 the activities of the Task Force.”.

14 (b) COMMUNITY PREVENTIVE SERVICES TASK
15 FORCE.—

16 (1) IN GENERAL.—Part P of title III of the
17 Public Health Service Act, as amended by paragraph
18 (2), is amended by adding at the end the following:

19 **“SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK**
20 **FORCE.**

21 “(a) ESTABLISHMENT AND PURPOSE.—The Director
22 of the Centers for Disease Control and Prevention shall
23 convene an independent Community Preventive Services
24 Task Force (referred to in this subsection as the ‘Task
25 Force’) to be composed of individuals with appropriate ex-

1 pertise. Such Task Force shall review the scientific evi-
2 dence related to the effectiveness, appropriateness, and
3 cost-effectiveness of community preventive interventions
4 for the purpose of developing recommendations, to be pub-
5 lished in the Guide to Community Preventive Services (re-
6 ferred to in this section as the ‘Guide’), for individuals
7 and organizations delivering population-based services, in-
8 cluding primary care professionals, health care systems,
9 professional societies, employers, community organiza-
10 tions, non-profit organizations, schools, governmental pub-
11 lic health agencies, Indian tribes, tribal organizations and
12 urban Indian organizations, medical groups, Congress and
13 other policy-makers. Community preventive services in-
14 clude any policies, programs, processes or activities de-
15 signed to affect or otherwise affecting health at the popu-
16 lation level.

17 “(b) DUTIES.—The duties of the Task Force shall
18 include—

19 “(1) the development of additional topic areas
20 for new recommendations and interventions related
21 to those topic areas, including those related to spe-
22 cific populations and age groups, as well as the so-
23 cial, economic and physical environments that can
24 have broad effects on the health and disease of pop-

1 ulations and health disparities among sub-popu-
2 lations and age groups;

3 “(2) at least once during every 5-year period,
4 review interventions and update recommendations
5 related to existing topic areas, including new or im-
6 proved techniques to assess the health effects of
7 interventions, including health impact assessment
8 and population health modeling;

9 “(3) improved integration with Federal Govern-
10 ment health objectives and related target setting for
11 health improvement;

12 “(4) the enhanced dissemination of rec-
13 ommendations;

14 “(5) the provision of technical assistance to
15 those health care professionals, agencies, and organi-
16 zations that request help in implementing the Guide
17 recommendations; and

18 “(6) providing yearly reports to Congress and
19 related agencies identifying gaps in research and
20 recommending priority areas that deserve further ex-
21 amination, including areas related to populations
22 and age groups not adequately addressed by current
23 recommendations.

24 “(c) ROLE OF AGENCY.—The Director shall provide
25 ongoing administrative, research, and technical support

1 for the operations of the Task Force, including coordi-
2 nating and supporting the dissemination of the rec-
3 ommendations of the Task Force, ensuring adequate staff
4 resources, and assistance to those organizations request-
5 ing it for implementation of Guide recommendations.

6 “(d) COORDINATION WITH PREVENTIVE SERVICES
7 TASK FORCE.—The Task Force shall take appropriate
8 steps to coordinate its work with the U.S. Preventive Serv-
9 ices Task Force and the Advisory Committee on Immuni-
10 zation Practices, including the examination of how each
11 task force’s recommendations interact at the nexus of clin-
12 ic and community.

13 “(e) OPERATION.—In carrying out the duties under
14 subsection (b), the Task Force shall not be subject to the
15 provisions of Appendix 2 of title 5, United States Code.

16 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
17 are authorized to be appropriated such sums as may be
18 necessary for each fiscal year to carry out the activities
19 of the Task Force.”.

20 (2) TECHNICAL AMENDMENTS.—

21 (A) Section 399R of the Public Health
22 Service Act (as added by section 2 of the ALS
23 Registry Act (Public Law 110-373; 122 Stat.
24 4047)) is redesignated as section 399S.

1 (B) Section 399R of such Act (as added by
2 section 3 of the Prenatally and Postnatally Di-
3 agnosed Conditions Awareness Act (Public Law
4 110–374; 122 Stat. 4051)) is redesignated as
5 section 399T.

6 **SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN RE-**
7 **GARDING PREVENTIVE BENEFITS.**

8 (a) IN GENERAL.—The Secretary of Health and
9 Human Services (referred to in this section as the “Sec-
10 retary”) shall provide for the planning and implementa-
11 tion of a national public–private partnership for a preven-
12 tion and health promotion outreach and education cam-
13 paign to raise public awareness of health improvement
14 across the life span. Such campaign shall include the dis-
15 semination of information that—

16 (1) describes the importance of utilizing preven-
17 tive services to promote wellness, reduce health dis-
18 parities, and mitigate chronic disease;

19 (2) promotes the use of preventive services rec-
20 ommended by the United States Preventive Services
21 Task Force and the Community Preventive Services
22 Task Force;

23 (3) encourages healthy behaviors linked to the
24 prevention of chronic diseases;

1 (4) explains the preventive services covered
2 under health plans offered through a Gateway;

3 (5) describes additional preventive care sup-
4 ported by the Centers for Disease Control and Pre-
5 vention, the Health Resources and Services Adminis-
6 tration, the Substance Abuse and Mental Health
7 Services Administration, the Advisory Committee on
8 Immunization Practices, and other appropriate agen-
9 cies; and

10 (6) includes general health promotion informa-
11 tion.

12 (b) CONSULTATION.—In coordinating the campaign
13 under subsection (a), the Secretary shall consult with the
14 Institute of Medicine to provide ongoing advice on evi-
15 dence-based scientific information for policy, program de-
16 velopment, and evaluation.

17 (c) MEDIA CAMPAIGN.—

18 (1) IN GENERAL.—Not later than 1 year after
19 the date of enactment of this Act, the Secretary, act-
20 ing through the Director of the Centers for Disease
21 Control and Prevention, shall establish and imple-
22 ment a national science-based media campaign on
23 health promotion and disease prevention.

24 (2) REQUIREMENT OF CAMPAIGN.—The cam-
25 paign implemented under paragraph (1)—

1 (A) shall be designed to address proper nu-
2 trition, regular exercise, smoking cessation, obe-
3 sity reduction, the 5 leading disease killers in
4 the United States, and secondary prevention
5 through disease screening promotion;

6 (B) shall be carried out through competi-
7 tively bid contracts awarded to entities pro-
8 viding for the professional production and de-
9 sign of such campaign;

10 (C) may include the use of television,
11 radio, Internet, and other commercial mar-
12 keting venues and may be targeted to specific
13 age groups based on peer-reviewed social re-
14 search;

15 (D) shall not be duplicative of any other
16 Federal efforts relating to health promotion and
17 disease prevention; and

18 (E) may include the use of humor and na-
19 tionally recognized positive role models.

20 (3) EVALUATION.—The Secretary shall ensure
21 that the campaign implemented under paragraph (1)
22 is subject to an independent evaluation every 2 years
23 and shall report every 2 years to Congress on the ef-
24 fectiveness of such campaigns towards meeting
25 science-based metrics.

1 (d) WEBSITE.—The Secretary, in consultation with
2 private-sector experts, shall maintain or enter into a con-
3 tract to maintain an Internet website to provide science-
4 based information on guidelines for nutrition, regular ex-
5 ercise, obesity reduction, smoking cessation, and specific
6 chronic disease prevention. Such website shall be designed
7 to provide information to health care providers and con-
8 sumers.

9 (e) DISSEMINATION OF INFORMATION THROUGH
10 PROVIDERS.—The Secretary, acting through the Centers
11 for Disease Control and Prevention, shall develop and im-
12 plement a plan for the dissemination of health promotion
13 and disease prevention information consistent with na-
14 tional priorities, to health care providers who participate
15 in Federal programs, including programs administered by
16 the Indian Health Service, the Department of Veterans
17 Affairs, the Department of Defense, and the Health Re-
18 sources and Services Administration, and Medicare and
19 Medicaid.

20 (f) PERSONALIZED PREVENTION PLANS.—

21 (1) CONTRACT.—The Secretary, acting through
22 the Director of the Centers for Disease Control and
23 Prevention, shall enter into a contract with a quali-
24 fied entity for the development and operation of a

1 Federal Internet website personalized prevention
2 plan tool.

3 (2) USE.—The website developed under para-
4 graph (1) shall be designed to be used as a source
5 of the most up-to-date scientific evidence relating to
6 disease prevention for use by individuals. Such
7 website shall contain a component that enables an
8 individual to determine their disease risk (based on
9 personal health and family history, BMI, and other
10 relevant information) relating to the 5 leading dis-
11 eases in the United States, and obtain personalized
12 suggestions for preventing such diseases.

13 (g) INTERNET PORTAL.—The Secretary shall estab-
14 lish an Internet portal for accessing risk-assessment tools
15 developed and maintained by private and academic enti-
16 ties.

17 (h) PRIORITY FUNDING.—Funding for the activities
18 authorized under this section shall take priority over fund-
19 ing provided through the Centers for Disease Control and
20 Prevention for grants to States and other entities for simi-
21 lar purposes and goals as provided for in this section. Not
22 to exceed \$500,000,000 shall be expended on the cam-
23 paigns and activities required under this section.

24 (i) PUBLIC AWARENESS OF PREVENTIVE AND OBE-
25 SITY-RELATED SERVICES.—

1 (1) INFORMATION TO STATES.—The Secretary
2 of Health and Human Services shall provide guid-
3 ance and relevant information to States and health
4 care providers regarding preventive and obesity-re-
5 lated services that are available to Medicaid enroll-
6 ees, including obesity screening and counseling for
7 children and adults.

8 (2) INFORMATION TO ENROLLEES.—Each State
9 shall design a public awareness campaign to educate
10 Medicaid enrollees regarding availability and cov-
11 erage of such services, with the goal of reducing
12 incidences of obesity.

13 (3) REPORT.—Not later than January 1, 2011,
14 and every 3 years thereafter through January 1,
15 2017, the Secretary of Health and Human Services
16 shall report to Congress on the status and effective-
17 ness of efforts under paragraphs (1) and (2), includ-
18 ing summaries of the States' efforts to increase
19 awareness of coverage of obesity-related services.

20 (j) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated such sums as may be
22 necessary to carry out this section.

1 **Subtitle B—Increasing Access to**
2 **Clinical Preventive Services**

3 **SEC. 4101. SCHOOL-BASED HEALTH CENTERS.**

4 (a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-
5 BASED HEALTH CENTERS.—

6 (1) PROGRAM.—The Secretary of Health and
7 Human Services (in this subsection referred to as
8 the “Secretary”) shall establish a program to award
9 grants to eligible entities to support the operation of
10 school-based health centers.

11 (2) ELIGIBILITY.—To be eligible for a grant
12 under this subsection, an entity shall—

13 (A) be a school-based health center or a
14 sponsoring facility of a school-based health cen-
15 ter; and

16 (B) submit an application at such time, in
17 such manner, and containing such information
18 as the Secretary may require, including at a
19 minimum an assurance that funds awarded
20 under the grant shall not be used to provide
21 any service that is not authorized or allowed by
22 Federal, State, or local law.

23 (3) PREFERENCE.—In awarding grants under
24 this section, the Secretary shall give preference to
25 awarding grants for school-based health centers that

1 serve a large population of children eligible for med-
2 ical assistance under the State Medicaid plan under
3 title XIX of the Social Security Act or under a waiv-
4 er of such plan or children eligible for child health
5 assistance under the State child health plan under
6 title XXI of that Act (42 U.S.C. 1397aa et seq.).

7 (4) LIMITATION ON USE OF FUNDS.—An eligi-
8 ble entity shall use funds provided under a grant
9 awarded under this subsection only for expenditures
10 for facilities (including the acquisition or improve-
11 ment of land, or the acquisition, construction, expan-
12 sion, replacement, or other improvement of any
13 building or other facility), equipment, or similar ex-
14 penditures, as specified by the Secretary. No funds
15 provided under a grant awarded under this section
16 shall be used for expenditures for personnel or to
17 provide health services.

18 (5) APPROPRIATIONS.—Out of any funds in the
19 Treasury not otherwise appropriated, there is appro-
20 priated for each of fiscal years 2010 through 2013,
21 \$50,000,000 for the purpose of carrying out this
22 subsection. Funds appropriated under this para-
23 graph shall remain available until expended.

24 (6) DEFINITIONS.—In this subsection, the
25 terms “school-based health center” and “sponsoring

1 facility” have the meanings given those terms in sec-
2 tion 2110(c)(9) of the Social Security Act (42
3 U.S.C. 1397jj(c)(9)).

4 (b) GRANTS FOR THE OPERATION OF SCHOOL-BASED
5 HEALTH CENTERS.—Part Q of title III of the Public
6 Health Service Act (42 U.S.C. 280h et seq.) is amended
7 by adding at the end the following:

8 **“SEC. 399Z-1. SCHOOL-BASED HEALTH CENTERS.**

9 “(a) DEFINITIONS; ESTABLISHMENT OF CRITERIA.—
10 In this section:

11 “(1) COMPREHENSIVE PRIMARY HEALTH SERV-
12 ICES.—The term ‘comprehensive primary health
13 services’ means the core services offered by school-
14 based health centers, which shall include the fol-
15 lowing:

16 “(A) PHYSICAL.—Comprehensive health
17 assessments, diagnosis, and treatment of minor,
18 acute, and chronic medical conditions, and re-
19 ferrals to, and follow-up for, specialty care and
20 oral health services.

21 “(B) MENTAL HEALTH.—Mental health
22 and substance use disorder assessments, crisis
23 intervention, counseling, treatment, and referral
24 to a continuum of services including emergency

1 psychiatric care, community support programs,
2 inpatient care, and outpatient programs.

3 “(2) MEDICALLY UNDERSERVED CHILDREN
4 AND ADOLESCENTS.—

5 “(A) IN GENERAL.—The term ‘medically
6 underserved children and adolescents’ means a
7 population of children and adolescents who are
8 residents of an area designated as a medically
9 underserved area or a health professional short-
10 age area by the Secretary.

11 “(B) CRITERIA.—The Secretary shall pre-
12 scribe criteria for determining the specific
13 shortages of personal health services for medi-
14 cally underserved children and adolescents
15 under subparagraph (A) that shall—

16 “(i) take into account any comments
17 received by the Secretary from the chief
18 executive officer of a State and local offi-
19 cials in a State; and

20 “(ii) include factors indicative of the
21 health status of such children and adoles-
22 cents of an area, including the ability of
23 the residents of such area to pay for health
24 services, the accessibility of such services,
25 the availability of health professionals to

1 such children and adolescents, and other
2 factors as determined appropriate by the
3 Secretary.

4 “(3) SCHOOL-BASED HEALTH CENTER.—The
5 term ‘school-based health center’ means a health
6 clinic that—

7 “(A) meets the definition of a school-based
8 health center under section 2110(c)(9)(A) of
9 the Social Security Act and is administered by
10 a sponsoring facility (as defined in section
11 2110(c)(9)(B) of the Social Security Act);

12 “(B) provides, at a minimum, comprehen-
13 sive primary health services during school hours
14 to children and adolescents by health profes-
15 sionals in accordance with established stand-
16 ards, community practice, reporting laws, and
17 other State laws, including parental consent
18 and notification laws that are not inconsistent
19 with Federal law; and

20 “(C) does not perform abortion services.

21 “(b) AUTHORITY TO AWARD GRANTS.—The Sec-
22 retary shall award grants for the costs of the operation
23 of school-based health centers (referred to in this section
24 as ‘SBHCs’) that meet the requirements of this section.

1 “(c) APPLICATIONS.—To be eligible to receive a grant
2 under this section, an entity shall—

3 “(1) be an SBHC (as defined in subsection
4 (a)(3)); and

5 “(2) submit to the Secretary an application at
6 such time, in such manner, and containing—

7 “(A) evidence that the applicant meets all
8 criteria necessary to be designated an SBHC;

9 “(B) evidence of local need for the services
10 to be provided by the SBHC;

11 “(C) an assurance that—

12 “(i) SBHC services will be provided to
13 those children and adolescents for whom
14 parental or guardian consent has been ob-
15 tained in cooperation with Federal, State,
16 and local laws governing health care serv-
17 ice provision to children and adolescents;

18 “(ii) the SBHC has made and will
19 continue to make every reasonable effort to
20 establish and maintain collaborative rela-
21 tionships with other health care providers
22 in the catchment area of the SBHC;

23 “(iii) the SBHC will provide on-site
24 access during the academic day when
25 school is in session and 24-hour coverage

1 through an on-call system and through its
2 backup health providers to ensure access to
3 services on a year-round basis when the
4 school or the SBHC is closed;

5 “(iv) the SBHC will be integrated into
6 the school environment and will coordinate
7 health services with school personnel, such
8 as administrators, teachers, nurses, coun-
9 selors, and support personnel, as well as
10 with other community providers co-located
11 at the school;

12 “(v) the SBHC sponsoring facility as-
13 sumes all responsibility for the SBHC ad-
14 ministration, operations, and oversight;
15 and

16 “(vi) the SBHC will comply with Fed-
17 eral, State, and local laws concerning pa-
18 tient privacy and student records, includ-
19 ing regulations promulgated under the
20 Health Insurance Portability and Account-
21 ability Act of 1996 and section 444 of the
22 General Education Provisions Act; and

23 “(D) such other information as the Sec-
24 retary may require.

1 “(d) PREFERENCES AND CONSIDERATION.—In re-
2 viewing applications:

3 “(1) The Secretary may give preference to ap-
4 plicants who demonstrate an ability to serve the fol-
5 lowing:

6 “(A) Communities that have evidenced
7 barriers to primary health care and mental
8 health and substance use disorder prevention
9 services for children and adolescents.

10 “(B) Communities with high per capita
11 numbers of children and adolescents who are
12 uninsured, underinsured, or enrolled in public
13 health insurance programs.

14 “(C) Populations of children and adoles-
15 cents that have historically demonstrated dif-
16 ficulty in accessing health and mental health
17 and substance use disorder prevention services.

18 “(2) The Secretary may give consideration to
19 whether an applicant has received a grant under
20 subsection (a) of section 4101 of the Patient Protec-
21 tion and Affordable Care Act.

22 “(e) WAIVER OF REQUIREMENTS.—The Secretary
23 may—

24 “(1) under appropriate circumstances, waive
25 the application of all or part of the requirements of

1 this subsection with respect to an SBHC for not to
2 exceed 2 years; and

3 “(2) upon a showing of good cause, waive the
4 requirement that the SBHC provide all required
5 comprehensive primary health services for a des-
6 ignated period of time to be determined by the Sec-
7 retary.

8 “(f) USE OF FUNDS.—

9 “(1) FUNDS.—Funds awarded under a grant
10 under this section—

11 “(A) may be used for—

12 “(i) acquiring and leasing equipment
13 (including the costs of amortizing the prin-
14 ciple of, and paying interest on, loans for
15 such equipment);

16 “(ii) providing training related to the
17 provision of required comprehensive pri-
18 mary health services and additional health
19 services;

20 “(iii) the management and operation
21 of health center programs;

22 “(iv) the payment of salaries for phy-
23 sicians, nurses, and other personnel of the
24 SBHC; and

25 “(B) may not be used to provide abortions.

1 “(2) CONSTRUCTION.—The Secretary may
2 award grants which may be used to pay the costs as-
3 sociated with expanding and modernizing existing
4 buildings for use as an SBHC, including the pur-
5 chase of trailers or manufactured buildings to install
6 on the school property.

7 “(3) LIMITATIONS.—

8 “(A) IN GENERAL.—Any provider of serv-
9 ices that is determined by a State to be in viola-
10 tion of a State law described in subsection
11 (a)(3)(B) with respect to activities carried out
12 at a SBHC shall not be eligible to receive addi-
13 tional funding under this section.

14 “(B) NO OVERLAPPING GRANT PERIOD.—
15 No entity that has received funding under sec-
16 tion 330 for a grant period shall be eligible for
17 a grant under this section for with respect to
18 the same grant period.

19 “(g) MATCHING REQUIREMENT.—

20 “(1) IN GENERAL.—Each eligible entity that re-
21 ceives a grant under this section shall provide, from
22 non-Federal sources, an amount equal to 20 percent
23 of the amount of the grant (which may be provided
24 in cash or in-kind) to carry out the activities sup-
25 ported by the grant.

1 “(2) WAIVER.—The Secretary may waive all or
2 part of the matching requirement described in para-
3 graph (1) for any fiscal year for the SBHC if the
4 Secretary determines that applying the matching re-
5 quirement to the SBHC would result in serious
6 hardship or an inability to carry out the purposes of
7 this section.

8 “(h) SUPPLEMENT, NOT SUPPLANT.—Grant funds
9 provided under this section shall be used to supplement,
10 not supplant, other Federal or State funds.

11 “(i) EVALUATION.—The Secretary shall develop and
12 implement a plan for evaluating SBHCs and monitoring
13 quality performance under the awards made under this
14 section.

15 “(j) AGE APPROPRIATE SERVICES.—An eligible enti-
16 ty receiving funds under this section shall only provide age
17 appropriate services through a SBHC funded under this
18 section to an individual.

19 “(k) PARENTAL CONSENT.—An eligible entity receiv-
20 ing funds under this section shall not provide services
21 through a SBHC funded under this section to an indi-
22 vidual without the consent of the parent or guardian of
23 such individual if such individual is considered a minor
24 under applicable State law.

1 “(b) ELIGIBILITY.—To be eligible for a grant under
2 this section, an entity shall—

3 “(1) be a community-based provider of dental
4 services (as defined by the Secretary), including a
5 Federally-qualified health center, a clinic of a hos-
6 pital owned or operated by a State (or by an instru-
7 mentality or a unit of government within a State),
8 a State or local department of health, a dental pro-
9 gram of the Indian Health Service, an Indian tribe
10 or tribal organization, or an urban Indian organiza-
11 tion (as such terms are defined in section 4 of the
12 Indian Health Care Improvement Act), a health sys-
13 tem provider, a private provider of dental services,
14 medical, dental, public health, nursing, nutrition
15 educational institutions, or national organizations in-
16 volved in improving children’s oral health; and

17 “(2) submit to the Secretary an application at
18 such time, in such manner, and containing such in-
19 formation as the Secretary may require.

20 “(c) USE OF FUNDS.—A grantee shall use amounts
21 received under a grant under this section to demonstrate
22 the effectiveness of research-based dental caries disease
23 management activities.

24 “(d) USE OF INFORMATION.—The Secretary shall
25 utilize information generated from grantees under this

1 section in planning and implementing the public education
2 campaign under section 399LL.

3 **“SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS.**

4 “There is authorized to be appropriated to carry out
5 this part, such sums as may be necessary.”.

6 (b) SCHOOL-BASED SEALANT PROGRAMS.—Section
7 317M(e)(1) of the Public Health Service Act (42 U.S.C.
8 247b-14(c)(1)) is amended by striking “may award grants
9 to States and Indian tribes” and inserting “shall award
10 a grant to each of the 50 States and territories and to
11 Indians, Indian tribes, tribal organizations and urban In-
12 dian organizations (as such terms are defined in section
13 4 of the Indian Health Care Improvement Act)”.

14 (c) ORAL HEALTH INFRASTRUCTURE.—Section
15 317M of the Public Health Service Act (42 U.S.C. 247b-
16 14) is amended—

17 (1) by redesignating subsections (d) and (e) as
18 subsections (e) and (f), respectively; and

19 (2) by inserting after subsection (c), the fol-
20 lowing:

21 “(d) ORAL HEALTH INFRASTRUCTURE.—

22 “(1) COOPERATIVE AGREEMENTS.—The Sec-
23 retary, acting through the Director of the Centers
24 for Disease Control and Prevention, shall enter into
25 cooperative agreements with State, territorial, and

1 Indian tribes or tribal organizations (as those terms
2 are defined in section 4 of the Indian Health Care
3 Improvement Act) to establish oral health leadership
4 and program guidance, oral health data collection
5 and interpretation, (including determinants of poor
6 oral health among vulnerable populations), a multi-
7 dimensional delivery system for oral health, and to
8 implement science-based programs (including dental
9 sealants and community water fluoridation) to im-
10 prove oral health.

11 “(2) AUTHORIZATION OF APPROPRIATIONS.—

12 There is authorized to be appropriated such sums as
13 necessary to carry out this subsection for fiscal years
14 2010 through 2014.”.

15 (d) UPDATING NATIONAL ORAL HEALTHCARE SUR-
16 VEILLANCE ACTIVITIES.—

17 (1) PRAMS.—

18 (A) IN GENERAL.—The Secretary of
19 Health and Human Services (referred to in this
20 subsection as the “Secretary”) shall carry out
21 activities to update and improve the Pregnancy
22 Risk Assessment Monitoring System (referred
23 to in this section as “PRAMS”) as it relates to
24 oral healthcare.

1 (B) STATE REPORTS AND MANDATORY
2 MEASUREMENTS.—

3 (i) IN GENERAL.—Not later than 5
4 years after the date of enactment of this
5 Act, and every 5 years thereafter, a State
6 shall submit to the Secretary a report con-
7 cerning activities conducted within the
8 State under PRAMS.

9 (ii) MEASUREMENTS.—The oral
10 healthcare measurements developed by the
11 Secretary for use under PRAMS shall be
12 mandatory with respect to States for pur-
13 poses of the State reports under clause (i).

14 (C) FUNDING.—There is authorized to be
15 appropriated to carry out this paragraph, such
16 sums as may be necessary.

17 (2) NATIONAL HEALTH AND NUTRITION EXAM-
18 INATION SURVEY.—The Secretary shall develop oral
19 healthcare components that shall include tooth-level
20 surveillance for inclusion in the National Health and
21 Nutrition Examination Survey. Such components
22 shall be updated by the Secretary at least every 6
23 years. For purposes of this paragraph, the term
24 “tooth-level surveillance” means a clinical examina-
25 tion where an examiner looks at each dental surface,

1 on each tooth in the mouth and as expanded by the
2 Division of Oral Health of the Centers for Disease
3 Control and Prevention.

4 (3) MEDICAL EXPENDITURES PANEL SURVEY.—
5 The Secretary shall ensure that the Medical Expend-
6 itures Panel Survey by the Agency for Healthcare
7 Research and Quality includes the verification of
8 dental utilization, expenditure, and coverage findings
9 through conduct of a look-back analysis.

10 (4) NATIONAL ORAL HEALTH SURVEILLANCE
11 SYSTEM.—

12 (A) APPROPRIATIONS.—There is author-
13 ized to be appropriated, such sums as may be
14 necessary for each of fiscal years 2010 through
15 2014 to increase the participation of States in
16 the National Oral Health Surveillance System
17 from 16 States to all 50 States, territories, and
18 District of Columbia.

19 (B) REQUIREMENTS.—The Secretary shall
20 ensure that the National Oral Health Surveil-
21 lance System include the measurement of early
22 childhood caries.

1 **SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS**
2 **VISIT PROVIDING A PERSONALIZED PREVEN-**
3 **TION PLAN.**

4 (a) **COVERAGE OF PERSONALIZED PREVENTION**
5 **PLAN SERVICES.—**

6 (1) **IN GENERAL.—**Section 1861(s)(2) of the
7 Social Security Act (42 U.S.C. 1395x(s)(2)) is
8 amended—

9 (A) in subparagraph (DD), by striking
10 “and” at the end;

11 (B) in subparagraph (EE), by adding
12 “and” at the end; and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(FF) personalized prevention plan services (as
16 defined in subsection (hhh));”.

17 (2) **CONFORMING AMENDMENTS.—**Clauses (i)
18 and (ii) of section 1861(s)(2)(K) of the Social Secu-
19 rity Act (42 U.S.C. 1395x(s)(2)(K)) are each
20 amended by striking “subsection (ww)(1)” and in-
21 serting “subsections (ww)(1) and (hhh)”.

22 (b) **PERSONALIZED PREVENTION PLAN SERVICES**
23 **DEFINED.—**Section 1861 of the Social Security Act (42
24 U.S.C. 1395x) is amended by adding at the end the fol-
25 lowing new subsection:

1 “Annual Wellness Visit

2 “(hhh)(1) The term ‘personalized prevention plan
3 services’ means the creation of a plan for an individual—

4 “(A) that includes a health risk assessment
5 (that meets the guidelines established by the Sec-
6 retary under paragraph (4)(A)) of the individual
7 that is completed prior to or as part of the same
8 visit with a health professional described in para-
9 graph (3); and

10 “(B) that—

11 “(i) takes into account the results of the
12 health risk assessment; and

13 “(ii) may contain the elements described in
14 paragraph (2).

15 “(2) Subject to paragraph (4)(H), the elements de-
16 scribed in this paragraph are the following:

17 “(A) The establishment of, or an update to, the
18 individual’s medical and family history.

19 “(B) A list of current providers and suppliers
20 that are regularly involved in providing medical care
21 to the individual (including a list of all prescribed
22 medications).

23 “(C) A measurement of height, weight, body
24 mass index (or waist circumference, if appropriate),
25 blood pressure, and other routine measurements.

1 “(D) Detection of any cognitive impairment.

2 “(E) The establishment of, or an update to, the
3 following:

4 “(i) A screening schedule for the next 5 to
5 10 years, as appropriate, based on rec-
6 ommendations of the United States Preventive
7 Services Task Force and the Advisory Com-
8 mittee on Immunization Practices, and the indi-
9 vidual’s health status, screening history, and
10 age-appropriate preventive services covered
11 under this title.

12 “(ii) A list of risk factors and conditions
13 for which primary, secondary, or tertiary pre-
14 vention interventions are recommended or are
15 underway, including any mental health condi-
16 tions or any such risk factors or conditions that
17 have been identified through an initial preven-
18 tive physical examination (as described under
19 subsection (ww)(1)), and a list of treatment op-
20 tions and their associated risks and benefits.

21 “(F) The furnishing of personalized health ad-
22 vice and a referral, as appropriate, to health edu-
23 cation or preventive counseling services or programs
24 aimed at reducing identified risk factors and improv-
25 ing self-management, or community-based lifestyle

1 interventions to reduce health risks and promote
2 self-management and wellness, including weight loss,
3 physical activity, smoking cessation, fall prevention,
4 and nutrition.

5 “(G) Any other element determined appropriate
6 by the Secretary.

7 “(3) A health professional described in this para-
8 graph is—

9 “(A) a physician;

10 “(B) a practitioner described in clause (i) of
11 section 1842(b)(18)(C); or

12 “(C) a medical professional (including a health
13 educator, registered dietitian, or nutrition profes-
14 sional) or a team of medical professionals, as deter-
15 mined appropriate by the Secretary, under the su-
16 pervision of a physician.

17 “(4)(A) For purposes of paragraph (1)(A), the Sec-
18 retary, not later than 1 year after the date of enactment
19 of this subsection, shall establish publicly available guide-
20 lines for health risk assessments. Such guidelines shall be
21 developed in consultation with relevant groups and entities
22 and shall provide that a health risk assessment—

23 “(i) identify chronic diseases, injury risks,
24 modifiable risk factors, and urgent health needs of
25 the individual; and

1 “(ii) may be furnished—

2 “(I) through an interactive telephonic or
3 web-based program that meets the standards
4 established under subparagraph (B);

5 “(II) during an encounter with a health
6 care professional;

7 “(III) through community-based preven-
8 tion programs; or

9 “(IV) through any other means the Sec-
10 retary determines appropriate to maximize ac-
11 cessibility and ease of use by beneficiaries, while
12 ensuring the privacy of such beneficiaries.

13 “(B) Not later than 1 year after the date of enact-
14 ment of this subsection, the Secretary shall establish
15 standards for interactive telephonic or web-based pro-
16 grams used to furnish health risk assessments under sub-
17 paragraph (A)(ii)(I). The Secretary may utilize any health
18 risk assessment developed under section 4004(f) of the
19 Patient Protection and Affordable Care Act as part of the
20 requirement to develop a personalized prevention plan to
21 comply with this subparagraph.

22 “(C)(i) Not later than 18 months after the date of
23 enactment of this subsection, the Secretary shall develop
24 and make available to the public a health risk assessment
25 model. Such model shall meet the guidelines under sub-

1 paragraph (A) and may be used to meet the requirement
2 under paragraph (1)(A).

3 “(ii) Any health risk assessment that meets the
4 guidelines under subparagraph (A) and is approved by the
5 Secretary may be used to meet the requirement under
6 paragraph (1)(A).

7 “(D) The Secretary may coordinate with community-
8 based entities (including State Health Insurance Pro-
9 grams, Area Agencies on Aging, Aging and Disability Re-
10 source Centers, and the Administration on Aging) to—

11 “(i) ensure that health risk assessments are ac-
12 cessible to beneficiaries; and

13 “(ii) provide appropriate support for the com-
14 pletion of health risk assessments by beneficiaries.

15 “(E) The Secretary shall establish procedures to
16 make beneficiaries and providers aware of the requirement
17 that a beneficiary complete a health risk assessment prior
18 to or at the same time as receiving personalized prevention
19 plan services.

20 “(F) To the extent practicable, the Secretary shall
21 encourage the use of, integration with, and coordination
22 of health information technology (including use of tech-
23 nology that is compatible with electronic medical records
24 and personal health records) and may experiment with the
25 use of personalized technology to aid in the development

1 of self-management skills and management of and adher-
2 ence to provider recommendations in order to improve the
3 health status of beneficiaries.

4 “(G)(i) A beneficiary shall only be eligible to receive
5 an initial preventive physical examination (as defined
6 under subsection (ww)(1)) at any time during the 12-
7 month period after the date that the beneficiary’s coverage
8 begins under part B and shall be eligible to receive person-
9 alized prevention plan services under this subsection pro-
10 vided that the beneficiary has not received such services
11 within the preceding 12-month period.

12 “(ii) The Secretary shall establish procedures to
13 make beneficiaries aware of the option to select an initial
14 preventive physical examination or personalized prevention
15 plan services during the period of 12 months after the date
16 that a beneficiary’s coverage begins under part B, which
17 shall include information regarding any relevant dif-
18 ferences between such services.

19 “(H) The Secretary shall issue guidance that—

20 “(i) identifies elements under paragraph (2)
21 that are required to be provided to a beneficiary as
22 part of their first visit for personalized prevention
23 plan services; and

24 “(ii) establishes a yearly schedule for appro-
25 priate provision of such elements thereafter.”.

1 (c) PAYMENT AND ELIMINATION OF COST-SHAR-
2 ING.—

3 (1) PAYMENT AND ELIMINATION OF COINSUR-
4 ANCE.—Section 1833(a)(1) of the Social Security
5 Act (42 U.S.C. 1395l(a)(1)) is amended—

6 (A) in subparagraph (N), by inserting
7 “other than personalized prevention plan serv-
8 ices (as defined in section 1861(hhh)(1))” after
9 “(as defined in section 1848(j)(3))”;

10 (B) by striking “and” before “(W)”; and

11 (C) by inserting before the semicolon at
12 the end the following: “, and (X) with respect
13 to personalized prevention plan services (as de-
14 fined in section 1861(hhh)(1)), the amount paid
15 shall be 100 percent of the lesser of the actual
16 charge for the services or the amount deter-
17 mined under the payment basis determined
18 under section 1848”.

19 (2) PAYMENT UNDER PHYSICIAN FEE SCHED-
20 ULE.—Section 1848(j)(3) of the Social Security Act
21 (42 U.S.C. 1395w-4(j)(3)) is amended by inserting
22 “(2)(FF) (including administration of the health
23 risk assessment) ,” after “(2)(EE),”.

24 (3) ELIMINATION OF COINSURANCE IN OUT-
25 PATIENT HOSPITAL SETTINGS.—

1 (A) EXCLUSION FROM OPD FEE SCHED-
2 ULE.—Section 1833(t)(1)(B)(iv) of the Social
3 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
4 amended by striking “and diagnostic mammog-
5 raphy” and inserting “, diagnostic mammog-
6 raphy, or personalized prevention plan services
7 (as defined in section 1861(hhh)(1))”.

8 (B) CONFORMING AMENDMENTS.—Section
9 1833(a)(2) of the Social Security Act (42
10 U.S.C. 1395l(a)(2)) is amended—

11 (i) in subparagraph (F), by striking
12 “and” at the end;

13 (ii) in subparagraph (G)(ii), by strik-
14 ing the comma at the end and inserting “;
15 and”; and

16 (iii) by inserting after subparagraph
17 (G)(ii) the following new subparagraph:

18 “(H) with respect to personalized preven-
19 tion plan services (as defined in section
20 1861(hhh)(1)) furnished by an outpatient de-
21 partment of a hospital, the amount determined
22 under paragraph (1)(X),”.

23 (4) WAIVER OF APPLICATION OF DEDUCT-
24 IBLE.—The first sentence of section 1833(b) of the

1 Social Security Act (42 U.S.C. 1395l(b)) is amend-
2 ed—

3 (A) by striking “and” before “(9)”; and

4 (B) by inserting before the period the fol-
5 lowing: “, and (10) such deductible shall not
6 apply with respect to personalized prevention
7 plan services (as defined in section
8 1861(hhh)(1))”.

9 (d) FREQUENCY LIMITATION.—Section 1862(a) of
10 the Social Security Act (42 U.S.C. 1395y(a)) is amend-
11 ed—

12 (1) in paragraph (1)—

13 (A) in subparagraph (N), by striking
14 “and” at the end;

15 (B) in subparagraph (O), by striking the
16 semicolon at the end and inserting “, and”; and

17 (C) by adding at the end the following new
18 subparagraph:

19 “(P) in the case of personalized prevention plan
20 services (as defined in section 1861(hhh)(1)), which
21 are performed more frequently than is covered under
22 such section;”; and

23 (2) in paragraph (7), by striking “or (K)” and
24 inserting “(K), or (P)”.

1 (e) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 2011.

4 **SEC. 4104. REMOVAL OF BARRIERS TO PREVENTIVE SERV-**
5 **ICES IN MEDICARE.**

6 (a) DEFINITION OF PREVENTIVE SERVICES.—Sec-
7 tion 1861(ddd) of the Social Security Act (42 U.S.C.
8 1395x(ddd)) is amended—

9 (1) in the heading, by inserting “; Preventive
10 Services” after “Services”;

11 (2) in paragraph (1), by striking “not otherwise
12 described in this title” and inserting “not described
13 in subparagraph (A) or (C) of paragraph (3)”; and

14 (3) by adding at the end the following new
15 paragraph:

16 “(3) The term ‘preventive services’ means the fol-
17 lowing:

18 “(A) The screening and preventive services de-
19 scribed in subsection (ww)(2) (other than the service
20 described in subparagraph (M) of such subsection).

21 “(B) An initial preventive physical examination
22 (as defined in subsection (ww)).

23 “(C) Personalized prevention plan services (as
24 defined in subsection (hhh)(1)).”.

25 (b) COINSURANCE.—

1 (1) GENERAL APPLICATION.—

2 (A) IN GENERAL.—Section 1833(a)(1) of
3 the Social Security Act (42 U.S.C.
4 1395l(a)(1)), as amended by section 4103(c)(1),
5 is amended—

6 (i) in subparagraph (T), by inserting
7 “(or 100 percent if such services are rec-
8 ommended with a grade of A or B by the
9 United States Preventive Services Task
10 Force for any indication or population and
11 are appropriate for the individual)” after
12 “80 percent”;

13 (ii) in subparagraph (W)—

14 (I) in clause (i), by inserting “(if
15 such subparagraph were applied, by
16 substituting ‘100 percent’ for ‘80 per-
17 cent’)” after “subparagraph (D)”;
18 and

19 (II) in clause (ii), by striking “80
20 percent” and inserting “100 percent”;

21 (iii) by striking “and” before “(X)”;

22 and

23 (iv) by inserting before the semicolon
24 at the end the following: “, and (Y) with
25 respect to preventive services described in

1 subparagraphs (A) and (B) of section
2 1861(ddd)(3) that are appropriate for the
3 individual and, in the case of such services
4 described in subparagraph (A), are rec-
5 ommended with a grade of A or B by the
6 United States Preventive Services Task
7 Force for any indication or population, the
8 amount paid shall be 100 percent of the
9 lesser of the actual charge for the services
10 or the amount determined under the fee
11 schedule that applies to such services
12 under this part”.

13 (2) ELIMINATION OF COINSURANCE IN OUT-
14 PATIENT HOSPITAL SETTINGS.—

15 (A) EXCLUSION FROM OPD FEE SCHED-
16 ULE.—Section 1833(t)(1)(B)(iv) of the Social
17 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as
18 amended by section 4103(c)(3)(A), is amend-
19 ed—

20 (i) by striking “or” before “personal-
21 ized prevention plan services”; and

22 (ii) by inserting before the period the
23 following: “, or preventive services de-
24 scribed in subparagraphs (A) and (B) of
25 section 1861(ddd)(3) that are appropriate

1 for the individual and, in the case of such
2 services described in subparagraph (A), are
3 recommended with a grade of A or B by
4 the United States Preventive Services Task
5 Force for any indication or population”.

6 (B) CONFORMING AMENDMENTS.—Section
7 1833(a)(2) of the Social Security Act (42
8 U.S.C. 1395l(a)(2)), as amended by section
9 4103(c)(3)(B), is amended—

10 (i) in subparagraph (G)(ii), by strik-
11 ing “and” after the semicolon at the end;

12 (ii) in subparagraph (H), by striking
13 the comma at the end and inserting “;
14 and”; and

15 (iii) by inserting after subparagraph
16 (H) the following new subparagraph:

17 “(I) with respect to preventive services de-
18 scribed in subparagraphs (A) and (B) of section
19 1861(ddd)(3) that are appropriate for the indi-
20 vidual and are furnished by an outpatient de-
21 partment of a hospital and, in the case of such
22 services described in subparagraph (A), are rec-
23 ommended with a grade of A or B by the
24 United States Preventive Services Task Force
25 for any indication or population, the amount

1 determined under paragraph (1)(W) or
2 (1)(Y),”.

3 (c) WAIVER OF APPLICATION OF DEDUCTIBLE FOR
4 PREVENTIVE SERVICES AND COLORECTAL CANCER
5 SCREENING TESTS.—Section 1833(b) of the Social Secu-
6 rity Act (42 U.S.C. 1395l(b)), as amended by section
7 4103(c)(4), is amended—

8 (1) in paragraph (1), by striking “items and
9 services described in section 1861(s)(10)(A)” and in-
10 serting “preventive services described in subpara-
11 graph (A) of section 1861(ddd)(3) that are rec-
12 ommended with a grade of A or B by the United
13 States Preventive Services Task Force for any indi-
14 cation or population and are appropriate for the in-
15 dividual.”; and

16 (2) by adding at the end the following new sen-
17 tence: “Paragraph (1) of the first sentence of this
18 subsection shall apply with respect to a colorectal
19 cancer screening test regardless of the code that is
20 billed for the establishment of a diagnosis as a result
21 of the test, or for the removal of tissue or other mat-
22 ter or other procedure that is furnished in connec-
23 tion with, as a result of, and in the same clinical en-
24 counter as the screening test.”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to items and services furnished on
3 or after January 1, 2011.

4 **SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE**
5 **SERVICES IN MEDICARE.**

6 (a) AUTHORITY TO MODIFY OR ELIMINATE COV-
7 ERAGE OF CERTAIN PREVENTIVE SERVICES.—Section
8 1834 of the Social Security Act (42 U.S.C. 1395m) is
9 amended by adding at the end the following new sub-
10 section:

11 “(n) AUTHORITY TO MODIFY OR ELIMINATE COV-
12 ERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwith-
13 standing any other provision of this title, effective begin-
14 ning on January 1, 2010, if the Secretary determines ap-
15 propriate, the Secretary may—

16 “(1) modify—

17 “(A) the coverage of any preventive service
18 described in subparagraph (A) of section
19 1861(ddd)(3) to the extent that such modifica-
20 tion is consistent with the recommendations of
21 the United States Preventive Services Task
22 Force; and

23 “(B) the services included in the initial
24 preventive physical examination described in
25 subparagraph (B) of such section; and

1 “(2) provide that no payment shall be made
2 under this title for a preventive service described in
3 subparagraph (A) of such section that has not re-
4 ceived a grade of A, B, C, or I by such Task
5 Force.”.

6 (b) CONSTRUCTION.—Nothing in the amendment
7 made by paragraph (1) shall be construed to affect the
8 coverage of diagnostic or treatment services under title
9 XVIII of the Social Security Act.

10 **SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES**
11 **FOR ELIGIBLE ADULTS IN MEDICAID.**

12 (a) CLARIFICATION OF INCLUSION OF SERVICES.—
13 Section 1905(a)(13) of the Social Security Act (42 U.S.C.
14 1396d(a)(13)) is amended to read as follows:

15 “(13) other diagnostic, screening, preventive,
16 and rehabilitative services, including—

17 “(A) any clinical preventive services that
18 are assigned a grade of A or B by the United
19 States Preventive Services Task Force;

20 “(B) with respect to an adult individual,
21 approved vaccines recommended by the Advi-
22 sory Committee on Immunization Practices (an
23 advisory committee established by the Sec-
24 retary, acting through the Director of the Cen-

1 ters for Disease Control and Prevention) and
2 their administration; and

3 “(C) any medical or remedial services (pro-
4 vided in a facility, a home, or other setting) rec-
5 ommended by a physician or other licensed
6 practitioner of the healing arts within the scope
7 of their practice under State law, for the max-
8 imum reduction of physical or mental disability
9 and restoration of an individual to the best pos-
10 sible functional level;”.

11 (b) INCREASED FMAP.—Section 1905(b) of the So-
12 cial Security Act (42 U.S.C. 1396d(b)), as amended by
13 sections 2001(a)(3)(A) and 2004(c)(1), is amended in the
14 first sentence—

15 (1) by striking “, and (4)” and inserting “,
16 (4)”;

17 (2) by inserting before the period the following:
18 “, and (5) in the case of a State that provides med-
19 ical assistance for services and vaccines described in
20 subparagraphs (A) and (B) of subsection (a)(13),
21 and prohibits cost-sharing for such services and vac-
22 cines, the Federal medical assistance percentage, as
23 determined under this subsection and subsection (y)
24 (without regard to paragraph (1)(C) of such sub-
25 section), shall be increased by 1 percentage point

1 with respect to medical assistance for such services
2 and vaccines and for items and services described in
3 subsection (a)(4)(D)”.

4 (c) EFFECTIVE DATE.—The amendments made
5 under this section shall take effect on January 1, 2013.

6 **SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CES-**
7 **SATION SERVICES FOR PREGNANT WOMEN IN**
8 **MEDICAID.**

9 (a) REQUIRING COVERAGE OF COUNSELING AND
10 PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE
11 BY PREGNANT WOMEN.—Section 1905 of the Social Secu-
12 rity Act (42 U.S.C. 1396d), as amended by sections
13 2001(a)(3)(B) and 2303, is further amended—

14 (1) in subsection (a)(4)—

15 (A) by striking “and” before “(C)”; and

16 (B) by inserting before the semicolon at
17 the end the following new subparagraph: “; and
18 (D) counseling and pharmacotherapy for ces-
19 sation of tobacco use by pregnant women (as
20 defined in subsection (bb))”; and

21 (2) by adding at the end the following:

22 “(bb)(1) For purposes of this title, the term ‘coun-
23 seling and pharmacotherapy for cessation of tobacco use
24 by pregnant women’ means diagnostic, therapy, and coun-
25 seling services and pharmacotherapy (including the cov-

1 erage of prescription and nonprescription tobacco ces-
2 sation agents approved by the Food and Drug Administra-
3 tion) for cessation of tobacco use by pregnant women who
4 use tobacco products or who are being treated for tobacco
5 use that is furnished—

6 “(A) by or under the supervision of a physician;

7 or

8 “(B) by any other health care professional
9 who—

10 “(i) is legally authorized to furnish such
11 services under State law (or the State regu-
12 latory mechanism provided by State law) of the
13 State in which the services are furnished; and

14 “(ii) is authorized to receive payment for
15 other services under this title or is designated
16 by the Secretary for this purpose.

17 “(2) Subject to paragraph (3), such term is limited
18 to—

19 “(A) services recommended with respect to
20 pregnant women in ‘Treating Tobacco Use and De-
21 pendence: 2008 Update: A Clinical Practice Guide-
22 line’, published by the Public Health Service in May
23 2008, or any subsequent modification of such Guide-
24 line; and

1 “(B) such other services that the Secretary rec-
2 ognizes to be effective for cessation of tobacco use
3 by pregnant women.

4 “(3) Such term shall not include coverage for drugs
5 or biologicals that are not otherwise covered under this
6 title.”.

7 (b) EXCEPTION FROM OPTIONAL RESTRICTION
8 UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—
9 Section 1927(d)(2)(F) of the Social Security Act (42
10 U.S.C. 1396r-8(d)(2)(F)), as redesignated by section
11 2502(a), is amended by inserting before the period at the
12 end the following: “, except, in the case of pregnant
13 women when recommended in accordance with the Guide-
14 line referred to in section 1905(bb)(2)(A), agents ap-
15 proved by the Food and Drug Administration under the
16 over-the-counter monograph process for purposes of pro-
17 moting, and when used to promote, tobacco cessation”.

18 (c) REMOVAL OF COST-SHARING FOR COUNSELING
19 AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO
20 USE BY PREGNANT WOMEN.—

21 (1) GENERAL COST-SHARING LIMITATIONS.—
22 Section 1916 of the Social Security Act (42 U.S.C.
23 1396o) is amended in each of subsections (a)(2)(B)
24 and (b)(2)(B) by inserting “, and counseling and
25 pharmacotherapy for cessation of tobacco use by

1 pregnant women (as defined in section 1905(bb))
2 and covered outpatient drugs (as defined in sub-
3 section (k)(2) of section 1927 and including non-
4 prescription drugs described in subsection (d)(2) of
5 such section) that are prescribed for purposes of
6 promoting, and when used to promote, tobacco ces-
7 sation by pregnant women in accordance with the
8 Guideline referred to in section 1905(bb)(2)(A)”
9 after “complicate the pregnancy”.

10 (2) APPLICATION TO ALTERNATIVE COST-SHAR-
11 ING.—Section 1916A(b)(3)(B)(iii) of such Act (42
12 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by insert-
13 ing “, and counseling and pharmacotherapy for ces-
14 sation of tobacco use by pregnant women (as defined
15 in section 1905(bb))” after “complicate the preg-
16 nancy”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section shall take effect on October 1, 2010.

19 **SEC. 4108. INCENTIVES FOR PREVENTION OF CHRONIC DIS-**
20 **EASES IN MEDICAID.**

21 (a) INITIATIVES.—

22 (1) ESTABLISHMENT.—

23 (A) IN GENERAL.—The Secretary shall
24 award grants to States to carry out initiatives

1 to provide incentives to Medicaid beneficiaries
2 who—

3 (i) successfully participate in a pro-
4 gram described in paragraph (3); and

5 (ii) upon completion of such participa-
6 tion, demonstrate changes in health risk
7 and outcomes, including the adoption and
8 maintenance of healthy behaviors by meet-
9 ing specific targets (as described in sub-
10 section (c)(2)).

11 (B) PURPOSE.—The purpose of the initia-
12 tives under this section is to test approaches
13 that may encourage behavior modification and
14 determine scalable solutions.

15 (2) DURATION.—

16 (A) INITIATION OF PROGRAM; RE-
17 SOURCES.—The Secretary shall awards grants
18 to States beginning on January 1, 2011, or be-
19 ginning on the date on which the Secretary de-
20 velops program criteria, whichever is earlier.
21 The Secretary shall develop program criteria for
22 initiatives under this section using relevant evi-
23 dence-based research and resources, including
24 the Guide to Community Preventive Services,
25 the Guide to Clinical Preventive Services, and

1 the National Registry of Evidence-Based Pro-
2 grams and Practices.

3 (B) DURATION OF PROGRAM.—A State
4 awarded a grant to carry out initiatives under
5 this section shall carry out such initiatives with-
6 in the 5-year period beginning on January 1,
7 2011, or beginning on the date on which the
8 Secretary develops program criteria, whichever
9 is earlier. Initiatives under this section shall be
10 carried out by a State for a period of not less
11 than 3 years.

12 (3) PROGRAM DESCRIBED.—

13 (A) IN GENERAL.—A program described in
14 this paragraph is a comprehensive, evidence-
15 based, widely available, and easily accessible
16 program, proposed by the State and approved
17 by the Secretary, that is designed and uniquely
18 suited to address the needs of Medicaid bene-
19 ficiaries and has demonstrated success in help-
20 ing individuals achieve one or more of the fol-
21 lowing:

- 22 (i) Ceasing use of tobacco products.
23 (ii) Controlling or reducing their
24 weight.
25 (iii) Lowering their cholesterol.

1 (iv) Lowering their blood pressure.

2 (v) Avoiding the onset of diabetes or,
3 in the case of a diabetic, improving the
4 management of that condition.

5 (B) CO-MORBIDITIES.—A program under
6 this section may also address co-morbidities (in-
7 cluding depression) that are related to any of
8 the conditions described in subparagraph (A).

9 (C) WAIVER AUTHORITY.—The Secretary
10 may waive the requirements of section
11 1902(a)(1) (relating to statewideness) of the
12 Social Security Act for a State awarded a grant
13 to conduct an initiative under this section and
14 shall ensure that a State makes any program
15 described in subparagraph (A) available and ac-
16 cessible to Medicaid beneficiaries.

17 (D) FLEXIBILITY IN IMPLEMENTATION.—
18 A State may enter into arrangements with pro-
19 viders participating in Medicaid, community-
20 based organizations, faith-based organizations,
21 public-private partnerships, Indian tribes, or
22 similar entities or organizations to carry out
23 programs described in subparagraph (A).

24 (4) APPLICATION.—Following the development
25 of program criteria by the Secretary, a State may

1 submit an application, in such manner and con-
2 taining such information as the Secretary may re-
3 quire, that shall include a proposal for programs de-
4 scribed in paragraph (3)(A) and a plan to make
5 Medicaid beneficiaries and providers participating in
6 Medicaid who reside in the State aware and in-
7 formed about such programs.

8 (b) EDUCATION AND OUTREACH CAMPAIGN.—

9 (1) STATE AWARENESS.—The Secretary shall
10 conduct an outreach and education campaign to
11 make States aware of the grants under this section.

12 (2) PROVIDER AND BENEFICIARY EDU-
13 CATION.—A State awarded a grant to conduct an
14 initiative under this section shall conduct an out-
15 reach and education campaign to make Medicaid
16 beneficiaries and providers participating in Medicaid
17 who reside in the State aware of the programs de-
18 scribed in subsection (a)(3) that are to be carried
19 out by the State under the grant.

20 (c) IMPACT.—A State awarded a grant to conduct an
21 initiative under this section shall develop and implement
22 a system to—

23 (1) track Medicaid beneficiary participation in
24 the program and validate changes in health risk and
25 outcomes with clinical data, including the adoption

1 and maintenance of health behaviors by such bene-
2 ficiaries;

3 (2) to the extent practicable, establish stand-
4 ards and health status targets for Medicaid bene-
5 ficiaries participating in the program and measure
6 the degree to which such standards and targets are
7 met;

8 (3) evaluate the effectiveness of the program
9 and provide the Secretary with such evaluations;

10 (4) report to the Secretary on processes that
11 have been developed and lessons learned from the
12 program; and

13 (5) report on preventive services as part of re-
14 porting on quality measures for Medicaid managed
15 care programs.

16 (d) EVALUATIONS AND REPORTS.—

17 (1) INDEPENDENT ASSESSMENT.—The Sec-
18 retary shall enter into a contract with an inde-
19 pendent entity or organization to conduct an evalua-
20 tion and assessment of the initiatives carried out by
21 States under this section, for the purpose of deter-
22 mining—

23 (A) the effect of such initiatives on the use
24 of health care services by Medicaid beneficiaries
25 participating in the program;

1 (B) the extent to which special populations
2 (including adults with disabilities, adults with
3 chronic illnesses, and children with special
4 health care needs) are able to participate in the
5 program;

6 (C) the level of satisfaction of Medicaid
7 beneficiaries with respect to the accessibility
8 and quality of health care services provided
9 through the program; and

10 (D) the administrative costs incurred by
11 State agencies that are responsible for adminis-
12 tration of the program.

13 (2) STATE REPORTING.—A State awarded a
14 grant to carry out initiatives under this section shall
15 submit reports to the Secretary, on a semi-annual
16 basis, regarding the programs that are supported by
17 the grant funds. Such report shall include informa-
18 tion, as specified by the Secretary, regarding—

19 (A) the specific uses of the grant funds;

20 (B) an assessment of program implementa-
21 tion and lessons learned from the programs;

22 (C) an assessment of quality improvements
23 and clinical outcomes under such programs; and

24 (D) estimates of cost savings resulting
25 from such programs.

1 (3) INITIAL REPORT.—Not later than January
2 1, 2014, the Secretary shall submit to Congress an
3 initial report on such initiatives based on informa-
4 tion provided by States through reports required
5 under paragraph (2). The initial report shall include
6 an interim evaluation of the effectiveness of the ini-
7 tiatives carried out with grants awarded under this
8 section and a recommendation regarding whether
9 funding for expanding or extending the initiatives
10 should be extended beyond January 1, 2016.

11 (4) FINAL REPORT.—Not later than July 1,
12 2016, the Secretary shall submit to Congress a final
13 report on the program that includes the results of
14 the independent assessment required under para-
15 graph (1), together with recommendations for such
16 legislation and administrative action as the Sec-
17 retary determines appropriate.

18 (e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT
19 OF, MEDICAID OR OTHER BENEFITS.—Any incentives
20 provided to a Medicaid beneficiary participating in a pro-
21 gram described in subsection (a)(3) shall not be taken into
22 account for purposes of determining the beneficiary's eligi-
23 bility for, or amount of, benefits under the Medicaid pro-
24 gram or any program funded in whole or in part with Fed-
25 eral funds.

1 (f) FUNDING.—Out of any funds in the Treasury not
2 otherwise appropriated, there are appropriated for the 5-
3 year period beginning on January 1, 2011, \$100,000,000
4 to the Secretary to carry out this section. Amounts appro-
5 priated under this subsection shall remain available until
6 expended.

7 (g) DEFINITIONS.—In this section:

8 (1) MEDICAID BENEFICIARY.—The term “Med-
9 icaid beneficiary” means an individual who is eligible
10 for medical assistance under a State plan or waiver
11 under title XIX of the Social Security Act (42
12 U.S.C. 1396 et seq.) and is enrolled in such plan or
13 waiver.

14 (2) STATE.—The term “State” has the mean-
15 ing given that term for purposes of title XIX of the
16 Social Security Act (42 U.S.C. 1396 et seq.).

17 **Subtitle C—Creating Healthier**
18 **Communities**

19 **SEC. 4201. COMMUNITY TRANSFORMATION GRANTS.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services (referred to in this section as the “Sec-
22 retary”), acting through the Director of the Centers for
23 Disease Control and Prevention (referred to in this section
24 as the “Director”), shall award competitive grants to
25 State and local governmental agencies and community-

1 based organizations for the implementation, evaluation,
2 and dissemination of evidence-based community preventive
3 health activities in order to reduce chronic disease rates,
4 prevent the development of secondary conditions, address
5 health disparities, and develop a stronger evidence-base of
6 effective prevention programming.

7 (b) ELIGIBILITY.—To be eligible to receive a grant
8 under subsection (a), an entity shall—

9 (1) be—

10 (A) a State governmental agency;

11 (B) a local governmental agency;

12 (C) a national network of community-based
13 organizations;

14 (D) a State or local non-profit organiza-
15 tion; or

16 (E) an Indian tribe; and

17 (2) submit to the Director an application at
18 such time, in such a manner, and containing such
19 information as the Director may require, including a
20 description of the program to be carried out under
21 the grant; and

22 (3) demonstrate a history or capacity, if fund-
23 ed, to develop relationships necessary to engage key
24 stakeholders from multiple sectors within and be-

1 yond health care and across a community, such as
2 healthy futures corps and health care providers.

3 (c) USE OF FUNDS.—

4 (1) IN GENERAL.—An eligible entity shall use
5 amounts received under a grant under this section to
6 carry out programs described in this subsection.

7 (2) COMMUNITY TRANSFORMATION PLAN.—

8 (A) IN GENERAL.—An eligible entity that
9 receives a grant under this section shall submit
10 to the Director (for approval) a detailed plan
11 that includes the policy, environmental, pro-
12 grammatic, and as appropriate infrastructure
13 changes needed to promote healthy living and
14 reduce disparities.

15 (B) ACTIVITIES.—Activities within the
16 plan may focus on (but not be limited to)—

17 (i) creating healthier school environ-
18 ments, including increasing healthy food
19 options, physical activity opportunities,
20 promotion of healthy lifestyle, emotional
21 wellness, and prevention curricula, and ac-
22 tivities to prevent chronic diseases;

23 (ii) creating the infrastructure to sup-
24 port active living and access to nutritious
25 foods in a safe environment;

1 (iii) developing and promoting pro-
2 grams targeting a variety of age levels to
3 increase access to nutrition, physical activ-
4 ity and smoking cessation, improve social
5 and emotional wellness, enhance safety in
6 a community, or address any other chronic
7 disease priority area identified by the
8 grantee;

9 (iv) assessing and implementing work-
10 site wellness programming and incentives;

11 (v) working to highlight healthy op-
12 tions at restaurants and other food venues;

13 (vi) prioritizing strategies to reduce
14 racial and ethnic disparities, including so-
15 cial, economic, and geographic deter-
16 minants of health; and

17 (vii) addressing special populations
18 needs, including all age groups and individ-
19 uals with disabilities, and individuals in
20 both urban and rural areas.

21 (3) COMMUNITY-BASED PREVENTION HEALTH
22 ACTIVITIES.—

23 (A) IN GENERAL.—An eligible entity shall
24 use amounts received under a grant under this
25 section to implement a variety of programs,

1 policies, and infrastructure improvements to
2 promote healthier lifestyles.

3 (B) ACTIVITIES.—An eligible entity shall
4 implement activities detailed in the community
5 transformation plan under paragraph (2).

6 (C) IN-KIND SUPPORT.—An eligible entity
7 may provide in-kind resources such as staff,
8 equipment, or office space in carrying out ac-
9 tivities under this section.

10 (4) EVALUATION.—

11 (A) IN GENERAL.—An eligible entity shall
12 use amounts provided under a grant under this
13 section to conduct activities to measure changes
14 in the prevalence of chronic disease risk factors
15 among community members participating in
16 preventive health activities

17 (B) TYPES OF MEASURES.—In carrying
18 out subparagraph (A), the eligible entity shall,
19 with respect to residents in the community,
20 measure—

- 21 (i) changes in weight;
22 (ii) changes in proper nutrition;
23 (iii) changes in physical activity;
24 (iv) changes in tobacco use prevalence;

1 (v) changes in emotional well-being
2 and overall mental health;

3 (vi) other factors using community-
4 specific data from the Behavioral Risk
5 Factor Surveillance Survey; and

6 (vii) other factors as determined by
7 the Secretary.

8 (C) REPORTING.—An eligible entity shall
9 annually submit to the Director a report con-
10 taining an evaluation of activities carried out
11 under the grant.

12 (5) DISSEMINATION.—A grantee under this sec-
13 tion shall—

14 (A) meet at least annually in regional or
15 national meetings to discuss challenges, best
16 practices, and lessons learned with respect to
17 activities carried out under the grant; and

18 (B) develop models for the replication of
19 successful programs and activities and the men-
20 toring of other eligible entities.

21 (d) TRAINING.—

22 (1) IN GENERAL.—The Director shall develop a
23 program to provide training for eligible entities on
24 effective strategies for the prevention and control of

1 chronic disease and the link between physical, emo-
 2 tional, and social well-being.

3 (2) **COMMUNITY TRANSFORMATION PLAN.**—The
 4 Director shall provide appropriate feedback and
 5 technical assistance to grantees to establish commu-
 6 nity transformation plans

7 (3) **EVALUATION.**—The Director shall provide a
 8 literature review and framework for the evaluation
 9 of programs conducted as part of the grant program
 10 under this section, in addition to working with aca-
 11 demic institutions or other entities with expertise in
 12 outcome evaluation.

13 (e) **PROHIBITION.**—A grantee shall not use funds
 14 provided under a grant under this section to create video
 15 games or to carry out any other activities that may lead
 16 to higher rates of obesity or inactivity.

17 (f) **AUTHORIZATION OF APPROPRIATIONS.**—There
 18 are authorized to be appropriated to carry out this section,
 19 such sums as may be necessary for each fiscal years 2010
 20 through 2014.

21 **SEC. 4202. HEALTHY AGING, LIVING WELL; EVALUATION OF**
 22 **COMMUNITY-BASED PREVENTION AND**
 23 **WELLNESS PROGRAMS FOR MEDICARE BENE-**
 24 **FICIARIES.**

25 (a) **HEALTHY AGING, LIVING WELL.**—

1 (1) IN GENERAL.—The Secretary of Health and
2 Human Services (referred to in this section as the
3 “Secretary”), acting through the Director of the
4 Centers for Disease Control and Prevention, shall
5 award grants to State or local health departments
6 and Indian tribes to carry out 5-year pilot programs
7 to provide public health community interventions,
8 screenings, and where necessary, clinical referrals
9 for individuals who are between 55 and 64 years of
10 age.

11 (2) ELIGIBILITY.—To be eligible to receive a
12 grant under paragraph (1), an entity shall—

13 (A) be—

14 (i) a State health department;

15 (ii) a local health department; or

16 (iii) an Indian tribe;

17 (B) submit to the Secretary an application
18 at such time, in such manner, and containing
19 such information as the Secretary may require
20 including a description of the program to be
21 carried out under the grant;

22 (C) design a strategy for improving the
23 health of the 55-to-64 year-old population
24 through community-based public health inter-
25 ventions; and

1 (D) demonstrate the capacity, if funded, to
2 develop the relationships necessary with rel-
3 evant health agencies, health care providers,
4 community-based organizations, and insurers to
5 carry out the activities described in paragraph
6 (3), such relationships to include the identifica-
7 tion of a community-based clinical partner, such
8 as a community health center or rural health
9 clinic.

10 (3) USE OF FUNDS.—

11 (A) IN GENERAL.—A State or local health
12 department shall use amounts received under a
13 grant under this subsection to carry out a pro-
14 gram to provide the services described in this
15 paragraph to individuals who are between 55
16 and 64 years of age.

17 (B) PUBLIC HEALTH INTERVENTIONS.—

18 (i) IN GENERAL.—In developing and
19 implementing such activities, a grantee
20 shall collaborate with the Centers for Dis-
21 ease Control and Prevention and the Ad-
22 ministration on Aging, and relevant local
23 agencies and organizations.

24 (ii) TYPES OF INTERVENTION ACTIVI-
25 TIES.—Intervention activities conducted

1 under this subparagraph may include ef-
 2 forts to improve nutrition, increase phys-
 3 ical activity, reduce tobacco use and sub-
 4 stance abuse, improve mental health, and
 5 promote healthy lifestyles among the target
 6 population.

7 (C) COMMUNITY PREVENTIVE
 8 SCREENINGS.—

9 (i) IN GENERAL.—In addition to com-
 10 munity-wide public health interventions, a
 11 State or local health department shall use
 12 amounts received under a grant under this
 13 subsection to conduct ongoing health
 14 screening to identify risk factors for car-
 15 diovascular disease, cancer, stroke, and di-
 16 abetes among individuals in both urban
 17 and rural areas who are between 55 and
 18 64 years of age.

19 (ii) TYPES OF SCREENING ACTIVI-
 20 TIES.—Screening activities conducted
 21 under this subparagraph may include—

22 (I) mental health/behavioral
 23 health and substance use disorders;

24 (II) physical activity, smoking,
 25 and nutrition; and

1 (III) any other measures deemed
2 appropriate by the Secretary.

3 (iii) MONITORING.—Grantees under
4 this section shall maintain records of
5 screening results under this subparagraph
6 to establish the baseline data for moni-
7 toring the targeted population

8 (D) CLINICAL REFERRAL/TREATMENT FOR
9 CHRONIC DISEASES.—

10 (i) IN GENERAL.—A State or local
11 health department shall use amounts re-
12 ceived under a grant under this subsection
13 to ensure that individuals between 55 and
14 64 years of age who are found to have
15 chronic disease risk factors through the
16 screening activities described in subpara-
17 graph (C)(ii), receive clinical referral/treat-
18 ment for follow-up services to reduce such
19 risk.

20 (ii) MECHANISM.—

21 (I) IDENTIFICATION AND DETER-
22 MINATION OF STATUS.—With respect
23 to each individual with risk factors for
24 or having heart disease, stroke, diabe-
25 tes, or any other condition for which

1 such individual was screened under
2 subparagraph (C), a grantee under
3 this section shall determine whether
4 or not such individual is covered
5 under any public or private health in-
6 surance program.

7 (II) INSURED INDIVIDUALS.—An
8 individual determined to be covered
9 under a health insurance program
10 under subclause (I) shall be referred
11 by the grantee to the existing pro-
12 viders under such program or, if such
13 individual does not have a current
14 provider, to a provider who is in-net-
15 work with respect to the program in-
16 volved.

17 (III) UNINSURED INDIVID-
18 UALS.—With respect to an individual
19 determined to be uninsured under
20 subclause (I), the grantee's commu-
21 nity-based clinical partner described
22 in paragraph (4)(D) shall assist the
23 individual in determining eligibility for
24 available public coverage options and
25 identify other appropriate community

1 health care resources and assistance
2 programs.

3 (iii) PUBLIC HEALTH INTERVENTION
4 PROGRAM.—A State or local health depart-
5 ment shall use amounts received under a
6 grant under this subsection to enter into
7 contracts with community health centers or
8 rural health clinics and mental health and
9 substance use disorder service providers to
10 assist in the referral/treatment of at risk
11 patients to community resources for clin-
12 ical follow-up and help determine eligibility
13 for other public programs.

14 (E) GRANTEE EVALUATION.—An eligible
15 entity shall use amounts provided under a grant
16 under this subsection to conduct activities to
17 measure changes in the prevalence of chronic
18 disease risk factors among participants.

19 (4) PILOT PROGRAM EVALUATION.—The Sec-
20 retary shall conduct an annual evaluation of the ef-
21 fectiveness of the pilot program under this sub-
22 section. In determining such effectiveness, the Sec-
23 retary shall consider changes in the prevalence of
24 uncontrolled chronic disease risk factors among new
25 Medicare enrollees (or individuals nearing enroll-

1 ment, including those who are 63 and 64 years of
2 age) who reside in States or localities receiving
3 grants under this section as compared with national
4 and historical data for those States and localities for
5 the same population.

6 (5) AUTHORIZATION OF APPROPRIATIONS.—

7 There are authorized to be appropriated to carry out
8 this subsection, such sums as may be necessary for
9 each of fiscal years 2010 through 2014.

10 (b) EVALUATION AND PLAN FOR COMMUNITY-BASED
11 PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE
12 BENEFICIARIES.—

13 (1) IN GENERAL.—The Secretary shall conduct
14 an evaluation of community-based prevention and
15 wellness programs and develop a plan for promoting
16 healthy lifestyles and chronic disease self-manage-
17 ment for Medicare beneficiaries.

18 (2) MEDICARE EVALUATION OF PREVENTION
19 AND WELLNESS PROGRAMS.—

20 (A) IN GENERAL.—The Secretary shall
21 evaluate community prevention and wellness
22 programs including those that are sponsored by
23 the Administration on Aging, are evidence-
24 based, and have demonstrated potential to help
25 Medicare beneficiaries (particularly beneficiaries

1 that have attained 65 years of age) reduce their
2 risk of disease, disability, and injury by making
3 healthy lifestyle choices, including exercise, diet,
4 and self-management of chronic diseases.

5 (B) EVALUATION.—The evaluation under
6 subparagraph (A) shall consist of the following:

7 (i) EVIDENCE REVIEW.—The Sec-
8 retary shall review available evidence, lit-
9 erature, best practices, and resources that
10 are relevant to programs that promote
11 healthy lifestyles and reduce risk factors
12 for the Medicare population. The Secretary
13 may determine the scope of the evidence
14 review and such issues to be considered,
15 which shall include, at a minimum—

16 (I) physical activity, nutrition,
17 and obesity;

18 (II) falls;

19 (III) chronic disease self-manage-
20 ment; and

21 (IV) mental health.

22 (ii) INDEPENDENT EVALUATION OF
23 EVIDENCE-BASED COMMUNITY PREVEN-
24 TION AND WELLNESS PROGRAMS.—The
25 Administrator of the Centers for Medicare

1 & Medicaid Services, in consultation with
2 the Assistant Secretary for Aging, shall, to
3 the extent feasible and practicable, conduct
4 an evaluation of existing community pre-
5 vention and wellness programs that are
6 sponsored by the Administration on Aging
7 to assess the extent to which Medicare
8 beneficiaries who participate in such pro-
9 grams—

10 (I) reduce their health risks, im-
11 prove their health outcomes, and
12 adopt and maintain healthy behaviors;

13 (II) improve their ability to man-
14 age their chronic conditions; and

15 (III) reduce their utilization of
16 health services and associated costs
17 under the Medicare program for con-
18 ditions that are amenable to improve-
19 ment under such programs.

20 (3) REPORT.—Not later than September 30,
21 2013, the Secretary shall submit to Congress a re-
22 port that includes—

23 (A) recommendations for such legislation
24 and administrative action as the Secretary de-
25 termines appropriate to promote healthy life-

1 styles and chronic disease self-management for
2 Medicare beneficiaries;

3 (B) any relevant findings relating to the
4 evidence review under paragraph (2)(B)(i); and

5 (C) the results of the evaluation under
6 paragraph (2)(B)(ii).

7 (4) FUNDING.—For purposes of carrying out
8 this subsection, the Secretary shall provide for the
9 transfer, from the Federal Hospital Insurance Trust
10 Fund under section 1817 of the Social Security Act
11 (42 U.S.C. 1395i) and the Federal Supplemental
12 Medical Insurance Trust Fund under section 1841
13 of such Act (42 U.S.C. 1395t), in such proportion
14 as the Secretary determines appropriate, of
15 \$50,000,000 to the Centers for Medicare & Medicaid
16 Services Program Management Account. Amounts
17 transferred under the preceding sentence shall re-
18 main available until expended.

19 (5) ADMINISTRATION.—Chapter 35 of title 44,
20 United States Code shall not apply to the this sub-
21 section.

22 (6) MEDICARE BENEFICIARY.—In this sub-
23 section, the term “Medicare beneficiary” means an
24 individual who is entitled to benefits under part A

1 of title XVIII of the Social Security Act and enrolled
2 under part B of such title.

3 **SEC. 4203. REMOVING BARRIERS AND IMPROVING ACCESS**
4 **TO WELLNESS FOR INDIVIDUALS WITH DIS-**
5 **ABILITIES.**

6 Title V of the Rehabilitation Act of 1973 (29 U.S.C.
7 791 et seq.) is amended by adding at the end of the fol-
8 lowing:

9 **“SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCES-**
10 **SIBLE MEDICAL DIAGNOSTIC EQUIPMENT.**

11 “(a) STANDARDS.—Not later than 24 months after
12 the date of enactment of the Affordable Health Choices
13 Act, the Architectural and Transportation Barriers Com-
14 pliance Board shall, in consultation with the Commis-
15 sioner of the Food and Drug Administration, promulgate
16 regulatory standards in accordance with the Administra-
17 tive Procedure Act (2 U.S.C. 551 et seq.) setting forth
18 the minimum technical criteria for medical diagnostic
19 equipment used in (or in conjunction with) physician’s of-
20 fices, clinics, emergency rooms, hospitals, and other med-
21 ical settings. The standards shall ensure that such equip-
22 ment is accessible to, and usable by, individuals with ac-
23 cessibility needs, and shall allow independent entry to, use
24 of, and exit from the equipment by such individuals to the
25 maximum extent possible.

1 “(b) MEDICAL DIAGNOSTIC EQUIPMENT COV-
2 ERED.—The standards issued under subsection (a) for
3 medical diagnostic equipment shall apply to equipment
4 that includes examination tables, examination chairs (in-
5 cluding chairs used for eye examinations or procedures,
6 and dental examinations or procedures), weight scales,
7 mammography equipment, x-ray machines, and other radi-
8 ological equipment commonly used for diagnostic purposes
9 by health professionals.

10 “(c) REVIEW AND AMENDMENT.—The Architectural
11 and Transportation Barriers Compliance Board, in con-
12 sultation with the Commissioner of the Food and Drug
13 Administration, shall periodically review and, as appro-
14 priate, amend the standards in accordance with the Ad-
15 ministrative Procedure Act (2 U.S.C. 551 et seq.).”.

16 **SEC. 4204. IMMUNIZATIONS.**

17 (a) STATE AUTHORITY TO PURCHASE REC-
18 OMMENDED VACCINES FOR ADULTS.—Section 317 of the
19 Public Health Service Act (42 U.S.C. 247b) is amended
20 by adding at the end the following:

21 “(l) AUTHORITY TO PURCHASE RECOMMENDED VAC-
22 CINES FOR ADULTS.—

23 “(1) IN GENERAL.—The Secretary may nego-
24 tiate and enter into contracts with manufacturers of

1 vaccines for the purchase and delivery of vaccines
2 for adults as provided for under subsection (e).

3 “(2) STATE PURCHASE.—A State may obtain
4 additional quantities of such adult vaccines (subject
5 to amounts specified to the Secretary by the State
6 in advance of negotiations) through the purchase of
7 vaccines from manufacturers at the applicable price
8 negotiated by the Secretary under this subsection.”.

9 (b) DEMONSTRATION PROGRAM TO IMPROVE IMMUNIZATION
10 NIZATION COVERAGE.—Section 317 of the Public Health
11 Service Act (42 U.S.C. 247b), as amended by subsection
12 (a), is further amended by adding at the end the following:

13 “(m) DEMONSTRATION PROGRAM TO IMPROVE IM-
14 MUNIZATION COVERAGE.—

15 “(1) IN GENERAL.—The Secretary, acting
16 through the Director of the Centers for Disease
17 Control and Prevention, shall establish a demonstra-
18 tion program to award grants to States to improve
19 the provision of recommended immunizations for
20 children, adolescents, and adults through the use of
21 evidence-based, population-based interventions for
22 high-risk populations.

23 “(2) STATE PLAN.—To be eligible for a grant
24 under paragraph (1), a State shall submit to the
25 Secretary an application at such time, in such man-

1 ner, and containing such information as the Sec-
2 retary may require, including a State plan that de-
3 scribes the interventions to be implemented under
4 the grant and how such interventions match with
5 local needs and capabilities, as determined through
6 consultation with local authorities.

7 “(3) USE OF FUNDS.—Funds received under a
8 grant under this subsection shall be used to imple-
9 ment interventions that are recommended by the
10 Task Force on Community Preventive Services (as
11 established by the Secretary, acting through the Di-
12 rector of the Centers for Disease Control and Pre-
13 vention) or other evidence-based interventions, in-
14 cluding—

15 “(A) providing immunization reminders or
16 recalls for target populations of clients, pa-
17 tients, and consumers;

18 “(B) educating targeted populations and
19 health care providers concerning immunizations
20 in combination with one or more other interven-
21 tions;

22 “(C) reducing out-of-pocket costs for fami-
23 lies for vaccines and their administration;

24 “(D) carrying out immunization-promoting
25 strategies for participants or clients of public

1 programs, including assessments of immuniza-
2 tion status, referrals to health care providers,
3 education, provision of on-site immunizations,
4 or incentives for immunization;

5 “(E) providing for home visits that pro-
6 mote immunization through education, assess-
7 ments of need, referrals, provision of immuniza-
8 tions, or other services;

9 “(F) providing reminders or recalls for im-
10 munization providers;

11 “(G) conducting assessments of, and pro-
12 viding feedback to, immunization providers;

13 “(H) any combination of one or more
14 interventions described in this paragraph; or

15 “(I) immunization information systems to
16 allow all States to have electronic databases for
17 immunization records.

18 “(4) CONSIDERATION.—In awarding grants
19 under this subsection, the Secretary shall consider
20 any reviews or recommendations of the Task Force
21 on Community Preventive Services.

22 “(5) EVALUATION.—Not later than 3 years
23 after the date on which a State receives a grant
24 under this subsection, the State shall submit to the
25 Secretary an evaluation of progress made toward im-

1 proving immunization coverage rates among high-
2 risk populations within the State.

3 “(6) REPORT TO CONGRESS.—Not later than 4
4 years after the date of enactment of the Affordable
5 Health Choices Act, the Secretary shall submit to
6 Congress a report concerning the effectiveness of the
7 demonstration program established under this sub-
8 section together with recommendations on whether
9 to continue and expand such program.

10 “(7) AUTHORIZATION OF APPROPRIATIONS.—
11 There is authorized to be appropriated to carry out
12 this subsection, such sums as may be necessary for
13 each of fiscal years 2010 through 2014.”.

14 (c) REAUTHORIZATION OF IMMUNIZATION PRO-
15 GRAM.—Section 317(j) of the Public Health Service Act
16 (42 U.S.C. 247b(j)) is amended—

17 (1) in paragraph (1), by striking “for each of
18 the fiscal years 1998 through 2005”; and

19 (2) in paragraph (2), by striking “after October
20 1, 1997,”.

21 (d) RULE OF CONSTRUCTION REGARDING ACCESS TO
22 IMMUNIZATIONS.—Nothing in this section (including the
23 amendments made by this section), or any other provision
24 of this Act (including any amendments made by this Act)

1 shall be construed to decrease children’s access to immuni-
2 zations.

3 (e) GAO STUDY AND REPORT ON MEDICARE BENE-
4 FICIARY ACCESS TO VACCINES.—

5 (1) STUDY.—The Comptroller General of the
6 United States (in this section referred to as the
7 “Comptroller General”) shall conduct a study on the
8 ability of Medicare beneficiaries who were 65 years
9 of age or older to access routinely recommended vac-
10 cines covered under the prescription drug program
11 under part D of title XVIII of the Social Security
12 Act over the period since the establishment of such
13 program. Such study shall include the following:

14 (A) An analysis and determination of—

15 (i) the number of Medicare bene-
16 ficiaries who were 65 years of age or older
17 and were eligible for a routinely rec-
18 ommended vaccination that was covered
19 under part D;

20 (ii) the number of such beneficiaries
21 who actually received a routinely rec-
22 ommended vaccination that was covered
23 under part D; and

24 (iii) any barriers to access by such
25 beneficiaries to routinely recommended

1 vaccinations that were covered under part
2 D.

3 (B) A summary of the findings and rec-
4 ommendations by government agencies, depart-
5 ments, and advisory bodies (as well as relevant
6 professional organizations) on the impact of
7 coverage under part D of routinely rec-
8 ommended adult immunizations for access to
9 such immunizations by Medicare beneficiaries.

10 (2) REPORT.—Not later than June 1, 2011, the
11 Comptroller General shall submit to the appropriate
12 committees of jurisdiction of the House of Rep-
13 resentatives and the Senate a report containing the
14 results of the study conducted under paragraph (1),
15 together with recommendations for such legislation
16 and administrative action as the Comptroller Gen-
17 eral determines appropriate.

18 (3) FUNDING.—Out of any funds in the Treas-
19 ury not otherwise appropriated, there are appro-
20 priated \$1,000,000 for fiscal year 2010 to carry out
21 this subsection.

1 **SEC. 4205. NUTRITION LABELING OF STANDARD MENU**
2 **ITEMS AT CHAIN RESTAURANTS.**

3 (a) TECHNICAL AMENDMENTS.—Section
4 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic
5 Act (21 U.S.C. 343(q)(5)(A)) is amended—

6 (1) in subitem (i), by inserting at the beginning
7 “except as provided in clause (H)(ii)(III),”; and

8 (2) in subitem (ii), by inserting at the begin-
9 ning “except as provided in clause (H)(ii)(III),”.

10 (b) LABELING REQUIREMENTS.—Section 403(q)(5)
11 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C.
12 343(q)(5)) is amended by adding at the end the following:

13 “(H) RESTAURANTS, RETAIL FOOD ESTABLISH-
14 MENTS, AND VENDING MACHINES.—

15 “(i) GENERAL REQUIREMENTS FOR RES-
16 TAURANTS AND SIMILAR RETAIL FOOD ESTABLISH-
17 MENTS.—Except for food described in subclause
18 (vii), in the case of food that is a standard menu
19 item that is offered for sale in a restaurant or simi-
20 lar retail food establishment that is part of a chain
21 with 20 or more locations doing business under the
22 same name (regardless of the type of ownership of
23 the locations) and offering for sale substantially the
24 same menu items, the restaurant or similar retail
25 food establishment shall disclose the information de-
26 scribed in subclauses (ii) and (iii).

1 “(ii) INFORMATION REQUIRED TO BE DIS-
2 CLOSED BY RESTAURANTS AND RETAIL FOOD ES-
3 TABLISHMENTS.—Except as provided in subclause
4 (vii), the restaurant or similar retail food establish-
5 ment shall disclose in a clear and conspicuous man-
6 ner—

7 “(I)(aa) in a nutrient content disclosure
8 statement adjacent to the name of the standard
9 menu item, so as to be clearly associated with
10 the standard menu item, on the menu listing
11 the item for sale, the number of calories con-
12 tained in the standard menu item, as usually
13 prepared and offered for sale; and

14 “(bb) a succinct statement concerning sug-
15 gested daily caloric intake, as specified by the
16 Secretary by regulation and posted prominently
17 on the menu and designed to enable the public
18 to understand, in the context of a total daily
19 diet, the significance of the caloric information
20 that is provided on the menu;

21 “(II)(aa) in a nutrient content disclosure
22 statement adjacent to the name of the standard
23 menu item, so as to be clearly associated with
24 the standard menu item, on the menu board,
25 including a drive-through menu board, the

1 number of calories contained in the standard
2 menu item, as usually prepared and offered for
3 sale; and

4 “(bb) a succinct statement concerning sug-
5 gested daily caloric intake, as specified by the
6 Secretary by regulation and posted prominently
7 on the menu board, designed to enable the pub-
8 lic to understand, in the context of a total daily
9 diet, the significance of the nutrition informa-
10 tion that is provided on the menu board;

11 “(III) in a written form, available on the prem-
12 ises of the restaurant or similar retail establishment
13 and to the consumer upon request, the nutrition in-
14 formation required under clauses (C) and (D) of
15 subparagraph (1); and

16 “(IV) on the menu or menu board, a promi-
17 nent, clear, and conspicuous statement regarding the
18 availability of the information described in item
19 (III).

20 “(iii) SELF-SERVICE FOOD AND FOOD ON DIS-
21 PLAY.—Except as provided in subclause (vii), in the
22 case of food sold at a salad bar, buffet line, cafeteria
23 line, or similar self-service facility, and for self-serv-
24 ice beverages or food that is on display and that is
25 visible to customers, a restaurant or similar retail

1 food establishment shall place adjacent to each food
2 offered a sign that lists calories per displayed food
3 item or per serving.

4 “(iv) REASONABLE BASIS.—For the purposes of
5 this clause, a restaurant or similar retail food estab-
6 lishment shall have a reasonable basis for its nutri-
7 ent content disclosures, including nutrient databases,
8 cookbooks, laboratory analyses, and other reasonable
9 means, as described in section 101.10 of title 21,
10 Code of Federal Regulations (or any successor regu-
11 lation) or in a related guidance of the Food and
12 Drug Administration.

13 “(v) MENU VARIABILITY AND COMBINATION
14 MEALS.—The Secretary shall establish by regulation
15 standards for determining and disclosing the nutri-
16 ent content for standard menu items that come in
17 different flavors, varieties, or combinations, but
18 which are listed as a single menu item, such as soft
19 drinks, ice cream, pizza, doughnuts, or children’s
20 combination meals, through means determined by
21 the Secretary, including ranges, averages, or other
22 methods.

23 “(vi) ADDITIONAL INFORMATION.—If the Sec-
24 retary determines that a nutrient, other than a nu-
25 trient required under subclause (ii)(III), should be

1 disclosed for the purpose of providing information to
2 assist consumers in maintaining healthy dietary
3 practices, the Secretary may require, by regulation,
4 disclosure of such nutrient in the written form re-
5 quired under subclause (ii)(III).

6 “(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

7 “(I) IN GENERAL.—Subclauses (i) through
8 (vi) do not apply to—

9 “(aa) items that are not listed on a
10 menu or menu board (such as condiments
11 and other items placed on the table or
12 counter for general use);

13 “(bb) daily specials, temporary menu
14 items appearing on the menu for less than
15 60 days per calendar year, or custom or-
16 ders; or

17 “(cc) such other food that is part of
18 a customary market test appearing on the
19 menu for less than 90 days, under terms
20 and conditions established by the Sec-
21 retary.

22 “(II) WRITTEN FORMS.—Subparagraph
23 (5)(C) shall apply to any regulations promul-
24 gated under subclauses (ii)(III) and (vi).

25 “(viii) VENDING MACHINES.—

1 “(I) IN GENERAL.—In the case of an arti-
2 cle of food sold from a vending machine that—

3 “(aa) does not permit a prospective
4 purchaser to examine the Nutrition Facts
5 Panel before purchasing the article or does
6 not otherwise provide visible nutrition in-
7 formation at the point of purchase; and

8 “(bb) is operated by a person who is
9 engaged in the business of owning or oper-
10 ating 20 or more vending machines,

11 the vending machine operator shall provide a
12 sign in close proximity to each article of food or
13 the selection button that includes a clear and
14 conspicuous statement disclosing the number of
15 calories contained in the article.

16 “(ix) VOLUNTARY PROVISION OF NUTRITION IN-
17 FORMATION.—

18 “(I) IN GENERAL.—An authorized official
19 of any restaurant or similar retail food estab-
20 lishment or vending machine operator not sub-
21 ject to the requirements of this clause may elect
22 to be subject to the requirements of such
23 clause, by registering biannually the name and
24 address of such restaurant or similar retail food
25 establishment or vending machine operator with

1 the Secretary, as specified by the Secretary by
2 regulation.

3 “(II) REGISTRATION.—Within 120 days of
4 enactment of this clause, the Secretary shall
5 publish a notice in the Federal Register speci-
6 fying the terms and conditions for implementa-
7 tion of item (I), pending promulgation of regu-
8 lations.

9 “(III) RULE OF CONSTRUCTION.—Nothing
10 in this subclause shall be construed to authorize
11 the Secretary to require an application, review,
12 or licensing process for any entity to register
13 with the Secretary, as described in such item.

14 “(x) REGULATIONS.—

15 “(I) PROPOSED REGULATION.—Not later
16 than 1 year after the date of enactment of this
17 clause, the Secretary shall promulgate proposed
18 regulations to carry out this clause.

19 “(II) CONTENTS.—In promulgating regula-
20 tions, the Secretary shall—

21 “(aa) consider standardization of rec-
22 ipes and methods of preparation, reason-
23 able variation in serving size and formula-
24 tion of menu items, space on menus and
25 menu boards, inadvertent human error,

1 training of food service workers, variations
2 in ingredients, and other factors, as the
3 Secretary determines; and

4 “(bb) specify the format and manner
5 of the nutrient content disclosure require-
6 ments under this subclause.

7 “(III) REPORTING.—The Secretary shall
8 submit to the Committee on Health, Education,
9 Labor, and Pensions of the Senate and the
10 Committee on Energy and Commerce of the
11 House of Representatives a quarterly report
12 that describes the Secretary’s progress toward
13 promulgating final regulations under this sub-
14 paragraph.

15 “(xi) DEFINITION.—In this clause, the term
16 ‘menu’ or ‘menu board’ means the primary writing
17 of the restaurant or other similar retail food estab-
18 lishment from which a consumer makes an order se-
19 lection.”

20 (c) NATIONAL UNIFORMITY.—Section 403A(a)(4) of
21 the Federal Food, Drug, and Cosmetic Act (21 U.S.C.
22 343-1(a)(4)) is amended by striking “except a require-
23 ment for nutrition labeling of food which is exempt under
24 subclause (i) or (ii) of section 403(q)(5)(A)” and inserting
25 “except that this paragraph does not apply to food that

1 is offered for sale in a restaurant or similar retail food
2 establishment that is not part of a chain with 20 or more
3 locations doing business under the same name (regardless
4 of the type of ownership of the locations) and offering for
5 sale substantially the same menu items unless such res-
6 taurant or similar retail food establishment complies with
7 the voluntary provision of nutrition information require-
8 ments under section 403(q)(5)(H)(ix)”.

9 (d) RULE OF CONSTRUCTION.—Nothing in the
10 amendments made by this section shall be construed—

11 (1) to preempt any provision of State or local
12 law, unless such provision establishes or continues
13 into effect nutrient content disclosures of the type
14 required under section 403(q)(5)(H) of the Federal
15 Food, Drug, and Cosmetic Act (as added by sub-
16 section (b)) and is expressly preempted under sub-
17 section (a)(4) of such section;

18 (2) to apply to any State or local requirement
19 respecting a statement in the labeling of food that
20 provides for a warning concerning the safety of the
21 food or component of the food; or

22 (3) except as provided in section
23 403(q)(5)(H)(ix) of the Federal Food, Drug, and
24 Cosmetic Act (as added by subsection (b)), to apply
25 to any restaurant or similar retail food establish-

1 ment other than a restaurant or similar retail food
2 establishment described in section 403(q)(5)(H)(i) of
3 such Act.

4 **SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDI-**
5 **VIDUALIZED WELLNESS PLAN.**

6 Section 330 of the Public Health Service Act (42
7 U.S.C. 245b) is amended by adding at the end the fol-
8 lowing:

9 “(s) DEMONSTRATION PROGRAM FOR INDIVIDUAL-
10 IZED WELLNESS PLANS.—

11 “(1) IN GENERAL.—The Secretary shall estab-
12 lish a pilot program to test the impact of providing
13 at-risk populations who utilize community health
14 centers funded under this section an individualized
15 wellness plan that is designed to reduce risk factors
16 for preventable conditions as identified by a com-
17 prehensive risk-factor assessment.

18 “(2) AGREEMENTS.—The Secretary shall enter
19 into agreements with not more than 10 community
20 health centers funded under this section to conduct
21 activities under the pilot program under paragraph
22 (1).

23 “(3) WELLNESS PLANS.—

24 “(A) IN GENERAL.—An individualized
25 wellness plan prepared under the pilot program

1 under this subsection may include one or more
2 of the following as appropriate to the individ-
3 ual's identified risk factors:

4 “(i) Nutritional counseling.

5 “(ii) A physical activity plan.

6 “(iii) Alcohol and smoking cessation
7 counseling and services.

8 “(iv) Stress management.

9 “(v) Dietary supplements that have
10 health claims approved by the Secretary.

11 “(vi) Compliance assistance provided
12 by a community health center employee.

13 “(B) RISK FACTORS.—Wellness plan risk
14 factors shall include—

15 “(i) weight;

16 “(ii) tobacco and alcohol use;

17 “(iii) exercise rates;

18 “(iv) nutritional status; and

19 “(v) blood pressure.

20 “(C) COMPARISONS.—Individualized
21 wellness plans shall make comparisons between
22 the individual involved and a control group of
23 individuals with respect to the risk factors de-
24 scribed in subparagraph (B).

1 pense when considered in relation to the size, financial re-
2 sources, nature, or structure of the employer’s business.

3 “(4) Nothing in this subsection shall preempt a State
4 law that provides greater protections to employees than
5 the protections provided for under this subsection.”.

6 **Subtitle D—Support for Prevention** 7 **and Public Health Innovation**

8 **SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF** 9 **PUBLIC HEALTH SERVICES.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services (referred to in this section as the “Sec-
12 retary”), acting through the Director of the Centers for
13 Disease Control and Prevention, shall provide funding for
14 research in the area of public health services and systems.

15 (b) REQUIREMENTS OF RESEARCH.—Research sup-
16 ported under this section shall include—

17 (1) examining evidence-based practices relating
18 to prevention, with a particular focus on high pri-
19 ority areas as identified by the Secretary in the Na-
20 tional Prevention Strategy or Healthy People 2020,
21 and including comparing community-based public
22 health interventions in terms of effectiveness and
23 cost;

24 (2) analyzing the translation of interventions
25 from academic settings to real world settings; and

1 **“TITLE XXXI—DATA COLLEC-**
2 **TION, ANALYSIS, AND QUAL-**
3 **ITY**

4 **“SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.**

5 “(a) DATA COLLECTION.—

6 “(1) IN GENERAL.—The Secretary shall ensure
7 that, by not later than 2 years after the date of en-
8 actment of this title, any federally conducted or sup-
9 ported health care or public health program, activity
10 or survey (including Current Population Surveys and
11 American Community Surveys conducted by the Bu-
12 reau of Labor Statistics and the Bureau of the Cen-
13 sus) collects and reports, to the extent practicable—

14 “(A) data on race, ethnicity, sex, primary
15 language, and disability status for applicants,
16 recipients, or participants;

17 “(B) data at the smallest geographic level
18 such as State, local, or institutional levels if
19 such data can be aggregated;

20 “(C) sufficient data to generate statis-
21 tically reliable estimates by racial, ethnic, sex,
22 primary language, and disability status sub-
23 groups for applicants, recipients or participants
24 using, if needed, statistical oversamples of these
25 subpopulations; and

1 “(D) any other demographic data as
2 deemed appropriate by the Secretary regarding
3 health disparities.

4 “(2) COLLECTION STANDARDS.—In collecting
5 data described in paragraph (1), the Secretary or
6 designee shall—

7 “(A) use Office of Management and Budg-
8 et standards, at a minimum, for race and eth-
9 nicity measures;

10 “(B) develop standards for the measure-
11 ment of sex, primary language, and disability
12 status;

13 “(C) develop standards for the collection of
14 data described in paragraph (1) that, at a min-
15 imum—

16 “(i) collects self-reported data by the
17 applicant, recipient, or participant; and

18 “(ii) collects data from a parent or
19 legal guardian if the applicant, recipient,
20 or participant is a minor or legally inca-
21 pacitated;

22 “(D) survey health care providers and es-
23 tablish other procedures in order to assess ac-
24 cess to care and treatment for individuals with
25 disabilities and to identify—

1 “(i) locations where individuals with
2 disabilities access primary, acute (including
3 intensive), and long-term care;

4 “(ii) the number of providers with ac-
5 cessible facilities and equipment to meet
6 the needs of the individuals with disabil-
7 ities, including medical diagnostic equip-
8 ment that meets the minimum technical
9 criteria set forth in section 510 of the Re-
10 habilitation Act of 1973; and

11 “(iii) the number of employees of
12 health care providers trained in disability
13 awareness and patient care of individuals
14 with disabilities; and

15 “(E) require that any reporting require-
16 ment imposed for purposes of measuring quality
17 under any ongoing or federally conducted or
18 supported health care or public health program,
19 activity, or survey includes requirements for the
20 collection of data on individuals receiving health
21 care items or services under such programs ac-
22 tivities by race, ethnicity, sex, primary lan-
23 guage, and disability status.

24 “(3) DATA MANAGEMENT.—In collecting data
25 described in paragraph (1), the Secretary, acting

1 through the National Coordinator for Health Infor-
2 mation Technology shall—

3 “(A) develop national standards for the
4 management of data collected; and

5 “(B) develop interoperability and security
6 systems for data management.

7 “(b) DATA ANALYSIS.—

8 “(1) IN GENERAL.—For each federally con-
9 ducted or supported health care or public health pro-
10 gram or activity, the Secretary shall analyze data
11 collected under paragraph (a) to detect and monitor
12 trends in health disparities (as defined for purposes
13 of section 485E) at the Federal and State levels.

14 “(c) DATA REPORTING AND DISSEMINATION.—

15 “(1) IN GENERAL.—The Secretary shall make
16 the analyses described in (b) available to—

17 “(A) the Office of Minority Health;

18 “(B) the National Center on Minority
19 Health and Health Disparities;

20 “(C) the Agency for Healthcare Research
21 and Quality;

22 “(D) the Centers for Disease Control and
23 Prevention;

24 “(E) the Centers for Medicare & Medicaid
25 Services;

1 “(F) the Indian Health Service and epide-
2 miology centers funded under the Indian Health
3 Care Improvement Act;

4 “(G) the Office of Rural health;

5 “(H) other agencies within the Department
6 of Health and Human Services; and

7 “(I) other entities as determined appro-
8 priate by the Secretary.

9 “(2) REPORTING OF DATA.—The Secretary
10 shall report data and analyses described in (a) and
11 (b) through—

12 “(A) public postings on the Internet
13 websites of the Department of Health and
14 Human Services; and

15 “(B) any other reporting or dissemination
16 mechanisms determined appropriate by the Sec-
17 retary.

18 “(3) AVAILABILITY OF DATA.—The Secretary
19 may make data described in (a) and (b) available for
20 additional research, analyses, and dissemination to
21 other Federal agencies, non-governmental entities,
22 and the public, in accordance with any Federal agen-
23 cy’s data user agreements.

24 “(d) LIMITATIONS ON USE OF DATA.—Nothing in
25 this section shall be construed to permit the use of infor-

1 mation collected under this section in a manner that would
2 adversely affect any individual.

3 “(e) PROTECTION AND SHARING OF DATA.—

4 “(1) PRIVACY AND OTHER SAFEGUARDS.—The
5 Secretary shall ensure (through the promulgation of
6 regulations or otherwise) that—

7 “(A) all data collected pursuant to sub-
8 section (a) is protected—

9 “(i) under privacy protections that are
10 at least as broad as those that the Sec-
11 retary applies to other health data under
12 the regulations promulgated under section
13 264(c) of the Health Insurance Portability
14 and Accountability Act of 1996 (Public
15 Law 104-191; 110 Stat. 2033); and

16 “(ii) from all inappropriate internal
17 use by any entity that collects, stores, or
18 receives the data, including use of such
19 data in determinations of eligibility (or
20 continued eligibility) in health plans, and
21 from other inappropriate uses, as defined
22 by the Secretary; and

23 “(B) all appropriate information security
24 safeguards are used in the collection, analysis,

1 and sharing of data collected pursuant to sub-
2 section (a).

3 “(2) DATA SHARING.—The Secretary shall es-
4 tablish procedures for sharing data collected pursu-
5 ant to subsection (a), measures relating to such
6 data, and analyses of such data, with other relevant
7 Federal and State agencies including the agencies,
8 centers, and entities within the Department of
9 Health and Human Services specified in subsection
10 (c)(1)..

11 “(f) DATA ON RURAL UNDERSERVED POPU-
12 LATIONS.—The Secretary shall ensure that any data col-
13 lected in accordance with this section regarding racial and
14 ethnic minority groups are also collected regarding under-
15 served rural and frontier populations.

16 “(g) AUTHORIZATION OF APPROPRIATIONS.—For the
17 purpose of carrying out this section, there are authorized
18 to be appropriated such sums as may be necessary for
19 each of fiscal years 2010 through 2014.

20 “(h) REQUIREMENT FOR IMPLEMENTATION.—Not-
21 withstanding any other provision of this section, data may
22 not be collected under this section unless funds are di-
23 rectly appropriated for such purpose in an appropriations
24 Act.

1 “(i) CONSULTATION.—The Secretary shall consult
2 with the Director of the Office of Personnel Management,
3 the Secretary of Defense, the Secretary of Veterans Af-
4 fairs, the Director of the Bureau of the Census, the Com-
5 missioner of Social Security, and the head of other appro-
6 priate Federal agencies in carrying out this section.”.

7 (b) ADDRESSING HEALTH CARE DISPARITIES IN
8 MEDICAID AND CHIP.—

9 (1) STANDARDIZED COLLECTION REQUIRE-
10 MENTS INCLUDED IN STATE PLANS.—

11 (A) MEDICAID.—Section 1902(a) of the
12 Social Security Act (42 U.S.C. 1396a(a)), as
13 amended by section 2001(d), is amended—

14 (i) in paragraph 4), by striking “and”
15 at the end;

16 (ii) in paragraph (75), by striking the
17 period at the end and inserting “; and”;
18 and

19 (iii) by inserting after paragraph (75)
20 the following new paragraph:

21 “(76) provide that any data collected under the
22 State plan meets the requirements of section 3101
23 of the Public Health Service Act.”.

24 (B) CHIP.—Section 2108(e) of the Social
25 Security Act (42 U.S.C. 1397hh(e)) is amended

1 by adding at the end the following new para-
2 graph:

3 “(7) Data collected and reported in accordance
4 with section 3101 of the Public Health Service Act,
5 with respect to individuals enrolled in the State child
6 health plan (and, in the case of enrollees under 19
7 years of age, their parents or legal guardians), in-
8 cluding data regarding the primary language of such
9 individuals, parents, and legal guardians.”.

10 (2) EXTENDING MEDICARE REQUIREMENT TO
11 ADDRESS HEALTH DISPARITIES DATA COLLECTION
12 TO MEDICAID AND CHIP.—Title XIX of the Social
13 Security Act (42 U.S.C. 1396 et seq.), as amended
14 by section 2703 is amended by adding at the end the
15 following new section:

16 **“SEC. 1946. ADDRESSING HEALTH CARE DISPARITIES.**

17 “(a) EVALUATING DATA COLLECTION AP-
18 PROACHES.—The Secretary shall evaluate approaches for
19 the collection of data under this title and title XXI, to
20 be performed in conjunction with existing quality report-
21 ing requirements and programs under this title and title
22 XXI, that allow for the ongoing, accurate, and timely col-
23 lection and evaluation of data on disparities in health care
24 services and performance on the basis of race, ethnicity,
25 sex, primary language, and disability status. In conducting

1 such evaluation, the Secretary shall consider the following
2 objectives:

3 “(1) Protecting patient privacy.

4 “(2) Minimizing the administrative burdens of
5 data collection and reporting on States, providers,
6 and health plans participating under this title or
7 title XXI.

8 “(3) Improving program data under this title
9 and title XXI on race, ethnicity, sex, primary lan-
10 guage, and disability status.

11 “(b) REPORTS TO CONGRESS.—

12 “(1) REPORT ON EVALUATION.—Not later than
13 18 months after the date of the enactment of this
14 section, the Secretary shall submit to Congress a re-
15 port on the evaluation conducted under subsection
16 (a). Such report shall, taking into consideration the
17 results of such evaluation—

18 “(A) identify approaches (including defin-
19 ing methodologies) for identifying and collecting
20 and evaluating data on health care disparities
21 on the basis of race, ethnicity, sex, primary lan-
22 guage, and disability status for the programs
23 under this title and title XXI; and

24 “(B) include recommendations on the most
25 effective strategies and approaches to reporting

1 HEDIS quality measures as required under sec-
2 tion 1852(e)(3) and other nationally recognized
3 quality performance measures, as appropriate,
4 on such bases.

5 “(2) REPORTS ON DATA ANALYSES.—Not later
6 than 4 years after the date of the enactment of this
7 section, and 4 years thereafter, the Secretary shall
8 submit to Congress a report that includes rec-
9 ommendations for improving the identification of
10 health care disparities for beneficiaries under this
11 title and under title XXI based on analyses of the
12 data collected under subsection (c).

13 “(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not
14 later than 24 months after the date of the enactment of
15 this section, the Secretary shall implement the approaches
16 identified in the report submitted under subsection (b)(1)
17 for the ongoing, accurate, and timely collection and eval-
18 uation of data on health care disparities on the basis of
19 race, ethnicity, sex, primary language, and disability sta-
20 tus.”.

21 **SEC. 4303. CDC AND EMPLOYER-BASED WELLNESS PRO-**
22 **GRAMS.**

23 Title III of the Public Health Service Act (42 U.S.C.
24 241 et seq.), by section 4102, is further amended by add-
25 ing at the end the following:

1 **“PART U—EMPLOYER-BASED WELLNESS**

2 **PROGRAM**

3 **“SEC. 399MM. TECHNICAL ASSISTANCE FOR EMPLOYER-**
4 **BASED WELLNESS PROGRAMS.**

5 “In order to expand the utilization of evidence-based
6 prevention and health promotion approaches in the work-
7 place, the Director shall—

8 “(1) provide employers (including small, me-
9 dium, and large employers, as determined by the Di-
10 rector) with technical assistance, consultation, tools,
11 and other resources in evaluating such employers’
12 employer-based wellness programs, including—

13 “(A) measuring the participation and
14 methods to increase participation of employees
15 in such programs;

16 “(B) developing standardized measures
17 that assess policy, environmental and systems
18 changes necessary to have a positive health im-
19 pact on employees’ health behaviors, health out-
20 comes, and health care expenditures; and

21 “(C) evaluating such programs as they re-
22 late to changes in the health status of employ-
23 ees, the absenteeism of employees, the produc-
24 tivity of employees, the rate of workplace in-
25 jury, and the medical costs incurred by employ-
26 ees; and

1 “(2) build evaluation capacity among workplace
2 staff by training employers on how to evaluate em-
3 ployer-based wellness programs by ensuring evalua-
4 tion resources, technical assistance, and consultation
5 are available to workplace staff as needed through
6 such mechanisms as web portals, call centers, or
7 other means.

8 **“SEC. 399MM-1. NATIONAL WORKSITE HEALTH POLICIES**
9 **AND PROGRAMS STUDY.**

10 “(a) IN GENERAL.—In order to assess, analyze, and
11 monitor over time data about workplace policies and pro-
12 grams, and to develop instruments to assess and evaluate
13 comprehensive workplace chronic disease prevention and
14 health promotion programs, policies and practices, not
15 later than 2 years after the date of enactment of this part,
16 and at regular intervals (to be determined by the Director)
17 thereafter, the Director shall conduct a national worksite
18 health policies and programs survey to assess employer-
19 based health policies and programs.

20 “(b) REPORT.—Upon the completion of each study
21 under subsection (a), the Director shall submit to Con-
22 gress a report that includes the recommendations of the
23 Director for the implementation of effective employer-
24 based health policies and programs.

1 **“SEC. 399MM-2. PRIORITIZATION OF EVALUATION BY SEC-**
 2 **RETARY.**

3 “The Secretary shall evaluate, in accordance with this
 4 part, all programs funded through the Centers for Disease
 5 Control and Prevention before conducting such an evalua-
 6 tion of privately funded programs unless an entity with
 7 a privately funded wellness program requests such an eval-
 8 uation.

9 **“SEC. 399MM-3. PROHIBITION OF FEDERAL WORKPLACE**
 10 **WELLNESS REQUIREMENTS.**

11 “Notwithstanding any other provision of this part,
 12 any recommendations, data, or assessments carried out
 13 under this part shall not be used to mandate requirements
 14 for workplace wellness programs.”.

15 **SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACITY**
 16 **GRANTS.**

17 Title XXVIII of the Public Health Service Act (42
 18 U.S.C. 300hh et seq.) is amended by adding at the end
 19 the following:

20 **“Subtitle C—Strengthening Public**
 21 **Health Surveillance Systems**

22 **“SEC. 2821. EPIDEMIOLOGY-LABORATORY CAPACITY**
 23 **GRANTS.**

24 “(a) IN GENERAL.—Subject to the availability of ap-
 25 propriations, the Secretary, acting through the Director
 26 of the Centers for Disease Control and Prevention, shall

1 establish an Epidemiology and Laboratory Capacity Grant
2 Program to award grants to State health departments as
3 well as local health departments and tribal jurisdictions
4 that meet such criteria as the Director determines appro-
5 priate. Academic centers that assist State and eligible
6 local and tribal health departments may also be eligible
7 for funding under this section as the Director determines
8 appropriate. Grants shall be awarded under this section
9 to assist public health agencies in improving surveillance
10 for, and response to, infectious diseases and other condi-
11 tions of public health importance by—

12 “(1) strengthening epidemiologic capacity to
13 identify and monitor the occurrence of infectious dis-
14 eases and other conditions of public health impor-
15 tance;

16 “(2) enhancing laboratory practice as well as
17 systems to report test orders and results electroni-
18 cally;

19 “(3) improving information systems including
20 developing and maintaining an information exchange
21 using national guidelines and complying with capac-
22 ities and functions determined by an advisory coun-
23 cil established and appointed by the Director; and

24 “(4) developing and implementing prevention
25 and control strategies.

1 “(b) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$190,000,000 for each of fiscal years 2010 through 2013,
4 of which—

5 “(1) not less than \$95,000,000 shall be made
6 available each such fiscal year for activities under
7 paragraphs (1) and (4) of subsection (a);

8 “(2) not less than \$60,000,000 shall be made
9 available each such fiscal year for activities under
10 subsection (a)(3); and

11 “(3) not less than \$32,000,000 shall be made
12 available each such fiscal year for activities under
13 subsection (a)(2).”.

14 **SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR**
15 **PAIN CARE MANAGEMENT.**

16 (a) INSTITUTE OF MEDICINE CONFERENCE ON
17 PAIN.—

18 (1) CONVENING.—Not later than 1 year after
19 funds are appropriated to carry out this subsection,
20 the Secretary of Health and Human Services shall
21 seek to enter into an agreement with the Institute
22 of Medicine of the National Academies to convene a
23 Conference on Pain (in this subsection referred to as
24 “the Conference”).

1 (2) PURPOSES.—The purposes of the Con-
2 ference shall be to—

3 (A) increase the recognition of pain as a
4 significant public health problem in the United
5 States;

6 (B) evaluate the adequacy of assessment,
7 diagnosis, treatment, and management of acute
8 and chronic pain in the general population, and
9 in identified racial, ethnic, gender, age, and
10 other demographic groups that may be dis-
11 proportionately affected by inadequacies in the
12 assessment, diagnosis, treatment, and manage-
13 ment of pain;

14 (C) identify barriers to appropriate pain
15 care;

16 (D) establish an agenda for action in both
17 the public and private sectors that will reduce
18 such barriers and significantly improve the
19 state of pain care research, education, and clin-
20 ical care in the United States.

21 (3) OTHER APPROPRIATE ENTITY.—If the In-
22 stitute of Medicine declines to enter into an agree-
23 ment under paragraph (1), the Secretary of Health
24 and Human Services may enter into such agreement
25 with another appropriate entity.

1 (4) REPORT.—A report summarizing the Con-
2 ference’s findings and recommendations shall be
3 submitted to the Congress not later than June 30,
4 2011.

5 (5) AUTHORIZATION OF APPROPRIATIONS.—For
6 the purpose of carrying out this subsection, there is
7 authorized to be appropriated such sums as may be
8 necessary for each of fiscal years 2010 and 2011.

9 (b) PAIN RESEARCH AT NATIONAL INSTITUTES OF
10 HEALTH.—Part B of title IV of the Public Health Service
11 Act (42 U.S.C. 284 et seq.) is amended by adding at the
12 end the following:

13 **“SEC. 409J. PAIN RESEARCH.**

14 “(a) RESEARCH INITIATIVES.—

15 “(1) IN GENERAL.—The Director of NIH is en-
16 couraged to continue and expand, through the Pain
17 Consortium, an aggressive program of basic and
18 clinical research on the causes of and potential treat-
19 ments for pain.

20 “(2) ANNUAL RECOMMENDATIONS.—Not less
21 than annually, the Pain Consortium, in consultation
22 with the Division of Program Coordination, Plan-
23 ning, and Strategic Initiatives, shall develop and
24 submit to the Director of NIH recommendations on
25 appropriate pain research initiatives that could be

1 undertaken with funds reserved under section
2 402A(c)(1) for the Common Fund or otherwise
3 available for such initiatives.

4 “(3) DEFINITION.—In this subsection, the term
5 ‘Pain Consortium’ means the Pain Consortium of
6 the National Institutes of Health or a similar trans-
7 National Institutes of Health coordinating entity
8 designated by the Secretary for purposes of this sub-
9 section.

10 “(b) INTERAGENCY PAIN RESEARCH COORDINATING
11 COMMITTEE.—

12 “(1) ESTABLISHMENT.—The Secretary shall es-
13 tablish not later than 1 year after the date of the
14 enactment of this section and as necessary maintain
15 a committee, to be known as the Interagency Pain
16 Research Coordinating Committee (in this section
17 referred to as the ‘Committee’), to coordinate all ef-
18 forts within the Department of Health and Human
19 Services and other Federal agencies that relate to
20 pain research.

21 “(2) MEMBERSHIP.—

22 “(A) IN GENERAL.—The Committee shall
23 be composed of the following voting members:

24 “(i) Not more than 7 voting Federal
25 representatives appoint by the Secretary

1 from agencies that conduct pain care re-
2 search and treatment.

3 “(ii) 12 additional voting members ap-
4 pointed under subparagraph (B).

5 “(B) ADDITIONAL MEMBERS.—The Com-
6 mittee shall include additional voting members
7 appointed by the Secretary as follows:

8 “(i) 6 non-Federal members shall be
9 appointed from among scientists, physi-
10 cians, and other health professionals.

11 “(ii) 6 members shall be appointed
12 from members of the general public, who
13 are representatives of leading research, ad-
14 vocacy, and service organizations for indi-
15 viduals with pain-related conditions.

16 “(C) NONVOTING MEMBERS.—The Com-
17 mittee shall include such nonvoting members as
18 the Secretary determines to be appropriate.

19 “(3) CHAIRPERSON.—The voting members of
20 the Committee shall select a chairperson from
21 among such members. The selection of a chairperson
22 shall be subject to the approval of the Director of
23 NIH.

24 “(4) MEETINGS.—The Committee shall meet at
25 the call of the chairperson of the Committee or upon

1 the request of the Director of NIH, but in no case
2 less often than once each year.

3 “(5) DUTIES.—The Committee shall—

4 “(A) develop a summary of advances in
5 pain care research supported or conducted by
6 the Federal agencies relevant to the diagnosis,
7 prevention, and treatment of pain and diseases
8 and disorders associated with pain;

9 “(B) identify critical gaps in basic and
10 clinical research on the symptoms and causes of
11 pain;

12 “(C) make recommendations to ensure that
13 the activities of the National Institutes of
14 Health and other Federal agencies are free of
15 unnecessary duplication of effort;

16 “(D) make recommendations on how best
17 to disseminate information on pain care; and

18 “(E) make recommendations on how to ex-
19 pand partnerships between public entities and
20 private entities to expand collaborative, cross-
21 cutting research.

22 “(6) REVIEW.—The Secretary shall review the
23 necessity of the Committee at least once every 2
24 years.”.

1 (c) PAIN CARE EDUCATION AND TRAINING.—Part D
2 of title VII of the Public Health Service Act (42 U.S.C.
3 294 et seq.) is amended by adding at the end the following
4 new section:

5 **“SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN**
6 **PAIN CARE.**

7 “(a) IN GENERAL.—The Secretary may make awards
8 of grants, cooperative agreements, and contracts to health
9 professions schools, hospices, and other public and private
10 entities for the development and implementation of pro-
11 grams to provide education and training to health care
12 professionals in pain care.

13 “(b) CERTAIN TOPICS.—An award may be made
14 under subsection (a) only if the applicant for the award
15 agrees that the program carried out with the award will
16 include information and education on—

17 “(1) recognized means for assessing, diag-
18 nosing, treating, and managing pain and related
19 signs and symptoms, including the medically appro-
20 priate use of controlled substances;

21 “(2) applicable laws, regulations, rules, and
22 policies on controlled substances, including the de-
23 gree to which misconceptions and concerns regarding
24 such laws, regulations, rules, and policies, or the en-

1 enforcement thereof, may create barriers to patient ac-
2 cess to appropriate and effective pain care;

3 “(3) interdisciplinary approaches to the delivery
4 of pain care, including delivery through specialized
5 centers providing comprehensive pain care treatment
6 expertise;

7 “(4) cultural, linguistic, literacy, geographic,
8 and other barriers to care in underserved popu-
9 lations; and

10 “(5) recent findings, developments, and im-
11 provements in the provision of pain care.

12 “(c) EVALUATION OF PROGRAMS.—The Secretary
13 shall (directly or through grants or contracts) provide for
14 the evaluation of programs implemented under subsection
15 (a) in order to determine the effect of such programs on
16 knowledge and practice of pain care.

17 “(d) PAIN CARE DEFINED.—For purposes of this
18 section the term ‘pain care’ means the assessment, diag-
19 nosis, treatment, or management of acute or chronic pain
20 regardless of causation or body location.

21 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section,
23 such sums as may be necessary for each of the fiscal years
24 2010 through 2012. Amounts appropriated under this
25 subsection shall remain available until expended.”.

1 **SEC. 4306. FUNDING FOR CHILDHOOD OBESITY DEM-**
2 **ONSTRATION PROJECT.**

3 Section 1139A(e)(8) of the Social Security Act (42
4 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

5 “(8) APPROPRIATION.—Out of any funds in the
6 Treasury not otherwise appropriated, there is appro-
7 priated to carry out this subsection, \$25,000,000 for
8 the period of fiscal years 2010 through 2014.”.

9 **Subtitle E—Miscellaneous**
10 **Provisions**

11 **SEC. 4401. SENSE OF THE SENATE CONCERNING CBO SCOR-**
12 **ING.**

13 (a) FINDING.—The Senate finds that the costs of
14 prevention programs are difficult to estimate due in part
15 because prevention initiatives are hard to measure and re-
16 sults may occur outside the 5 and 10 year budget win-
17 dows.

18 (b) SENSE OF CONGRESS.—It is the sense of the Sen-
19 ate that Congress should work with the Congressional
20 Budget Office to develop better methodologies for scoring
21 progress to be made in prevention and wellness programs.

22 **SEC. 4402. EFFECTIVENESS OF FEDERAL HEALTH AND**
23 **WELLNESS INITIATIVES.**

24 To determine whether existing Federal health and
25 wellness initiatives are effective in achieving their stated

1 goals, the Secretary of Health and Human Services
2 shall—

3 (1) conduct an evaluation of such programs as
4 they relate to changes in health status of the Amer-
5 ican public and specifically on the health status of
6 the Federal workforce, including absenteeism of em-
7 ployees, the productivity of employees, the rate of
8 workplace injury, and the medical costs incurred by
9 employees, and health conditions, including work-
10 place fitness, healthy food and beverages, and incen-
11 tives in the Federal Employee Health Benefits Pro-
12 gram; and

13 (2) submit to Congress a report concerning
14 such evaluation, which shall include conclusions con-
15 cerning the reasons that such existing programs
16 have proven successful or not successful and what
17 factors contributed to such conclusions.

18 **TITLE V—HEALTH CARE**

19 **WORKFORCE**

20 **Subtitle A—Purpose and**

21 **Definitions**

22 **SEC. 5001. PURPOSE.**

23 The purpose of this title is to improve access to and
24 the delivery of health care services for all individuals, par-

1 ticularly low income, underserved, uninsured, minority,
2 health disparity, and rural populations by—

3 (1) gathering and assessing comprehensive data
4 in order for the health care workforce to meet the
5 health care needs of individuals, including research
6 on the supply, demand, distribution, diversity, and
7 skills needs of the health care workforce;

8 (2) increasing the supply of a qualified health
9 care workforce to improve access to and the delivery
10 of health care services for all individuals;

11 (3) enhancing health care workforce education
12 and training to improve access to and the delivery
13 of health care services for all individuals; and

14 (4) providing support to the existing health care
15 workforce to improve access to and the delivery of
16 health care services for all individuals.

17 **SEC. 5002. DEFINITIONS.**

18 (a) THIS TITLE.—In this title:

19 (1) ALLIED HEALTH PROFESSIONAL.—The
20 term “allied health professional” means an allied
21 health professional as defined in section 799B(5) of
22 the Public Health Service Act (42 U.S.C. 295p(5))
23 who—

1 (A) has graduated and received an allied
2 health professions degree or certificate from an
3 institution of higher education; and

4 (B) is employed with a Federal, State,
5 local or tribal public health agency, or in a set-
6 ting where patients might require health care
7 services, including acute care facilities, ambula-
8 tory care facilities, personal residences, and
9 other settings located in health professional
10 shortage areas, medically underserved areas, or
11 medically underserved populations, as recog-
12 nized by the Secretary of Health and Human
13 Services.

14 (2) HEALTH CARE CAREER PATHWAY.—The
15 term “healthcare career pathway” means a rigorous,
16 engaging, and high quality set of courses and serv-
17 ices that—

18 (A) includes an articulated sequence of
19 academic and career courses, including 21st
20 century skills;

21 (B) is aligned with the needs of healthcare
22 industries in a region or State;

23 (C) prepares students for entry into the
24 full range of postsecondary education options,

1 including registered apprenticeships, and ca-
2 reers;

3 (D) provides academic and career coun-
4 seling in student-to-counselor ratios that allow
5 students to make informed decisions about aca-
6 demic and career options;

7 (E) meets State academic standards, State
8 requirements for secondary school graduation
9 and is aligned with requirements for entry into
10 postsecondary education, and applicable indus-
11 try standards; and

12 (F) leads to 2 or more credentials, includ-
13 ing—

14 (i) a secondary school diploma; and

15 (ii) a postsecondary degree, an ap-
16 prenticeship or other occupational certifi-
17 cation, a certificate, or a license.

18 (3) INSTITUTION OF HIGHER EDUCATION.—The
19 term “institution of higher education” has the
20 meaning given the term in sections 101 and 102 of
21 the Higher Education Act of 1965 (20 U.S.C. 1001
22 and 1002).

23 (4) LOW INCOME INDIVIDUAL, STATE WORK-
24 FORCE INVESTMENT BOARD, AND LOCAL WORK-
25 FORCE INVESTMENT BOARD.—

1 (A) LOW-INCOME INDIVIDUAL.—The term
2 “low-income individual” has the meaning given
3 that term in section 101 of the Workforce in-
4 vestment Act of 1998 (29 U.S.C. 2801).

5 (B) STATE WORKFORCE INVESTMENT
6 BOARD; LOCAL WORKFORCE INVESTMENT
7 BOARD.—The terms “State workforce invest-
8 ment board” and “local workforce investment
9 board”, refer to a State workforce investment
10 board established under section 111 of the
11 Workforce Investment Act of 1998 (29 U.S.C.
12 2821) and a local workforce investment board
13 established under section 117 of such Act (29
14 U.S.C. 2832), respectively.

15 (5) POSTSECONDARY EDUCATION.—The term
16 “postsecondary education” means—

17 (A) a 4-year program of instruction, or not
18 less than a 1-year program of instruction that
19 is acceptable for credit toward an associate or
20 a baccalaureate degree, offered by an institution
21 of higher education; or

22 (B) a certificate or registered apprentice-
23 ship program at the postsecondary level offered
24 by an institution of higher education or a non-
25 profit educational institution.

1 (6) REGISTERED APPRENTICESHIP PROGRAM.—
2 The term “registered apprenticeship program”
3 means an industry skills training program at the
4 postsecondary level that combines technical and the-
5 oretical training through structure on the job learn-
6 ing with related instruction (in a classroom or
7 through distance learning) while an individual is em-
8 ployed, working under the direction of qualified per-
9 sonnel or a mentor, and earning incremental wage
10 increases aligned to enhance job proficiency, result-
11 ing in the acquisition of a nationally recognized and
12 portable certificate, under a plan approved by the
13 Office of Apprenticeship or a State agency recog-
14 nized by the Department of Labor.

15 (b) TITLE VII OF THE PUBLIC HEALTH SERVICE
16 ACT.—Section 799B of the Public Health Service Act (42
17 U.S.C. 295p) is amended—

18 (1) by striking paragraph (3) and inserting the
19 following:

20 “(3) PHYSICIAN ASSISTANT EDUCATION PRO-
21 GRAM.—The term ‘physician assistant education
22 program’ means an educational program in a public
23 or private institution in a State that—

24 “(A) has as its objective the education of
25 individuals who, upon completion of their stud-

1 ies in the program, be qualified to provide pri-
2 mary care medical services with the supervision
3 of a physician; and

4 “(B) is accredited by the Accreditation Re-
5 view Commission on Education for the Physi-
6 cian Assistant.”; and

7 (2) by adding at the end the following:

8 “(12) AREA HEALTH EDUCATION CENTER.—

9 The term ‘area health education center’ means a
10 public or nonprofit private organization that has a
11 cooperative agreement or contract in effect with an
12 entity that has received an award under subsection
13 (a)(1) or (a)(2) of section 751, satisfies the require-
14 ments in section 751(d)(1), and has as one of its
15 principal functions the operation of an area health
16 education center. Appropriate organizations may in-
17 clude hospitals, health organizations with accredited
18 primary care training programs, accredited physician
19 assistant educational programs associated with a col-
20 lege or university, and universities or colleges not
21 operating a school of medicine or osteopathic medi-
22 cine.

23 “(13) AREA HEALTH EDUCATION CENTER PRO-
24 GRAM.—The term ‘area health education center pro-
25 gram’ means cooperative program consisting of an

1 entity that has received an award under subsection
2 (a)(1) or (a)(2) of section 751 for the purpose of
3 planning, developing, operating, and evaluating an
4 area health education center program and one or
5 more area health education centers, which carries
6 out the required activities described in section
7 751(c), satisfies the program requirements in such
8 section, has as one of its principal functions identi-
9 fying and implementing strategies and activities that
10 address health care workforce needs in its service
11 area, in coordination with the local workforce invest-
12 ment boards.

13 “(14) CLINICAL SOCIAL WORKER.—The term
14 ‘clinical social worker’ has the meaning given the
15 term in section 1861(hh)(1) of the Social Security
16 Act (42 U.S.C. 1395x(hh)(1)).

17 “(15) CULTURAL COMPETENCY.—The term
18 ‘cultural competency’ shall be defined by the Sec-
19 retary in a manner consistent with section
20 1707(d)(3).

21 “(16) DIRECT CARE WORKER.—The term ‘di-
22 rect care worker’ has the meaning given that term
23 in the 2010 Standard Occupational Classifications of
24 the Department of Labor for Home Health Aides
25 [31–1011], Psychiatric Aides [31–1013], Nursing

1 Assistants [31–1014], and Personal Care Aides [39–
2 9021].

3 “(17) FEDERALLY QUALIFIED HEALTH CEN-
4 TER.—The term ‘Federally qualified health center’
5 has the meaning given that term in section 1861(aa)
6 of the Social Security Act (42 U.S.C. 1395x(aa)).

7 “(18) FRONTIER HEALTH PROFESSIONAL
8 SHORTAGE AREA.—The term ‘frontier health profes-
9 sional shortage area’ means an area—

10 “(A) with a population density less than 6
11 persons per square mile within the service area;
12 and

13 “(B) with respect to which the distance or
14 time for the population to access care is exces-
15 sive.

16 “(19) GRADUATE PSYCHOLOGY.—The term
17 ‘graduate psychology’ means an accredited program
18 in professional psychology.

19 “(20) HEALTH DISPARITY POPULATION.—The
20 term ‘health disparity population’ has the meaning
21 given such term in section 903(d)(1).

22 “(21) HEALTH LITERACY.—The term ‘health
23 literacy’ means the degree to which an individual has
24 the capacity to obtain, communicate, process, and

1 understand health information and services in order
2 to make appropriate health decisions.

3 “(22) MENTAL HEALTH SERVICE PROFES-
4 SIONAL.—The term ‘mental health service profes-
5 sional’ means an individual with a graduate or post-
6 graduate degree from an accredited institution of
7 higher education in psychiatry, psychology, school
8 psychology, behavioral pediatrics, psychiatric nurs-
9 ing, social work, school social work, substance abuse
10 disorder prevention and treatment, marriage and
11 family counseling, school counseling, or professional
12 counseling.

13 “(23) ONE-STOP DELIVERY SYSTEM CENTER.—
14 The term ‘one-stop delivery system’ means a one-
15 stop delivery system described in section 134(c) of
16 the Workforce Investment Act of 1998 (29 U.S.C.
17 2864(c)).

18 “(24) PARAPROFESSIONAL CHILD AND ADOLES-
19 CENT MENTAL HEALTH WORKER.—The term ‘para-
20 professional child and adolescent mental health
21 worker’ means an individual who is not a mental or
22 behavioral health service professional, but who works
23 at the first stage of contact with children and fami-
24 lies who are seeking mental or behavioral health

1 services, including substance abuse prevention and
2 treatment services.

3 “(25) RACIAL AND ETHNIC MINORITY GROUP;
4 RACIAL AND ETHNIC MINORITY POPULATION.—The
5 terms ‘racial and ethnic minority group’ and ‘racial
6 and ethnic minority population’ have the meaning
7 given the term ‘racial and ethnic minority group’ in
8 section 1707.

9 “(26) RURAL HEALTH CLINIC.—The term
10 ‘rural health clinic’ has the meaning given that term
11 in section 1861(aa) of the Social Security Act (42
12 U.S.C. 1395x(aa)).”.

13 (c) TITLE VIII OF THE PUBLIC HEALTH SERVICE
14 ACT.—Section 801 of the Public Health Service Act (42
15 U.S.C. 296) is amended—

16 (1) in paragraph (2)—

17 (A) by striking “means a” and inserting
18 “means an accredited (as defined in paragraph
19 6)”; and

20 (B) by striking the period as inserting the
21 following: “where graduates are—

22 “(A) authorized to sit for the National
23 Council Licensure EXamination-Registered
24 Nurse (NCLEX-RN); or

1 “(B) licensed registered nurses who will re-
2 ceive a graduate or equivalent degree or train-
3 ing to become an advanced education nurse as
4 defined by section 811(b).”; and

5 (2) by adding at the end the following:

6 “(16) ACCELERATED NURSING DEGREE PRO-
7 GRAM.—The term ‘accelerated nursing degree pro-
8 gram’ means a program of education in professional
9 nursing offered by an accredited school of nursing in
10 which an individual holding a bachelors degree in
11 another discipline receives a BSN or MSN degree in
12 an accelerated time frame as determined by the ac-
13 credited school of nursing.

14 “(17) BRIDGE OR DEGREE COMPLETION PRO-
15 GRAM.—The term ‘bridge or degree completion pro-
16 gram’ means a program of education in professional
17 nursing offered by an accredited school of nursing,
18 as defined in paragraph (2), that leads to a bacca-
19 laureate degree in nursing. Such programs may in-
20 clude, Registered Nurse (RN) to Bachelor’s of
21 Science of Nursing (BSN) programs, RN to MSN
22 (Master of Science of Nursing) programs, or BSN to
23 Doctoral programs.”.

1 **Subtitle B—Innovations in the**
2 **Health Care Workforce**

3 **SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMIS-**
4 **SION.**

5 (a) **PURPOSE.**—It is the purpose of this section to
6 establish a National Health Care Workforce Commission
7 that—

8 (1) serves as a national resource for Congress,
9 the President, States, and localities;

10 (2) communicates and coordinates with the De-
11 partments of Health and Human Services, Labor,
12 Veterans Affairs, Homeland Security, and Education
13 on related activities administered by one or more of
14 such Departments;

15 (3) develops and commissions evaluations of
16 education and training activities to determine wheth-
17 er the demand for health care workers is being met;

18 (4) identifies barriers to improved coordination
19 at the Federal, State, and local levels and rec-
20 ommend ways to address such barriers; and

21 (5) encourages innovations to address popu-
22 lation needs, constant changes in technology, and
23 other environmental factors.

1 (b) ESTABLISHMENT.—There is hereby established
2 the National Health Care Workforce Commission (in this
3 section referred to as the “Commission”).

4 (c) MEMBERSHIP.—

5 (1) NUMBER AND APPOINTMENT.—The Com-
6 mission shall be composed of 15 members to be ap-
7 pointed by the Comptroller General, without regard
8 to section 5 of the Federal Advisory Committee Act
9 (5 U.S.C. App.).

10 (2) QUALIFICATIONS.—

11 (A) IN GENERAL.—The membership of the
12 Commission shall include individuals—

13 (i) with national recognition for their
14 expertise in health care labor market anal-
15 ysis, including health care workforce anal-
16 ysis; health care finance and economics;
17 health care facility management; health
18 care plans and integrated delivery systems;
19 health care workforce education and train-
20 ing; health care philanthropy; providers of
21 health care services; and other related
22 fields; and

23 (ii) who will provide a combination of
24 professional perspectives, broad geographic
25 representation, and a balance between

1 urban, suburban, rural, and frontier rep-
2 resentatives.

3 (B) INCLUSION.—

4 (i) IN GENERAL.—The membership of
5 the Commission shall include no less than
6 one representative of—

7 (I) the health care workforce and
8 health professionals;

9 (II) employers;

10 (III) third-party payers;

11 (IV) individuals skilled in the
12 conduct and interpretation of health
13 care services and health economics re-
14 search;

15 (V) representatives of consumers;

16 (VI) labor unions;

17 (VII) State or local workforce in-
18 vestment boards; and

19 (VIII) educational institutions
20 (which may include elementary and
21 secondary institutions, institutions of
22 higher education, including 2 and 4
23 year institutions, or registered ap-
24 prenticeship programs).

1 (ii) ADDITIONAL MEMBERS.—The re-
2 remaining membership may include addi-
3 tional representatives from clause (i) and
4 other individuals as determined appro-
5 priate by the Comptroller General of the
6 United States.

7 (C) MAJORITY NON-PROVIDERS.—Individ-
8 uals who are directly involved in health profes-
9 sions education or practice shall not constitute
10 a majority of the membership of the Commis-
11 sion.

12 (D) ETHICAL DISCLOSURE.—The Comp-
13 troller General shall establish a system for pub-
14 lic disclosure by members of the Commission of
15 financial and other potential conflicts of interest
16 relating to such members. Members of the
17 Commission shall be treated as employees of
18 Congress for purposes of applying title I of the
19 Ethics in Government Act of 1978. Members of
20 the Commission shall not be treated as special
21 government employees under title 18, United
22 States Code.

23 (3) TERMS.—

24 (A) IN GENERAL.—The terms of members
25 of the Commission shall be for 3 years except

1 that the Comptroller General shall designate
2 staggered terms for the members first ap-
3 pointed.

4 (B) VACANCIES.—Any member appointed
5 to fill a vacancy occurring before the expiration
6 of the term for which the member's predecessor
7 was appointed shall be appointed only for the
8 remainder of that term. A member may serve
9 after the expiration of that member's term until
10 a successor has taken office. A vacancy in the
11 Commission shall be filled in the manner in
12 which the original appointment was made.

13 (C) INITIAL APPOINTMENTS.—The Comp-
14 troller General shall make initial appointments
15 of members to the Commission not later than
16 September 30, 2010.

17 (4) COMPENSATION.—While serving on the
18 business of the Commission (including travel time),
19 a member of the Commission shall be entitled to
20 compensation at the per diem equivalent of the rate
21 provided for level IV of the Executive Schedule
22 under section 5315 of title 5, United States Code,
23 and while so serving away from home and the mem-
24 ber's regular place of business, a member may be al-
25 lowed travel expenses, as authorized by the Chair-

1 man of the Commission. Physicians serving as per-
2 sonnel of the Commission may be provided a physi-
3 cian comparability allowance by the Commission in
4 the same manner as Government physicians may be
5 provided such an allowance by an agency under sec-
6 tion 5948 of title 5, United States Code, and for
7 such purpose subsection (i) of such section shall
8 apply to the Commission in the same manner as it
9 applies to the Tennessee Valley Authority. For pur-
10 poses of pay (other than pay of members of the
11 Commission) and employment benefits, rights, and
12 privileges, all personnel of the Commission shall be
13 treated as if they were employees of the United
14 States Senate. Personnel of the Commission shall
15 not be treated as employees of the Government Ac-
16 countability Office for any purpose.

17 (5) CHAIRMAN, VICE CHAIRMAN.—The Comp-
18 troller General shall designate a member of the
19 Commission, at the time of appointment of the mem-
20 ber, as Chairman and a member as Vice Chairman
21 for that term of appointment, except that in the case
22 of vacancy of the chairmanship or vice chairman-
23 ship, the Comptroller General may designate another
24 member for the remainder of that member's term.

1 (6) MEETINGS.—The Commission shall meet at
2 the call of the chairman, but no less frequently than
3 on a quarterly basis.

4 (d) DUTIES.—

5 (1) RECOGNITION, DISSEMINATION, AND COM-
6 MUNICATION.—The Commission shall—

7 (A) recognize efforts of Federal, State, and
8 local partnerships to develop and offer health
9 care career pathways of proven effectiveness;

10 (B) disseminate information on promising
11 retention practices for health care professionals;
12 and

13 (C) communicate information on important
14 policies and practices that affect the recruit-
15 ment, education and training, and retention of
16 the health care workforce.

17 (2) REVIEW OF HEALTH CARE WORKFORCE
18 AND ANNUAL REPORTS.—In order to develop a fis-
19 cally sustainable integrated workforce that supports
20 a high-quality, readily accessible health care delivery
21 system that meets the needs of patients and popu-
22 lations, the Commission, in consultation with rel-
23 evant Federal, State, and local agencies, shall—

1 (A) review current and projected health
2 care workforce supply and demand, including
3 the topics described in paragraph (3);

4 (B) make recommendations to Congress
5 and the Administration concerning national
6 health care workforce priorities, goals, and poli-
7 cies;

8 (C) by not later than October 1 of each
9 year (beginning with 2011), submit a report to
10 Congress and the Administration containing the
11 results of such reviews and recommendations
12 concerning related policies; and

13 (D) by not later than April 1 of each year
14 (beginning with 2011), submit a report to Con-
15 gress and the Administration containing a re-
16 view of, and recommendations on, at a min-
17 imum one high priority area as described in
18 paragraph (4).

19 (3) SPECIFIC TOPICS TO BE REVIEWED.—The
20 topics described in this paragraph include—

21 (A) current health care workforce supply
22 and distribution, including demographics, skill
23 sets, and demands, with projected demands
24 during the subsequent 10 and 25 year periods;

1 (B) health care workforce education and
2 training capacity, including the number of stu-
3 dents who have completed education and train-
4 ing, including registered apprenticeships; the
5 number of qualified faculty; the education and
6 training infrastructure; and the education and
7 training demands, with projected demands dur-
8 ing the subsequent 10 and 25 year periods;

9 (C) the education loan and grant programs
10 in titles VII and VIII of the Public Health
11 Service Act (42 U.S.C. 292 et seq. and 296 et
12 seq.), with recommendations on whether such
13 programs should become part of the Higher
14 Education Act of 1965 (20 U.S.C. 1001 et
15 seq);

16 (D) the implications of new and existing
17 Federal policies which affect the health care
18 workforce, including Medicare and Medicaid
19 graduate medical education policies, titles VII
20 and VIII of the Public Health Service Act (42
21 U.S.C. 292 et seq. and 296 et seq.), the Na-
22 tional Health Service Corps (with recommenda-
23 tions for aligning such programs with national
24 health workforce priorities and goals), and
25 other health care workforce programs, including

1 those supported through the Workforce Invest-
2 ment Act of 1998 (29 U.S.C. 2801 et seq.), the
3 Carl D. Perkins Career and Technical Edu-
4 cation Act of 2006 (20 U.S.C. 2301 et seq.),
5 the Higher Education Act of 1965 (20 U.S.C.
6 1001 et seq.), and any other Federal health
7 care workforce programs;

8 (E) the health care workforce needs of spe-
9 cial populations, such as minorities, rural popu-
10 lations, medically underserved populations, gen-
11 der specific needs, individuals with disabilities,
12 and geriatric and pediatric populations with
13 recommendations for new and existing Federal
14 policies to meet the needs of these special popu-
15 lations; and

16 (F) recommendations creating or revising
17 national loan repayment programs and scholar-
18 ship programs to require low-income, minority
19 medical students to serve in their home commu-
20 nities, if designated as medical underserved
21 community.

22 (4) HIGH PRIORITY AREAS.—

23 (A) IN GENERAL.—The initial high priority
24 topics described in this paragraph include each
25 of the following:

1 (i) Integrated health care workforce
2 planning that identifies health care profes-
3 sional skills needed and maximizes the skill
4 sets of health care professionals across dis-
5 ciplines.

6 (ii) An analysis of the nature, scopes
7 of practice, and demands for health care
8 workers in the enhanced information tech-
9 nology and management workplace.

10 (iii) An analysis of how to align Medi-
11 care and Medicaid graduate medical edu-
12 cation policies with national workforce
13 goals.

14 (iv) The education and training capac-
15 ity, projected demands, and integration
16 with the health care delivery system of
17 each of the following:

18 (I) Nursing workforce capacity at
19 all levels.

20 (II) Oral health care workforce
21 capacity at all levels.

22 (III) Mental and behavioral
23 health care workforce capacity at all
24 levels.

1 (IV) Allied health and public
2 health care workforce capacity at all
3 levels.

4 (V) Emergency medical service
5 workforce capacity, including the re-
6 tention and recruitment of the volun-
7 teer workforce, at all levels.

8 (VI) The geographic distribution
9 of health care providers as compared
10 to the identified health care workforce
11 needs of States and regions.

12 (B) FUTURE DETERMINATIONS.—The
13 Commission may require that additional topics
14 be included under subparagraph (A). The ap-
15 propriate committees of Congress may rec-
16 ommend to the Commission the inclusion of
17 other topics for health care workforce develop-
18 ment areas that require special attention.

19 (5) GRANT PROGRAM.—The Commission
20 shall—

21 (A) review implementation progress reports
22 on, and report to Congress about, the State
23 Health Care Workforce Development Grant
24 program established in section 5102;

1 (B) in collaboration with the Department
2 of Labor and in coordination with the Depart-
3 ment of Education and other relevant Federal
4 agencies, make recommendations to the fiscal
5 and administrative agent under section 5102(b)
6 for grant recipients under section 5102;

7 (C) assess the implementation of the
8 grants under such section; and

9 (D) collect performance and report infor-
10 mation, including identified models and best
11 practices, on grants from the fiscal and admin-
12 istrative agent under such section and dis-
13 tribute this information to Congress, relevant
14 Federal agencies, and to the public.

15 (6) STUDY.—The Commission shall study effec-
16 tive mechanisms for financing education and train-
17 ing for careers in health care, including public health
18 and allied health.

19 (7) RECOMMENDATIONS.—The Commission
20 shall submit recommendations to Congress, the De-
21 partment of Labor, and the Department of Health
22 and Human Services about improving safety, health,
23 and worker protections in the workplace for the
24 health care workforce.

1 (8) ASSESSMENT.—The Commission shall as-
2 sess and receive reports from the National Center
3 for Health Care Workforce Analysis established
4 under section 761(b) of the Public Service Health
5 Act (as amended by section 5103).

6 (e) CONSULTATION WITH FEDERAL, STATE, AND
7 LOCAL AGENCIES, CONGRESS, AND OTHER ORGANIZA-
8 TIONS.—

9 (1) IN GENERAL.—The Commission shall con-
10 sult with Federal agencies (including the Depart-
11 ments of Health and Human Services, Labor, Edu-
12 cation, Commerce, Agriculture, Defense, and Vet-
13 erans Affairs and the Environmental Protection
14 Agency), Congress, the Medicare Payment Advisory
15 Commission, the Medicaid and CHIP Payment and
16 Access Commission, and, to the extent practicable,
17 with State and local agencies, Indian tribes, vol-
18 untary health care organizations, professional soci-
19 eties, and other relevant public-private health care
20 partnerships.

21 (2) OBTAINING OFFICIAL DATA.—The Commis-
22 sion, consistent with established privacy rules, may
23 secure directly from any department or agency of
24 the Executive Branch information necessary to en-
25 able the Commission to carry out this section.

1 (3) DETAIL OF FEDERAL GOVERNMENT EM-
2 PLOYEES.—An employee of the Federal Government
3 may be detailed to the Commission without reim-
4 bursement. The detail of such an employee shall be
5 without interruption or loss of civil service status.

6 (f) DIRECTOR AND STAFF; EXPERTS AND CONSULT-
7 ANTS.—Subject to such review as the Comptroller General
8 of the United States determines to be necessary to ensure
9 the efficient administration of the Commission, the Com-
10 mission may—

11 (1) employ and fix the compensation of an execu-
12 tive director that shall not exceed the rate of basic
13 pay payable for level V of the Executive Schedule
14 and such other personnel as may be necessary to
15 carry out its duties (without regard to the provisions
16 of title 5, United States Code, governing appoint-
17 ments in the competitive service);

18 (2) seek such assistance and support as may be
19 required in the performance of its duties from ap-
20 propriate Federal departments and agencies;

21 (3) enter into contracts or make other arrange-
22 ments, as may be necessary for the conduct of the
23 work of the Commission (without regard to section
24 3709 of the Revised Statutes (41 U.S.C. 5));

1 (4) make advance, progress, and other pay-
2 ments which relate to the work of the Commission;

3 (5) provide transportation and subsistence for
4 persons serving without compensation; and

5 (6) prescribe such rules and regulations as the
6 Commission determines to be necessary with respect
7 to the internal organization and operation of the
8 Commission.

9 (g) POWERS.—

10 (1) DATA COLLECTION.—In order to carry out
11 its functions under this section, the Commission
12 shall—

13 (A) utilize existing information, both pub-
14 lished and unpublished, where possible, collected
15 and assessed either by its own staff or under
16 other arrangements made in accordance with
17 this section, including coordination with the Bu-
18 reau of Labor Statistics;

19 (B) carry out, or award grants or con-
20 tracts for the carrying out of, original research
21 and development, where existing information is
22 inadequate, and

23 (C) adopt procedures allowing interested
24 parties to submit information for the Commis-

1 sion's use in making reports and recommenda-
2 tions.

3 (2) ACCESS OF THE GOVERNMENT ACCOUNT-
4 ABILITY OFFICE TO INFORMATION.—The Comp-
5 troller General of the United States shall have unre-
6 stricted access to all deliberations, records, and data
7 of the Commission, immediately upon request.

8 (3) PERIODIC AUDIT.—The Commission shall
9 be subject to periodic audit by an independent public
10 accountant under contract to the Commission.

11 (h) AUTHORIZATION OF APPROPRIATIONS.—

12 (1) REQUEST FOR APPROPRIATIONS.—The
13 Commission shall submit requests for appropriations
14 in the same manner as the Comptroller General of
15 the United States submits requests for appropria-
16 tions. Amounts so appropriated for the Commission
17 shall be separate from amounts appropriated for the
18 Comptroller General.

19 (2) AUTHORIZATION.—There are authorized to
20 be appropriated such sums as may be necessary to
21 carry out this section.

22 (3) GIFTS AND SERVICES.—The Commission
23 may not accept gifts, bequeaths, or donations of
24 property, but may accept and use donations of serv-
25 ices for purposes of carrying out this section.

1 (i) DEFINITIONS.—In this section:

2 (1) HEALTH CARE WORKFORCE.—The term
3 “health care workforce” includes all health care pro-
4 viders with direct patient care and support respon-
5 sibilities, such as physicians, nurses, nurse practi-
6 tioners, primary care providers, preventive medicine
7 physicians, optometrists, ophthalmologists, physician
8 assistants, pharmacists, dentists, dental hygienists,
9 and other oral healthcare professionals, allied health
10 professionals, doctors of chiropractic, community
11 health workers, health care paraprofessionals, direct
12 care workers, psychologists and other behavioral and
13 mental health professionals (including substance
14 abuse prevention and treatment providers), social
15 workers, physical and occupational therapists, cer-
16 tified nurse midwives, podiatrists, the EMS work-
17 force (including professional and volunteer ambu-
18 lance personnel and firefighters who perform emer-
19 gency medical services), licensed complementary and
20 alternative medicine providers, integrative health
21 practitioners, public health professionals, and any
22 other health professional that the Comptroller Gen-
23 eral of the United States determines appropriate.

24 (2) HEALTH PROFESSIONALS.—The term
25 “health professionals” includes—

1 (A) dentists, dental hygienists, primary
2 care providers, specialty physicians, nurses,
3 nurse practitioners, physician assistants, psy-
4 chologists and other behavioral and mental
5 health professionals (including substance abuse
6 prevention and treatment providers), social
7 workers, physical and occupational therapists,
8 public health professionals, clinical pharmacists,
9 allied health professionals, doctors of chiro-
10 practic, community health workers, school
11 nurses, certified nurse midwives, podiatrists, li-
12 censed complementary and alternative medicine
13 providers, the EMS workforce (including profes-
14 sional and volunteer ambulance personnel and
15 firefighters who perform emergency medical
16 services), and integrative health practitioners;

17 (B) national representatives of health pro-
18 fessionals;

19 (C) representatives of schools of medicine,
20 osteopathy, nursing, dentistry, optometry, phar-
21 macy, chiropractic, allied health, educational
22 programs for public health professionals, behav-
23 ioral and mental health professionals (as so de-
24 fined), social workers, pharmacists, physical
25 and occupational therapists, oral health care in-

1 industry dentistry and dental hygiene, and physi-
2 cian assistants;

3 (D) representatives of public and private
4 teaching hospitals, and ambulatory health facili-
5 ties, including Federal medical facilities; and

6 (E) any other health professional the
7 Comptroller General of the United States deter-
8 mines appropriate.

9 **SEC. 5102. STATE HEALTH CARE WORKFORCE DEVELOP-**
10 **MENT GRANTS.**

11 (a) **ESTABLISHMENT.**—There is established a com-
12 petitive health care workforce development grant program
13 (referred to in this section as the “program”) for the pur-
14 pose of enabling State partnerships to complete com-
15 prehensive planning and to carry out activities leading to
16 coherent and comprehensive health care workforce devel-
17 opment strategies at the State and local levels.

18 (b) **FISCAL AND ADMINISTRATIVE AGENT.**—The
19 Health Resources and Services Administration of the De-
20 partment of Health and Human Services (referred to in
21 this section as the “Administration”) shall be the fiscal
22 and administrative agent for the grants awarded under
23 this section. The Administration is authorized to carry out
24 the program, in consultation with the National Health
25 Care Workforce Commission (referred to in this section

1 as the “Commission”), which shall review reports on the
2 development, implementation, and evaluation activities of
3 the grant program, including—

4 (1) administering the grants;

5 (2) providing technical assistance to grantees;

6 and

7 (3) reporting performance information to the
8 Commission.

9 (c) PLANNING GRANTS.—

10 (1) AMOUNT AND DURATION.—A planning
11 grant shall be awarded under this subsection for a
12 period of not more than one year and the maximum
13 award may not be more than \$150,000.

14 (2) ELIGIBILITY.—To be eligible to receive a
15 planning grant, an entity shall be an eligible part-
16 nership. An eligible partnership shall be a State
17 workforce investment board, if it includes or modi-
18 fies the members to include at least one representa-
19 tive from each of the following: health care em-
20 ployer, labor organization, a public 2-year institution
21 of higher education, a public 4-year institution of
22 higher education, the recognized State federation of
23 labor, the State public secondary education agency,
24 the State P-16 or P-20 Council if such a council ex-
25 ists, and a philanthropic organization that is actively

1 engaged in providing learning, mentoring, and work
2 opportunities to recruit, educate, and train individ-
3 uals for, and retain individuals in, careers in health
4 care and related industries.

5 (3) FISCAL AND ADMINISTRATIVE AGENT.—The
6 Governor of the State receiving a planning grant has
7 the authority to appoint a fiscal and an administra-
8 tive agency for the partnership.

9 (4) APPLICATION.—Each State partnership de-
10 siring a planning grant shall submit an application
11 to the Administrator of the Administration at such
12 time and in such manner, and accompanied by such
13 information as the Administrator may reasonable re-
14 quire. Each application submitted for a planning
15 grant shall describe the members of the State part-
16 nership, the activities for which assistance is sought,
17 the proposed performance benchmarks to be used to
18 measure progress under the planning grant, a budg-
19 et for use of the funds to complete the required ac-
20 tivities described in paragraph (5), and such addi-
21 tional assurance and information as the Adminis-
22 trator determines to be essential to ensure compli-
23 ance with the grant program requirements.

1 (5) REQUIRED ACTIVITIES.—A State partner-
2 ship receiving a planning grant shall carry out the
3 following:

4 (A) Analyze State labor market informa-
5 tion in order to create health care career path-
6 ways for students and adults, including dis-
7 located workers.

8 (B) Identify current and projected high de-
9 mand State or regional health care sectors for
10 purposes of planning career pathways.

11 (C) Identify existing Federal, State, and
12 private resources to recruit, educate or train,
13 and retain a skilled health care workforce and
14 strengthen partnerships.

15 (D) Describe the academic and health care
16 industry skill standards for high school gradua-
17 tion, for entry into postsecondary education,
18 and for various credentials and licensure.

19 (E) Describe State secondary and postsec-
20 ondary education and training policies, models,
21 or practices for the health care sector, including
22 career information and guidance counseling.

23 (F) Identify Federal or State policies or
24 rules to developing a coherent and comprehen-
25 sive health care workforce development strategy

1 and barriers and a plan to resolve these bar-
2 riers.

3 (G) Participate in the Administration's
4 evaluation and reporting activities.

5 (6) PERFORMANCE AND EVALUATION.—Before
6 the State partnership receives a planning grant,
7 such partnership and the Administrator of the Ad-
8 ministration shall jointly determine the performance
9 benchmarks that will be established for the purposes
10 of the planning grant.

11 (7) MATCH.—Each State partnership receiving
12 a planning grant shall provide an amount, in cash
13 or in kind, that is not less than 15 percent of the
14 amount of the grant, to carry out the activities sup-
15 ported by the grant. The matching requirement may
16 be provided from funds available under other Fed-
17 eral, State, local or private sources to carry out the
18 activities.

19 (8) REPORT.—

20 (A) REPORT TO ADMINISTRATION.—Not
21 later than 1 year after a State partnership re-
22 ceives a planning grant, the partnership shall
23 submit a report to the Administration on the
24 State's performance of the activities under the
25 grant, including the use of funds, including

1 matching funds, to carry out required activities,
2 and a description of the progress of the State
3 workforce investment board in meeting the per-
4 formance benchmarks.

5 (B) REPORT TO CONGRESS.—The Admin-
6 istration shall submit a report to Congress ana-
7 lyzing the planning activities, performance, and
8 fund utilization of each State grant recipient,
9 including an identification of promising prac-
10 tices and a profile of the activities of each State
11 grant recipient.

12 (d) IMPLEMENTATION GRANTS.—

13 (1) IN GENERAL.—The Administration shall—

14 (A) competitively award implementation
15 grants to State partnerships to enable such
16 partnerships to implement activities that will
17 result in a coherent and comprehensive plan for
18 health workforce development that will address
19 current and projected workforce demands with-
20 in the State; and

21 (B) inform the Commission and Congress
22 about the awards made.

23 (2) DURATION.—An implementation grant shall
24 be awarded for a period of no more than 2 years,
25 except in those cases where the Administration de-

1 terminates that the grantee is high performing and the
2 activities supported by the grant warrant up to 1 ad-
3 ditional year of funding.

4 (3) ELIGIBILITY.—To be eligible for an imple-
5 mentation grant, a State partnership shall have—

6 (A) received a planning grant under sub-
7 section (c) and completed all requirements of
8 such grant; or

9 (B) completed a satisfactory application,
10 including a plan to coordinate with required
11 partners and complete the required activities
12 during the 2 year period of the implementation
13 grant.

14 (4) FISCAL AND ADMINISTRATIVE AGENT.—A
15 State partnership receiving an implementation grant
16 shall appoint a fiscal and an administration agent
17 for the implementation of such grant.

18 (5) APPLICATION.—Each eligible State partner-
19 ship desiring an implementation grant shall submit
20 an application to the Administration at such time, in
21 such manner, and accompanied by such information
22 as the Administration may reasonably require. Each
23 application submitted shall include—

24 (A) a description of the members of the
25 State partnership;

1 (B) a description of how the State partner-
2 ship completed the required activities under the
3 planning grant, if applicable;

4 (C) a description of the activities for which
5 implementation grant funds are sought, includ-
6 ing grants to regions by the State partnership
7 to advance coherent and comprehensive regional
8 health care workforce planning activities;

9 (D) a description of how the State partner-
10 ship will coordinate with required partners and
11 complete the required partnership activities
12 during the duration of an implementation
13 grant;

14 (E) a budget proposal of the cost of the
15 activities supported by the implementation
16 grant and a timeline for the provision of match-
17 ing funds required;

18 (F) proposed performance benchmarks to
19 be used to assess and evaluate the progress of
20 the partnership activities;

21 (G) a description of how the State partner-
22 ship will collect data to report progress in grant
23 activities; and

1 (H) such additional assurances as the Ad-
2 ministration determines to be essential to en-
3 sure compliance with grant requirements.

4 (6) REQUIRED ACTIVITIES.—

5 (A) IN GENERAL.—A State partnership
6 that receives an implementation grant may re-
7 serve not less than 60 percent of the grant
8 funds to make grants to be competitively
9 awarded by the State partnership, consistent
10 with State procurement rules, to encourage re-
11 gional partnerships to address health care
12 workforce development needs and to promote
13 innovative health care workforce career pathway
14 activities, including career counseling, learning,
15 and employment.

16 (B) ELIGIBLE PARTNERSHIP DUTIES.—An
17 eligible State partnership receiving an imple-
18 mentation grant shall—

19 (i) identify and convene regional lead-
20 ership to discuss opportunities to engage in
21 statewide health care workforce develop-
22 ment planning, including the potential use
23 of competitive grants to improve the devel-
24 opment, distribution, and diversity of the
25 regional health care workforce; the align-

1 ment of curricula for health care careers;
2 and the access to quality career informa-
3 tion and guidance and education and train-
4 ing opportunities;

5 (ii) in consultation with key stake-
6 holders and regional leaders, take appro-
7 priate steps to reduce Federal, State, or
8 local barriers to a comprehensive and co-
9 herent strategy, including changes in State
10 or local policies to foster coherent and
11 comprehensive health care workforce devel-
12 opment activities, including health care ca-
13 reer pathways at the regional and State
14 levels, career planning information, re-
15 training for dislocated workers, and as ap-
16 propriate, requests for Federal program or
17 administrative waivers;

18 (iii) develop, disseminate, and review
19 with key stakeholders a preliminary state-
20 wide strategy that addresses short- and
21 long-term health care workforce develop-
22 ment supply versus demand;

23 (iv) convene State partnership mem-
24 bers on a regular basis, and at least on a
25 semiannual basis;

1 (v) assist leaders at the regional level
2 to form partnerships, including technical
3 assistance and capacity building activities;

4 (vi) collect and assess data on and re-
5 port on the performance benchmarks se-
6 lected by the State partnership and the
7 Administration for implementation activi-
8 ties carried out by regional and State part-
9 nerships; and

10 (vii) participate in the Administra-
11 tion's evaluation and reporting activities.

12 (7) PERFORMANCE AND EVALUATION.—Before
13 the State partnership receives an implementation
14 grant, it and the Administrator shall jointly deter-
15 mine the performance benchmarks that shall be es-
16 tablished for the purposes of the implementation
17 grant.

18 (8) MATCH.—Each State partnership receiving
19 an implementation grant shall provide an amount, in
20 cash or in kind that is not less than 25 percent of
21 the amount of the grant, to carry out the activities
22 supported by the grant. The matching funds may be
23 provided from funds available from other Federal,
24 State, local, or private sources to carry out such ac-
25 tivities.

1 (9) REPORTS.—

2 (A) REPORT TO ADMINISTRATION.—For
3 each year of the implementation grant, the
4 State partnership receiving the implementation
5 grant shall submit a report to the Administra-
6 tion on the performance of the State of the
7 grant activities, including a description of the
8 use of the funds, including matched funds, to
9 complete activities, and a description of the per-
10 formance of the State partnership in meeting
11 the performance benchmarks.

12 (B) REPORT TO CONGRESS.—The Admin-
13 istration shall submit a report to Congress ana-
14 lyzing implementation activities, performance,
15 and fund utilization of the State grantees, in-
16 cluding an identification of promising practices
17 and a profile of the activities of each State
18 grantee.

19 (e) AUTHORIZATION FOR APPROPRIATIONS.—

20 (1) PLANNING GRANTS.—There are authorized
21 to be appropriated to award planning grants under
22 subsection (c) \$8,000,000 for fiscal year 2010, and
23 such sums as may be necessary for each subsequent
24 fiscal year.

1 (2) IMPLEMENTATION GRANTS.—There are au-
2 thorized to be appropriated to award implementation
3 grants under subsection (d), \$150,000,000 for fiscal
4 year 2010, and such sums as may be necessary for
5 each subsequent fiscal year.

6 **SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.**

7 (a) IN GENERAL.—Section 761 of the Public Health
8 Service Act (42 U.S.C. 294m) is amended—

9 (1) by redesignating subsection (c) as sub-
10 section (e);

11 (2) by striking subsection (b) and inserting the
12 following:

13 “(b) NATIONAL CENTER FOR HEALTH CARE WORK-
14 FORCE ANALYSIS.—

15 “(1) ESTABLISHMENT.—The Secretary shall es-
16 tablish the National Center for Health Workforce
17 Analysis (referred to in this section as the ‘National
18 Center’).

19 “(2) PURPOSES.—The National Center, in co-
20 ordination to the extent practicable with the Na-
21 tional Health Care Workforce Commission (estab-
22 lished in section 5101 of the Patient Protection and
23 Affordable Care Act), and relevant regional and
24 State centers and agencies, shall—

1 “(A) provide for the development of infor-
2 mation describing and analyzing the health care
3 workforce and workforce related issues;

4 “(B) carry out the activities under section
5 792(a);

6 “(C) annually evaluate programs under
7 this title;

8 “(D) develop and publish performance
9 measures and benchmarks for programs under
10 this title; and

11 “(E) establish, maintain, and publicize a
12 national Internet registry of each grant award-
13 ed under this title and a database to collect
14 data from longitudinal evaluations (as described
15 in subsection (d)(2)) on performance measures
16 (as developed under sections 749(d)(3),
17 757(d)(3), and 762(a)(3)).

18 “(3) COLLABORATION AND DATA SHARING.—

19 “(A) IN GENERAL.—The National Center
20 shall collaborate with Federal agencies and rel-
21 evant professional and educational organiza-
22 tions or societies for the purpose of linking data
23 regarding grants awarded under this title.

24 “(B) CONTRACTS FOR HEALTH WORK-
25 FORCE ANALYSIS.—For the purpose of carrying

1 out the activities described in subparagraph
2 (A), the National Center may enter into con-
3 tracts with relevant professional and edu-
4 cational organizations or societies.

5 “(c) STATE AND REGIONAL CENTERS FOR HEALTH
6 WORKFORCE ANALYSIS.—

7 “(1) IN GENERAL.—The Secretary shall award
8 grants to, or enter into contracts with, eligible enti-
9 ties for purposes of—

10 “(A) collecting, analyzing, and reporting
11 data regarding programs under this title to the
12 National Center and to the public; and

13 “(B) providing technical assistance to local
14 and regional entities on the collection, analysis,
15 and reporting of data.

16 “(2) ELIGIBLE ENTITIES.—To be eligible for a
17 grant or contract under this subsection, an entity
18 shall—

19 “(A) be a State, a State workforce invest-
20 ment board, a public health or health profes-
21 sions school, an academic health center, or an
22 appropriate public or private nonprofit entity;
23 and

24 “(B) submit to the Secretary an applica-
25 tion at such time, in such manner, and con-

1 taining such information as the Secretary may
2 require.

3 “(d) INCREASE IN GRANTS FOR LONGITUDINAL
4 EVALUATIONS.—

5 “(1) IN GENERAL.—The Secretary shall in-
6 crease the amount awarded to an eligible entity
7 under this title for a longitudinal evaluation of indi-
8 viduals who have received education, training, or fi-
9 nancial assistance from programs under this title.

10 “(2) CAPABILITY.—A longitudinal evaluation
11 shall be capable of—

12 “(A) studying practice patterns; and

13 “(B) collecting and reporting data on per-
14 formance measures developed under sections
15 749(d)(3), 757(d)(3), and 762(a)(3).

16 “(3) GUIDELINES.—A longitudinal evaluation
17 shall comply with guidelines issued under sections
18 749(d)(4), 757(d)(4), and 762(a)(4).

19 “(4) ELIGIBLE ENTITIES.—To be eligible to ob-
20 tain an increase under this section, an entity shall
21 be a recipient of a grant or contract under this
22 title.”; and

23 (3) in subsection (e), as so redesignated—

24 (A) by striking paragraph (1) and insert-
25 ing the following:

1 “(1) IN GENERAL.—

2 “(A) NATIONAL CENTER.—To carry out
3 subsection (b), there are authorized to be ap-
4 propriated \$7,500,000 for each of fiscal years
5 2010 through 2014.

6 “(B) STATE AND REGIONAL CENTERS.—
7 To carry out subsection (c), there are author-
8 ized to be appropriated \$4,500,000 for each of
9 fiscal years 2010 through 2014.

10 “(C) GRANTS FOR LONGITUDINAL EVALUA-
11 TIONS.—To carry out subsection (d), there are
12 authorized to be appropriated such sums as
13 may be necessary for fiscal years 2010 through
14 2014.”; and

15 (4) in paragraph (2), by striking “subsection
16 (a)” and inserting “paragraph (1)”.

17 (b) TRANSFERS.—Not later than 180 days after the
18 date of enactment of this Act, the responsibilities and re-
19 sources of the National Center for Health Workforce Anal-
20 ysis, as in effect on the date before the date of enactment
21 of this Act, shall be transferred to the National Center
22 for Health Care Workforce Analysis established under sec-
23 tion 761 of the Public Health Service Act, as amended
24 by subsection (a).

1 (c) USE OF LONGITUDINAL EVALUATIONS.—Section
2 791(a)(1) of the Public Health Service Act (42 U.S.C.
3 295j(a)(1)) is amended—

4 (1) in subparagraph (A), by striking “or” at
5 the end;

6 (2) in subparagraph (B), by striking the period
7 and inserting “; or”; and

8 (3) by adding at the end the following:

9 “(C) utilizes a longitudinal evaluation (as
10 described in section 761(d)(2)) and reports data
11 from such system to the national workforce
12 database (as established under section
13 761(b)(2)(E)).”.

14 (d) PERFORMANCE MEASURES; GUIDELINES FOR
15 LONGITUDINAL EVALUATIONS.—

16 (1) ADVISORY COMMITTEE ON TRAINING IN PRI-
17 MARY CARE MEDICINE AND DENTISTRY.—Section
18 748(d) of the Public Health Service Act is amend-
19 ed—

20 (A) in paragraph (1), by striking “and” at
21 the end;

22 (B) in paragraph (2), by striking the pe-
23 riod and inserting a semicolon; and

24 (C) by adding at the end the following:

1 “(3) develop, publish, and implement perform-
2 ance measures for programs under this part;

3 “(4) develop and publish guidelines for longitu-
4 dinal evaluations (as described in section 761(d)(2))
5 for programs under this part; and

6 “(5) recommend appropriation levels for pro-
7 grams under this part.”.

8 (2) ADVISORY COMMITTEE ON INTERDISCIPLI-
9 NARY, COMMUNITY-BASED LINKAGES.—Section
10 756(d) of the Public Health Service Act is amend-
11 ed—

12 (A) in paragraph (1), by striking “and” at
13 the end;

14 (B) in paragraph (2), by striking the pe-
15 riod and inserting a semicolon; and

16 (C) by adding at the end the following:

17 “(3) develop, publish, and implement perform-
18 ance measures for programs under this part;

19 “(4) develop and publish guidelines for longitu-
20 dinal evaluations (as described in section 761(d)(2))
21 for programs under this part; and

22 “(5) recommend appropriation levels for pro-
23 grams under this part.”.

1 (3) ADVISORY COUNCIL ON GRADUATE MEDICAL
2 EDUCATION.—Section 762(a) of the Public Health
3 Service Act (42 U.S.C. 294o(a)) is amended—

4 (A) in paragraph (1), by striking “and” at
5 the end;

6 (B) in paragraph (2), by striking the pe-
7 riod and inserting a semicolon; and

8 (C) by adding at the end the following:

9 “(3) develop, publish, and implement perform-
10 ance measures for programs under this title, except
11 for programs under part C or D;

12 “(4) develop and publish guidelines for longitu-
13 dinal evaluations (as described in section 761(d)(2))
14 for programs under this title, except for programs
15 under part C or D; and

16 “(5) recommend appropriation levels for pro-
17 grams under this title, except for programs under
18 part C or D.”.

19 **Subtitle C—Increasing the Supply**
20 **of the Health Care Workforce**

21 **SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.**

22 (a) MEDICAL SCHOOLS AND PRIMARY HEALTH
23 CARE.—Section 723 of the Public Health Service Act (42
24 U.S.C. 292s) is amended—

25 (1) in subsection (a)—

1 (A) in paragraph (1), by striking subpara-
2 graph (B) and inserting the following:

3 “(B) to practice in such care for 10 years
4 (including residency training in primary health
5 care) or through the date on which the loan is
6 repaid in full, whichever occurs first.”; and

7 (B) by striking paragraph (3) and insert-
8 ing the following:

9 “(3) NONCOMPLIANCE BY STUDENT.—Each
10 agreement entered into with a student pursuant to
11 paragraph (1) shall provide that, if the student fails
12 to comply with such agreement, the loan involved
13 will begin to accrue interest at a rate of 2 percent
14 per year greater than the rate at which the student
15 would pay if compliant in such year.”; and

16 (2) by adding at the end the following:

17 “(d) SENSE OF CONGRESS.—It is the sense of Con-
18 gress that funds repaid under the loan program under this
19 section should not be transferred to the Treasury of the
20 United States or otherwise used for any other purpose
21 other than to carry out this section.”.

22 (b) STUDENT LOAN GUIDELINES.—The Secretary of
23 Health and Human Services shall not require parental fi-
24 nancial information for an independent student to deter-
25 mine financial need under section 723 of the Public

1 Health Service Act (42 U.S.C. 292s) and the determina-
2 tion of need for such information shall be at the discretion
3 of applicable school loan officer. The Secretary shall
4 amend guidelines issued by the Health Resources and
5 Services Administration in accordance with the preceding
6 sentence.

7 **SEC. 5202. NURSING STUDENT LOAN PROGRAM.**

8 (a) LOAN AGREEMENTS.—Section 836(a) of the Pub-
9 lic Health Service Act (42 U.S.C. 297b(a)) is amended—

10 (1) by striking “\$2,500” and inserting
11 “\$3,300”;

12 (2) by striking “\$4,000” and inserting
13 “\$5,200”; and

14 (3) by striking “\$13,000” and all that follows
15 through the period and inserting “\$17,000 in the
16 case of any student during fiscal years 2010 and
17 2011. After fiscal year 2011, such amounts shall be
18 adjusted to provide for a cost-of-attendance increase
19 for the yearly loan rate and the aggregate of the
20 loans.”.

21 (b) LOAN PROVISIONS.—Section 836(b) of the Public
22 Health Service Act (42 U.S.C. 297b(b)) is amended—

23 (1) in paragraph (1)(C), by striking “1986”
24 and inserting “2000”; and

1 (2) in paragraph (3), by striking “the date of
2 enactment of the Nurse Training Amendments of
3 1979” and inserting “September 29, 1995”.

4 **SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT**
5 **PROGRAMS.**

6 Part E of title VII of the Public Health Service Act
7 (42 U.S.C. 294n et seq.) is amended by adding at the end
8 the following:

9 **“Subpart 3—Recruitment and Retention Programs**

10 **“SEC. 775. INVESTMENT IN TOMORROW’S PEDIATRIC**
11 **HEALTH CARE WORKFORCE.**

12 “(a) ESTABLISHMENT.—The Secretary shall estab-
13 lish and carry out a pediatric specialty loan repayment
14 program under which the eligible individual agrees to be
15 employed full-time for a specified period (which shall not
16 be less than 2 years) in providing pediatric medical sub-
17 specialty, pediatric surgical specialty, or child and adoles-
18 cent mental and behavioral health care, including sub-
19 stance abuse prevention and treatment services.

20 “(b) PROGRAM ADMINISTRATION.—Through the pro-
21 gram established under this section, the Secretary shall
22 enter into contracts with qualified health professionals
23 under which—

24 “(1) such qualified health professionals will
25 agree to provide pediatric medical subspecialty, pedi-

1 atric surgical specialty, or child and adolescent men-
2 tal and behavioral health care in an area with a
3 shortage of the specified pediatric subspecialty that
4 has a sufficient pediatric population to support such
5 pediatric subspecialty, as determined by the Sec-
6 retary; and

7 “(2) the Secretary agrees to make payments on
8 the principal and interest of undergraduate, grad-
9 uate, or graduate medical education loans of profes-
10 sionals described in paragraph (1) of not more than
11 \$35,000 a year for each year of agreed upon service
12 under such paragraph for a period of not more than
13 3 years during the qualified health professional’s—

14 “(A) participation in an accredited pedi-
15 atric medical subspecialty, pediatric surgical
16 specialty, or child and adolescent mental health
17 subspecialty residency or fellowship; or

18 “(B) employment as a pediatric medical
19 subspecialist, pediatric surgical specialist, or
20 child and adolescent mental health professional
21 serving an area or population described in such
22 paragraph.

23 “(c) IN GENERAL.—

24 “(1) ELIGIBLE INDIVIDUALS.—

1 “(A) PEDIATRIC MEDICAL SPECIALISTS
2 AND PEDIATRIC SURGICAL SPECIALISTS.—For
3 purposes of contracts with respect to pediatric
4 medical specialists and pediatric surgical spe-
5 cialists, the term ‘qualified health professional’
6 means a licensed physician who—

7 “(i) is entering or receiving training
8 in an accredited pediatric medical sub-
9 specialty or pediatric surgical specialty
10 residency or fellowship; or

11 “(ii) has completed (but not prior to
12 the end of the calendar year in which this
13 section is enacted) the training described
14 in subparagraph (B).

15 “(B) CHILD AND ADOLESCENT MENTAL
16 AND BEHAVIORAL HEALTH.—For purposes of
17 contracts with respect to child and adolescent
18 mental and behavioral health care, the term
19 ‘qualified health professional’ means a health
20 care professional who—

21 “(i) has received specialized training
22 or clinical experience in child and adoles-
23 cent mental health in psychiatry, psy-
24 chology, school psychology, behavioral pedi-
25 atrics, psychiatric nursing, social work,

1 school social work, substance abuse dis-
2 order prevention and treatment, marriage
3 and family therapy, school counseling, or
4 professional counseling;

5 “(ii) has a license or certification in a
6 State to practice allopathic medicine, os-
7 teopathic medicine, psychology, school psy-
8 chology, psychiatric nursing, social work,
9 school social work, marriage and family
10 therapy, school counseling, or professional
11 counseling; or

12 “(iii) is a mental health service pro-
13 fessional who completed (but not before
14 the end of the calendar year in which this
15 section is enacted) specialized training or
16 clinical experience in child and adolescent
17 mental health described in clause (i).

18 “(2) ADDITIONAL ELIGIBILITY REQUIRE-
19 MENTS.—The Secretary may not enter into a con-
20 tract under this subsection with an eligible indi-
21 vidual unless—

22 “(A) the individual agrees to work in, or
23 for a provider serving, a health professional
24 shortage area or medically underserved area, or
25 to serve a medically underserved population;

1 “(B) the individual is a United States cit-
2 izen or a permanent legal United States resi-
3 dent; and

4 “(C) if the individual is enrolled in a grad-
5 uate program, the program is accredited, and
6 the individual has an acceptable level of aca-
7 demic standing (as determined by the Sec-
8 retary).

9 “(d) PRIORITY.—In entering into contracts under
10 this subsection, the Secretary shall give priority to appli-
11 cants who—

12 “(1) are or will be working in a school or other
13 pre-kindergarten, elementary, or secondary edu-
14 cation setting;

15 “(2) have familiarity with evidence-based meth-
16 ods and cultural and linguistic competence health
17 care services; and

18 “(3) demonstrate financial need.

19 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
20 is authorized to be appropriated \$30,000,000 for each of
21 fiscal years 2010 through 2014 to carry out subsection
22 (c)(1)(A) and \$20,000,000 for each of fiscal years 2010
23 through 2013 to carry out subsection (c)(1)(B).”.

1 **SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT**
2 **AND RETENTION PROGRAMS.**

3 Part E of title VII of the Public Health Service Act
4 (42 U.S.C. 294n et seq.), as amended by section 5203,
5 is further amended by adding at the end the following:

6 **“SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT**
7 **PROGRAM.**

8 “(a) **ESTABLISHMENT.**—The Secretary shall estab-
9 lish the Public Health Workforce Loan Repayment Pro-
10 gram (referred to in this section as the ‘Program’) to as-
11 sure an adequate supply of public health professionals to
12 eliminate critical public health workforce shortages in
13 Federal, State, local, and tribal public health agencies.

14 “(b) **ELIGIBILITY.**—To be eligible to participate in
15 the Program, an individual shall—

16 “(1)(A) be accepted for enrollment, or be en-
17 rolled, as a student in an accredited academic edu-
18 cational institution in a State or territory in the
19 final year of a course of study or program leading
20 to a public health or health professions degree or
21 certificate; and have accepted employment with a
22 Federal, State, local, or tribal public health agency,
23 or a related training fellowship, as recognized by the
24 Secretary, to commence upon graduation;

25 “(B)(i) have graduated, during the preceding
26 10-year period, from an accredited educational insti-

1 tution in a State or territory and received a public
2 health or health professions degree or certificate;
3 and

4 “(ii) be employed by, or have accepted employ-
5 ment with, a Federal, State, local, or tribal public
6 health agency or a related training fellowship, as
7 recognized by the Secretary;

8 “(2) be a United States citizen; and

9 “(3)(A) submit an application to the Secretary
10 to participate in the Program;

11 “(B) execute a written contract as required in
12 subsection (c); and

13 “(4) not have received, for the same service, a
14 reduction of loan obligations under section 455(m),
15 428J, 428K, 428L, or 460 of the Higher Education
16 Act of 1965.

17 “(c) CONTRACT.—The written contract (referred to
18 in this section as the ‘written contract’) between the Sec-
19 retary and an individual shall contain—

20 “(1) an agreement on the part of the Secretary
21 that the Secretary will repay on behalf of the indi-
22 vidual loans incurred by the individual in the pursuit
23 of the relevant degree or certificate in accordance
24 with the terms of the contract;

1 “(2) an agreement on the part of the individual
2 that the individual will serve in the full-time employ-
3 ment of a Federal, State, local, or tribal public
4 health agency or a related fellowship program in a
5 position related to the course of study or program
6 for which the contract was awarded for a period of
7 time (referred to in this section as the ‘period of ob-
8 ligated service’) equal to the greater of—

9 “(A) 3 years; or

10 “(B) such longer period of time as deter-
11 mined appropriate by the Secretary and the in-
12 dividual;

13 “(3) an agreement, as appropriate, on the part
14 of the individual to relocate to a priority service area
15 (as determined by the Secretary) in exchange for an
16 additional loan repayment incentive amount to be
17 determined by the Secretary;

18 “(4) a provision that any financial obligation of
19 the United States arising out of a contract entered
20 into under this section and any obligation of the in-
21 dividual that is conditioned thereon, is contingent on
22 funds being appropriated for loan repayments under
23 this section;

1 “(5) a statement of the damages to which the
2 United States is entitled, under this section for the
3 individual’s breach of the contract; and

4 “(6) such other statements of the rights and li-
5 abilities of the Secretary and of the individual, not
6 inconsistent with this section.

7 “(d) PAYMENTS.—

8 “(1) IN GENERAL.—A loan repayment provided
9 for an individual under a written contract under the
10 Program shall consist of payment, in accordance
11 with paragraph (2), on behalf of the individual of
12 the principal, interest, and related expenses on gov-
13 ernment and commercial loans received by the indi-
14 vidual regarding the undergraduate or graduate edu-
15 cation of the individual (or both), which loans were
16 made for tuition expenses incurred by the individual.

17 “(2) PAYMENTS FOR YEARS SERVED.—For
18 each year of obligated service that an individual con-
19 tracts to serve under subsection (c) the Secretary
20 may pay up to \$35,000 on behalf of the individual
21 for loans described in paragraph (1). With respect to
22 participants under the Program whose total eligible
23 loans are less than \$105,000, the Secretary shall
24 pay an amount that does not exceed $\frac{1}{3}$ of the eligi-

1 ble loan balance for each year of obligated service of
2 the individual.

3 “(3) TAX LIABILITY.—For the purpose of pro-
4 viding reimbursements for tax liability resulting
5 from payments under paragraph (2) on behalf of an
6 individual, the Secretary shall, in addition to such
7 payments, make payments to the individual in an
8 amount not to exceed 39 percent of the total amount
9 of loan repayments made for the taxable year in-
10 volved.

11 “(e) POSTPONING OBLIGATED SERVICE.—With re-
12 spect to an individual receiving a degree or certificate from
13 a health professions or other related school, the date of
14 the initiation of the period of obligated service may be
15 postponed as approved by the Secretary.

16 “(f) BREACH OF CONTRACT.—An individual who fails
17 to comply with the contract entered into under subsection
18 (c) shall be subject to the same financial penalties as pro-
19 vided for under section 338E for breaches of loan repay-
20 ment contracts under section 338B.

21 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
22 is authorized to be appropriated to carry out this section
23 \$195,000,000 for fiscal year 2010, and such sums as may
24 be necessary for each of fiscal years 2011 through 2015.”.

1 **SEC. 5205. ALLIED HEALTH WORKFORCE RECRUITMENT**
 2 **AND RETENTION PROGRAMS.**

3 (a) **PURPOSE.**—The purpose of this section is to as-
 4 sure an adequate supply of allied health professionals to
 5 eliminate critical allied health workforce shortages in Fed-
 6 eral, State, local, and tribal public health agencies or in
 7 settings where patients might require health care services,
 8 including acute care facilities, ambulatory care facilities,
 9 personal residences and other settings, as recognized by
 10 the Secretary of Health and Human Services by author-
 11 izing an Allied Health Loan Forgiveness Program.

12 (b) **ALLIED HEALTH WORKFORCE RECRUITMENT**
 13 **AND RETENTION PROGRAM.**—Section 428K of the Higher
 14 Education Act of 1965 (20 U.S.C. 1078–11) is amend-
 15 ed—

16 (1) in subsection (b), by adding at the end the
 17 following:

18 “(18) **ALLIED HEALTH PROFESSIONALS.**—The
 19 individual is employed full-time as an allied health
 20 professional—

21 “(A) in a Federal, State, local, or tribal
 22 public health agency; or

23 “(B) in a setting where patients might re-
 24 quire health care services, including acute care
 25 facilities, ambulatory care facilities, personal
 26 residences and other settings located in health

1 professional shortage areas, medically under-
2 served areas, or medically underserved popu-
3 lations, as recognized by the Secretary of
4 Health and Human Services.”; and

5 (2) in subsection (g)—

6 (A) by redesignating paragraphs (1)
7 through (9) as paragraphs (2) through (10), re-
8 spectively; and

9 (B) by inserting before paragraph (2) (as
10 redesignated by subparagraph (A)) the fol-
11 lowing:

12 “(1) ALLIED HEALTH PROFESSIONAL.—The
13 term ‘allied health professional’ means an allied
14 health professional as defined in section 799B(5) of
15 the Public Health Service Act (42 U.S.C. 295p(5))
16 who—

17 “(A) has graduated and received an allied
18 health professions degree or certificate from an
19 institution of higher education; and

20 “(B) is employed with a Federal, State,
21 local or tribal public health agency, or in a set-
22 ting where patients might require health care
23 services, including acute care facilities, ambula-
24 tory care facilities, personal residences and
25 other settings located in health professional

1 shortage areas, medically underserved areas, or
2 medically underserved populations, as recog-
3 nized by the Secretary of Health and Human
4 Services.”.

5 **SEC. 5206. GRANTS FOR STATE AND LOCAL PROGRAMS.**

6 (a) IN GENERAL.—Section 765(d) of the Public
7 Health Service Act (42 U.S.C. 295(d)) is amended—

8 (1) in paragraph (7), by striking “; or” and in-
9 serting a semicolon;

10 (2) by redesignating paragraph (8) as para-
11 graph (9); and

12 (3) by inserting after paragraph (7) the fol-
13 lowing:

14 “(8) public health workforce loan repayment
15 programs; or”.

16 (b) TRAINING FOR MID-CAREER PUBLIC HEALTH
17 PROFESSIONALS.—Part E of title VII of the Public
18 Health Service Act (42 U.S.C. 294n et seq.), as amended
19 by section 5204, is further amended by adding at the end
20 the following:

21 **“SEC. 777. TRAINING FOR MID-CAREER PUBLIC AND ALLIED**
22 **HEALTH PROFESSIONALS.**

23 “(a) IN GENERAL.—The Secretary may make grants
24 to, or enter into contracts with, any eligible entity to
25 award scholarships to eligible individuals to enroll in de-

1 gree or professional training programs for the purpose of
2 enabling mid-career professionals in the public health and
3 allied health workforce to receive additional training in the
4 field of public health and allied health.

5 “(b) ELIGIBILITY.—

6 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
7 tity’ indicates an accredited educational institution
8 that offers a course of study, certificate program, or
9 professional training program in public or allied
10 health or a related discipline, as determined by the
11 Secretary

12 “(2) ELIGIBLE INDIVIDUALS.—The term ‘eligi-
13 ble individuals’ includes those individuals employed
14 in public and allied health positions at the Federal,
15 State, tribal, or local level who are interested in re-
16 taining or upgrading their education.

17 “(c) AUTHORIZATION OF APPROPRIATIONS.—There
18 is authorized to be appropriated to carry out this section,
19 \$60,000,000 for fiscal year 2010 and such sums as may
20 be necessary for each of fiscal years 2011 through 2015.
21 Fifty percent of appropriated funds shall be allotted to
22 public health mid-career professionals and 50 percent shall
23 be allotted to allied health mid-career professionals.”.

1 **SEC. 5207. FUNDING FOR NATIONAL HEALTH SERVICE**
2 **CORPS.**

3 Section 338H(a) of the Public Health Service Act (42
4 U.S.C. 254q(a)) is amended to read as follows:

5 “(a) AUTHORIZATION OF APPROPRIATIONS.—For the
6 purpose of carrying out this section, there is authorized
7 to be appropriated, out of any funds in the Treasury not
8 otherwise appropriated, the following:

9 “(1) For fiscal year 2010, \$320,461,632.

10 “(2) For fiscal year 2011, \$414,095,394.

11 “(3) For fiscal year 2012, \$535,087,442.

12 “(4) For fiscal year 2013, \$691,431,432.

13 “(5) For fiscal year 2014, \$893,456,433.

14 “(6) For fiscal year 2015, \$1,154,510,336.

15 “(7) For fiscal year 2016, and each subsequent
16 fiscal year, the amount appropriated for the pre-
17 ceding fiscal year adjusted by the product of—

18 “(A) one plus the average percentage in-
19 crease in the costs of health professions edu-
20 cation during the prior fiscal year; and

21 “(B) one plus the average percentage
22 change in the number of individuals residing in
23 health professions shortage areas designated
24 under section 333 during the prior fiscal year,
25 relative to the number of individuals residing in
26 such areas during the previous fiscal year.”.

1 **SEC. 5208. NURSE-MANAGED HEALTH CLINICS.**

2 (a) PURPOSE.—The purpose of this section is to fund
3 the development and operation of nurse-managed health
4 clinics.

5 (b) GRANTS.—Subpart 1 of part D of title III of the
6 Public Health Service Act (42 U.S.C. 254b et seq.) is
7 amended by inserting after section 330A the following:

8 **“SEC. 330A-1. GRANTS TO NURSE-MANAGED HEALTH CLIN-**
9 **ICS.**

10 “(a) DEFINITIONS.—

11 “(1) COMPREHENSIVE PRIMARY HEALTH CARE
12 SERVICES.—In this section, the term ‘comprehensive
13 primary health care services’ means the primary
14 health services described in section 330(b)(1).

15 “(2) NURSE-MANAGED HEALTH CLINIC.—The
16 term ‘nurse-managed health clinic’ means a nurse-
17 practice arrangement, managed by advanced practice
18 nurses, that provides primary care or wellness serv-
19 ices to underserved or vulnerable populations and
20 that is associated with a school, college, university or
21 department of nursing, federally qualified health
22 center, or independent nonprofit health or social
23 services agency.

24 “(b) AUTHORITY TO AWARD GRANTS.—The Sec-
25 retary shall award grants for the cost of the operation of

1 nurse-managed health clinics that meet the requirements
2 of this section.

3 “(c) APPLICATIONS.—To be eligible to receive a grant
4 under this section, an entity shall—

5 “(1) be an NMHC; and

6 “(2) submit to the Secretary an application at
7 such time, in such manner, and containing—

8 “(A) assurances that nurses are the major
9 providers of services at the NMHC and that at
10 least 1 advanced practice nurse holds an execu-
11 tive management position within the organiza-
12 tional structure of the NMHC;

13 “(B) an assurance that the NMHC will
14 continue providing comprehensive primary
15 health care services or wellness services without
16 regard to income or insurance status of the pa-
17 tient for the duration of the grant period; and

18 “(C) an assurance that, not later than 90
19 days of receiving a grant under this section, the
20 NMHC will establish a community advisory
21 committee, for which a majority of the members
22 shall be individuals who are served by the
23 NMHC.

1 “(d) GRANT AMOUNT.—The amount of any grant
2 made under this section for any fiscal year shall be deter-
3 mined by the Secretary, taking into account—

4 “(1) the financial need of the NMHC, consid-
5 ering State, local, and other operational funding pro-
6 vided to the NMHC; and

7 “(2) other factors, as the Secretary determines
8 appropriate.

9 “(e) AUTHORIZATION OF APPROPRIATIONS.—For the
10 purposes of carrying out this section, there are authorized
11 to be appropriated \$50,000,000 for the fiscal year 2010
12 and such sums as may be necessary for each of the fiscal
13 years 2011 through 2014.”.

14 **SEC. 5209. ELIMINATION OF CAP ON COMMISSIONED**
15 **CORPS.**

16 Section 202 of the Department of Health and Human
17 Services Appropriations Act, 1993 (Public Law 102-394)
18 is amended by striking “not to exceed 2,800”.

19 **SEC. 5210. ESTABLISHING A READY RESERVE CORPS.**

20 Section 203 of the Public Health Service Act (42
21 U.S.C. 204) is amended to read as follows:

22 **“SEC. 203. COMMISSIONED CORPS AND READY RESERVE**
23 **CORPS.**

24 “(a) ESTABLISHMENT.—

1 “(1) IN GENERAL.—There shall be in the Serv-
2 ice a commissioned Regular Corps and a Ready Re-
3 serve Corps for service in time of national emer-
4 gency.

5 “(2) REQUIREMENT.—All commissioned officers
6 shall be citizens of the United States and shall be
7 appointed without regard to the civil-service laws
8 and compensated without regard to the Classifica-
9 tion Act of 1923, as amended.

10 “(3) APPOINTMENT.—Commissioned officers of
11 the Ready Reserve Corps shall be appointed by the
12 President and commissioned officers of the Regular
13 Corps shall be appointed by the President with the
14 advice and consent of the Senate.

15 “(4) ACTIVE DUTY.—Commissioned officers of
16 the Ready Reserve Corps shall at all times be sub-
17 ject to call to active duty by the Surgeon General,
18 including active duty for the purpose of training.

19 “(5) WARRANT OFFICERS.—Warrant officers
20 may be appointed to the Service for the purpose of
21 providing support to the health and delivery systems
22 maintained by the Service and any warrant officer
23 appointed to the Service shall be considered for pur-
24 poses of this Act and title 37, United States Code,

1 to be a commissioned officer within the Commis-
2 sioned Corps of the Service.

3 “(b) ASSIMILATING RESERVE CORP OFFICERS INTO
4 THE REGULAR CORPS.—Effective on the date of enact-
5 ment of the Patient Protection and Affordable Care Act,
6 all individuals classified as officers in the Reserve Corps
7 under this section (as such section existed on the day be-
8 fore the date of enactment of such Act) and serving on
9 active duty shall be deemed to be commissioned officers
10 of the Regular Corps.

11 “(c) PURPOSE AND USE OF READY RESEARCH.—

12 “(1) PURPOSE.—The purpose of the Ready Re-
13 serve Corps is to fulfill the need to have additional
14 Commissioned Corps personnel available on short
15 notice (similar to the uniformed service’s reserve
16 program) to assist regular Commissioned Corps per-
17 sonnel to meet both routine public health and emer-
18 gency response missions.

19 “(2) USES.—The Ready Reserve Corps shall—

20 “(A) participate in routine training to
21 meet the general and specific needs of the Com-
22 missioned Corps;

23 “(B) be available and ready for involuntary
24 calls to active duty during national emergencies

1 and public health crises, similar to the uni-
2 formed service reserve personnel;

3 “(C) be available for backfilling critical po-
4 sitions left vacant during deployment of active
5 duty Commissioned Corps members, as well as
6 for deployment to respond to public health
7 emergencies, both foreign and domestic; and

8 “(D) be available for service assignment in
9 isolated, hardship, and medically underserved
10 communities (as defined in section 799B) to
11 improve access to health services.

12 “(d) FUNDING.—For the purpose of carrying out the
13 duties and responsibilities of the Commissioned Corps
14 under this section, there are authorized to be appropriated
15 \$5,000,000 for each of fiscal years 2010 through 2014
16 for recruitment and training and \$12,500,000 for each of
17 fiscal years 2010 through 2014 for the Ready Reserve
18 Corps.”.

19 **Subtitle D—Enhancing Health Care**
20 **Workforce Education and Training**

21 **SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL IN-**
22 **TERNAL MEDICINE, GENERAL PEDIATRICS,**
23 **AND PHYSICIAN ASSISTANTSHIP.**

24 Part C of title VII (42 U.S.C. 293k et seq.) is amend-
25 ed by striking section 747 and inserting the following:

1 **“SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.**

2 “(a) SUPPORT AND DEVELOPMENT OF PRIMARY
3 CARE TRAINING PROGRAMS.—

4 “(1) IN GENERAL.—The Secretary may make
5 grants to, or enter into contracts with, an accredited
6 public or nonprofit private hospital, school of medi-
7 cine or osteopathic medicine, academically affiliated
8 physician assistant training program, or a public or
9 private nonprofit entity which the Secretary has de-
10 termined is capable of carrying out such grant or
11 contract—

12 “(A) to plan, develop, operate, or partici-
13 pate in an accredited professional training pro-
14 gram, including an accredited residency or in-
15 ternship program in the field of family medi-
16 cine, general internal medicine, or general pedi-
17 atrics for medical students, interns, residents,
18 or practicing physicians as defined by the Sec-
19 retary;

20 “(B) to provide need-based financial assist-
21 ance in the form of traineeships and fellowships
22 to medical students, interns, residents, prac-
23 ticing physicians, or other medical personnel,
24 who are participants in any such program, and
25 who plan to specialize or work in the practice
26 of the fields defined in subparagraph (A);

1 “(C) to plan, develop, and operate a pro-
2 gram for the training of physicians who plan to
3 teach in family medicine, general internal medi-
4 cine, or general pediatrics training programs;

5 “(D) to plan, develop, and operate a pro-
6 gram for the training of physicians teaching in
7 community-based settings;

8 “(E) to provide financial assistance in the
9 form of traineeships and fellowships to physi-
10 cians who are participants in any such pro-
11 grams and who plan to teach or conduct re-
12 search in a family medicine, general internal
13 medicine, or general pediatrics training pro-
14 gram;

15 “(F) to plan, develop, and operate a physi-
16 cian assistant education program, and for the
17 training of individuals who will teach in pro-
18 grams to provide such training;

19 “(G) to plan, develop, and operate a dem-
20 onstration program that provides training in
21 new competencies, as recommended by the Ad-
22 visory Committee on Training in Primary Care
23 Medicine and Dentistry and the National
24 Health Care Workforce Commission established

1 in section 5101 of the Patient Protection and
2 Affordable Care Act, which may include—

3 “(i) providing training to primary
4 care physicians relevant to providing care
5 through patient-centered medical homes
6 (as defined by the Secretary for purposes
7 of this section);

8 “(ii) developing tools and curricula
9 relevant to patient-centered medical homes;
10 and

11 “(iii) providing continuing education
12 to primary care physicians relevant to pa-
13 tient-centered medical homes; and

14 “(H) to plan, develop, and operate joint
15 degree programs to provide interdisciplinary
16 and interprofessional graduate training in pub-
17 lic health and other health professions to pro-
18 vide training in environmental health, infectious
19 disease control, disease prevention and health
20 promotion, epidemiological studies and injury
21 control.

22 “(2) DURATION OF AWARDS.—The period dur-
23 ing which payments are made to an entity from an
24 award of a grant or contract under this subsection
25 shall be 5 years.

1 “(b) CAPACITY BUILDING IN PRIMARY CARE.—

2 “(1) IN GENERAL.—The Secretary may make
3 grants to or enter into contracts with accredited
4 schools of medicine or osteopathic medicine to estab-
5 lish, maintain, or improve—

6 “(A) academic units or programs that im-
7 prove clinical teaching and research in fields de-
8 fined in subsection (a)(1)(A); or

9 “(B) programs that integrate academic ad-
10 ministrative units in fields defined in subsection
11 (a)(1)(A) to enhance interdisciplinary recruit-
12 ment, training, and faculty development.

13 “(2) PREFERENCE IN MAKING AWARDS UNDER
14 THIS SUBSECTION.—In making awards of grants
15 and contracts under paragraph (1), the Secretary
16 shall give preference to any qualified applicant for
17 such an award that agrees to expend the award for
18 the purpose of—

19 “(A) establishing academic units or pro-
20 grams in fields defined in subsection (a)(1)(A);
21 or

22 “(B) substantially expanding such units or
23 programs.

24 “(3) PRIORITIES IN MAKING AWARDS.—In
25 awarding grants or contracts under paragraph (1),

1 the Secretary shall give priority to qualified appli-
2 cants that—

3 “(A) proposes a collaborative project be-
4 tween academic administrative units of primary
5 care;

6 “(B) proposes innovative approaches to
7 clinical teaching using models of primary care,
8 such as the patient centered medical home,
9 team management of chronic disease, and inter-
10 professional integrated models of health care
11 that incorporate transitions in health care set-
12 tings and integration physical and mental
13 health provision;

14 “(C) have a record of training the greatest
15 percentage of providers, or that have dem-
16 onstrated significant improvements in the per-
17 centage of providers trained, who enter and re-
18 main in primary care practice;

19 “(D) have a record of training individuals
20 who are from underrepresented minority groups
21 or from a rural or disadvantaged background;

22 “(E) provide training in the care of vulner-
23 able populations such as children, older adults,
24 homeless individuals, victims of abuse or trau-
25 ma, individuals with mental health or sub-

1 stance-related disorders, individuals with HIV/
2 AIDS, and individuals with disabilities;

3 “(F) establish formal relationships and
4 submit joint applications with federally qualified
5 health centers, rural health clinics, area health
6 education centers, or clinics located in under-
7 served areas or that serve underserved popu-
8 lations;

9 “(G) teach trainees the skills to provide
10 interprofessional, integrated care through col-
11 laboration among health professionals;

12 “(H) provide training in enhanced commu-
13 nication with patients, evidence-based practice,
14 chronic disease management, preventive care,
15 health information technology, or other com-
16 petencies as recommended by the Advisory
17 Committee on Training in Primary Care Medi-
18 cine and Dentistry and the National Health
19 Care Workforce Commission established in sec-
20 tion 5101 of the Patient Protection and Afford-
21 able Care Act; or

22 “(I) provide training in cultural com-
23 petency and health literacy.

24 “(4) DURATION OF AWARDS.—The period dur-
25 ing which payments are made to an entity from an

1 award of a grant or contract under this subsection
2 shall be 5 years.

3 “(c) AUTHORIZATION OF APPROPRIATIONS.—

4 “(1) IN GENERAL.—For purposes of carrying
5 out this section (other than subsection (b)(1)(B)),
6 there are authorized to be appropriated
7 \$125,000,000 for fiscal year 2010, and such sums
8 as may be necessary for each of fiscal years 2011
9 through 2014.

10 “(2) TRAINING PROGRAMS.—Fifteen percent of
11 the amount appropriated pursuant to paragraph (1)
12 in each such fiscal year shall be allocated to the phy-
13 sician assistant training programs described in sub-
14 section (a)(1)(F), which prepare students for prac-
15 tice in primary care.

16 “(3) INTEGRATING ACADEMIC ADMINISTRATIVE
17 UNITS.—For purposes of carrying out subsection
18 (b)(1)(B), there are authorized to be appropriated
19 \$750,000 for each of fiscal years 2010 through
20 2014.”.

21 **SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE**
22 **WORKERS.**

23 Part C of title VII of the Public Health Service Act
24 (42 U.S.C. 293k et seq.) is amended by inserting after
25 section 747, as amended by section 5301, the following:

1 **“SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE**
2 **WORKERS.**

3 “(a) IN GENERAL.—The Secretary shall award
4 grants to eligible entities to enable such entities to provide
5 new training opportunities for direct care workers who are
6 employed in long-term care settings such as nursing
7 homes (as defined in section 1908(e)(1) of the Social Se-
8 curity Act (42 U.S.C. 1396g(e)(1)), assisted living facili-
9 ties and skilled nursing facilities, intermediate care facili-
10 ties for individuals with mental retardation, home and
11 community based settings, and any other setting the Sec-
12 retary determines to be appropriate.

13 “(b) ELIGIBILITY.—To be eligible to receive a grant
14 under this section, an entity shall—

15 “(1) be an institution of higher education (as
16 defined in section 102 of the Higher Education Act
17 of 1965 (20 U.S.C. 1002)) that—

18 “(A) is accredited by a nationally recog-
19 nized accrediting agency or association listed
20 under section 101(c) of the Higher Education
21 Act of 1965 (20 U.S.C. 1001(c)); and

22 “(B) has established a public-private edu-
23 cational partnership with a nursing home or
24 skilled nursing facility, agency or entity pro-
25 viding home and community based services to

1 individuals with disabilities, or other long-term
2 care provider; and

3 “(2) submit to the Secretary an application at
4 such time, in such manner, and containing such in-
5 formation as the Secretary may require.

6 “(c) USE OF FUNDS.—An eligible entity shall use
7 amounts awarded under a grant under this section to pro-
8 vide assistance to eligible individuals to offset the cost of
9 tuition and required fees for enrollment in academic pro-
10 grams provided by such entity.

11 “(d) ELIGIBLE INDIVIDUAL.—

12 “(1) ELIGIBILITY.—To be eligible for assistance
13 under this section, an individual shall be enrolled in
14 courses provided by a grantee under this subsection
15 and maintain satisfactory academic progress in such
16 courses.

17 “(2) CONDITION OF ASSISTANCE.—As a condi-
18 tion of receiving assistance under this section, an in-
19 dividual shall agree that, following completion of the
20 assistance period, the individual will work in the
21 field of geriatrics, disability services, long term serv-
22 ices and supports, or chronic care management for
23 a minimum of 2 years under guidelines set by the
24 Secretary.

1 “(e) AUTHORIZATION OF APPROPRIATIONS.—There
 2 is authorized to be appropriated to carry out this section,
 3 \$10,000,000 for the period of fiscal years 2011 through
 4 2013.”.

5 **SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC**
 6 **HEALTH DENTISTRY.**

7 Part C of Title VII of the Public Health Service Act
 8 (42 U.S.C. 293k et seq.) is amended by—

9 (1) redesignating section 748, as amended by
 10 section 5103 of this Act, as section 749; and

11 (2) inserting after section 747A, as added by
 12 section 5302, the following:

13 **“SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC**
 14 **HEALTH DENTISTRY.**

15 “(a) SUPPORT AND DEVELOPMENT OF DENTAL
 16 TRAINING PROGRAMS.—

17 “(1) IN GENERAL.—The Secretary may make
 18 grants to, or enter into contracts with, a school of
 19 dentistry, public or nonprofit private hospital, or a
 20 public or private nonprofit entity which the Sec-
 21 retary has determined is capable of carrying out
 22 such grant or contract—

23 “(A) to plan, develop, and operate, or par-
 24 ticipate in, an approved professional training
 25 program in the field of general dentistry, pedi-

1 atric dentistry, or public health dentistry for
2 dental students, residents, practicing dentists,
3 dental hygienists, or other approved primary
4 care dental trainees, that emphasizes training
5 for general, pediatric, or public health dentistry;

6 “(B) to provide financial assistance to den-
7 tal students, residents, practicing dentists, and
8 dental hygiene students who are in need there-
9 of, who are participants in any such program,
10 and who plan to work in the practice of general,
11 pediatric, public health dentistry, or dental hy-
12 giene;

13 “(C) to plan, develop, and operate a pro-
14 gram for the training of oral health care pro-
15 viders who plan to teach in general, pediatric,
16 public health dentistry, or dental hygiene;

17 “(D) to provide financial assistance in the
18 form of traineeships and fellowships to dentists
19 who plan to teach or are teaching in general,
20 pediatric, or public health dentistry;

21 “(E) to meet the costs of projects to estab-
22 lish, maintain, or improve dental faculty devel-
23 opment programs in primary care (which may
24 be departments, divisions or other units);

1 “(F) to meet the costs of projects to estab-
2 lish, maintain, or improve predoctoral and
3 postdoctoral training in primary care programs;

4 “(G) to create a loan repayment program
5 for faculty in dental programs; and

6 “(H) to provide technical assistance to pe-
7 diatric training programs in developing and im-
8 plementing instruction regarding the oral health
9 status, dental care needs, and risk-based clin-
10 ical disease management of all pediatric popu-
11 lations with an emphasis on underserved chil-
12 dren.

13 “(2) FACULTY LOAN REPAYMENT.—

14 “(A) IN GENERAL.—A grant or contract
15 under subsection (a)(1)(G) may be awarded to
16 a program of general, pediatric, or public health
17 dentistry described in such subsection to plan,
18 develop, and operate a loan repayment program
19 under which—

20 “(i) individuals agree to serve full-
21 time as faculty members; and

22 “(ii) the program of general, pediatric
23 or public health dentistry agrees to pay the
24 principal and interest on the outstanding
25 student loans of the individuals.

1 “(B) MANNER OF PAYMENTS.—With re-
2 spect to the payments described in subpara-
3 graph (A)(ii), upon completion by an individual
4 of each of the first, second, third, fourth, and
5 fifth years of service, the program shall pay an
6 amount equal to 10, 15, 20, 25, and 30 per-
7 cent, respectively, of the individual’s student
8 loan balance as calculated based on principal
9 and interest owed at the initiation of the agree-
10 ment.

11 “(b) ELIGIBLE ENTITY.—For purposes of this sub-
12 section, entities eligible for such grants or contracts in
13 general, pediatric, or public health dentistry shall include
14 entities that have programs in dental or dental hygiene
15 schools, or approved residency or advanced education pro-
16 grams in the practice of general, pediatric, or public health
17 dentistry. Eligible entities may partner with schools of
18 public health to permit the education of dental students,
19 residents, and dental hygiene students for a master’s year
20 in public health at a school of public health.

21 “(c) PRIORITIES IN MAKING AWARDS.—With respect
22 to training provided for under this section, the Secretary
23 shall give priority in awarding grants or contracts to the
24 following:

1 “(1) Qualified applicants that propose collabo-
2 rative projects between departments of primary care
3 medicine and departments of general, pediatric, or
4 public health dentistry.

5 “(2) Qualified applicants that have a record of
6 training the greatest percentage of providers, or that
7 have demonstrated significant improvements in the
8 percentage of providers, who enter and remain in
9 general, pediatric, or public health dentistry.

10 “(3) Qualified applicants that have a record of
11 training individuals who are from a rural or dis-
12 advantaged background, or from underrepresented
13 minorities.

14 “(4) Qualified applicants that establish formal
15 relationships with Federally qualified health centers,
16 rural health centers, or accredited teaching facilities
17 and that conduct training of students, residents, fel-
18 lows, or faculty at the center or facility.

19 “(5) Qualified applicants that conduct teaching
20 programs targeting vulnerable populations such as
21 older adults, homeless individuals, victims of abuse
22 or trauma, individuals with mental health or sub-
23 stance-related disorders, individuals with disabilities,
24 and individuals with HIV/AIDS, and in the risk-
25 based clinical disease management of all populations.

1 “(6) Qualified applicants that include edu-
2 cational activities in cultural competency and health
3 literacy.

4 “(7) Qualified applicants that have a high rate
5 for placing graduates in practice settings that serve
6 underserved areas or health disparity populations, or
7 who achieve a significant increase in the rate of
8 placing graduates in such settings.

9 “(8) Qualified applicants that intend to estab-
10 lish a special populations oral health care education
11 center or training program for the didactic and clin-
12 ical education of dentists, dental health profes-
13 sionals, and dental hygienists who plan to teach oral
14 health care for people with developmental disabili-
15 ties, cognitive impairment, complex medical prob-
16 lems, significant physical limitations, and vulnerable
17 elderly.

18 “(d) APPLICATION.—An eligible entity desiring a
19 grant under this section shall submit to the Secretary an
20 application at such time, in such manner, and containing
21 such information as the Secretary may require.

22 “(e) DURATION OF AWARD.—The period during
23 which payments are made to an entity from an award of
24 a grant or contract under subsection (a) shall be 5 years.
25 The provision of such payments shall be subject to annual

1 approval by the Secretary and subject to the availability
 2 of appropriations for the fiscal year involved to make the
 3 payments.

4 “(f) AUTHORIZATIONS OF APPROPRIATIONS.—For
 5 the purpose of carrying out subsections (a) and (b), there
 6 is authorized to be appropriated \$30,000,000 for fiscal
 7 year 2010 and such sums as may be necessary for each
 8 of fiscal years 2011 through 2015.

9 “(g) CARRYOVER FUNDS.—An entity that receives an
 10 award under this section may carry over funds from 1 fis-
 11 cal year to another without obtaining approval from the
 12 Secretary. In no case may any funds be carried over pur-
 13 suant to the preceding sentence for more than 3 years.”.

14 **SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PRO-**
 15 **VIDERS DEMONSTRATION PROJECT.**

16 Subpart X of part D of title III of the Public Health
 17 Service Act (42 U.S.C. 256f et seq.) is amended by adding
 18 at the end the following:

19 **“SEC. 340G-1. DEMONSTRATION PROGRAM.**

20 “(a) IN GENERAL.—

21 “(1) AUTHORIZATION.—The Secretary is au-
 22 thorized to award grants to 15 eligible entities to en-
 23 able such entities to establish a demonstration pro-
 24 gram to establish training programs to train, or to
 25 employ, alternative dental health care providers in

1 order to increase access to dental health care serv-
2 ices in rural and other underserved communities.

3 “(2) DEFINITION.—The term ‘alternative den-
4 tal health care providers’ includes community dental
5 health coordinators, advance practice dental hygien-
6 ists, independent dental hygienists, supervised dental
7 hygienists, primary care physicians, dental thera-
8 pists, dental health aides, and any other health pro-
9 fessional that the Secretary determines appropriate.

10 “(b) TIMEFRAME.—The demonstration projects fund-
11 ed under this section shall begin not later than 2 years
12 after the date of enactment of this section, and shall con-
13 clude not later than 7 years after such date of enactment.

14 “(c) ELIGIBLE ENTITIES.—To be eligible to receive
15 a grant under subsection (a), an entity shall—

16 “(1) be—

17 “(A) an institution of higher education, in-
18 cluding a community college;

19 “(B) a public-private partnership;

20 “(C) a federally qualified health center;

21 “(D) an Indian Health Service facility or a
22 tribe or tribal organization (as such terms are
23 defined in section 4 of the Indian Self-Deter-
24 mination and Education Assistance Act);

1 “(E) a State or county public health clinic,
2 a health facility operated by an Indian tribe or
3 tribal organization, or urban Indian organiza-
4 tion providing dental services; or

5 “(F) a public hospital or health system;

6 “(2) be within a program accredited by the
7 Commission on Dental Accreditation or within a
8 dental education program in an accredited institu-
9 tion; and

10 “(3) shall submit an application to the Sec-
11 retary at such time, in such manner, and containing
12 such information as the Secretary may require.

13 “(d) ADMINISTRATIVE PROVISIONS.—

14 “(1) AMOUNT OF GRANT.—Each grant under
15 this section shall be in an amount that is not less
16 than \$4,000,000 for the 5-year period during which
17 the demonstration project being conducted.

18 “(2) DISBURSEMENT OF FUNDS.—

19 “(A) PRELIMINARY DISBURSEMENTS.—Be-
20 ginning 1 year after the enactment of this sec-
21 tion, the Secretary may disperse to any entity
22 receiving a grant under this section not more
23 than 20 percent of the total funding awarded to
24 such entity under such grant, for the purpose

1 of enabling the entity to plan the demonstration
2 project to be conducted under such grant.

3 “(B) SUBSEQUENT DISBURSEMENTS.—The
4 remaining amount of grant funds not dispersed
5 under subparagraph (A) shall be dispersed such
6 that not less than 15 percent of such remaining
7 amount is dispersed each subsequent year.

8 “(e) COMPLIANCE WITH STATE REQUIREMENTS.—
9 Each entity receiving a grant under this section shall cer-
10 tify that it is in compliance with all applicable State licens-
11 ing requirements.

12 “(f) EVALUATION.—The Secretary shall contract
13 with the Director of the Institute of Medicine to conduct
14 a study of the demonstration programs conducted under
15 this section that shall provide analysis, based upon quan-
16 titative and qualitative data, regarding access to dental
17 health care in the United States.

18 “(g) CLARIFICATION REGARDING DENTAL HEALTH
19 AIDE PROGRAM.—Nothing in this section shall prohibit a
20 dental health aide training program approved by the In-
21 dian Health Service from being eligible for a grant under
22 this section.

23 “(h) AUTHORIZATION OF APPROPRIATIONS.—There
24 is authorized to be appropriated such sums as may be nec-
25 essary to carry out this section.”.

1 **SEC. 5305. GERIATRIC EDUCATION AND TRAINING; CAREER**
2 **AWARDS; COMPREHENSIVE GERIATRIC EDU-**
3 **CATION.**

4 (a) WORKFORCE DEVELOPMENT; CAREER
5 AWARDS.—Section 753 of the Public Health Service Act
6 (42 U.S.C. 294c) is amended by adding at the end the
7 following:

8 “(d) GERIATRIC WORKFORCE DEVELOPMENT.—

9 “(1) IN GENERAL.—The Secretary shall award
10 grants or contracts under this subsection to entities
11 that operate a geriatric education center pursuant to
12 subsection (a)(1).

13 “(2) APPLICATION.—To be eligible for an
14 award under paragraph (1), an entity described in
15 such paragraph shall submit to the Secretary an ap-
16 plication at such time, in such manner, and con-
17 taining such information as the Secretary may re-
18 quire.

19 “(3) USE OF FUNDS.—Amounts awarded under
20 a grant or contract under paragraph (1) shall be
21 used to—

22 “(A) carry out the fellowship program de-
23 scribed in paragraph (4); and

24 “(B) carry out 1 of the 2 activities de-
25 scribed in paragraph (5).

26 “(4) FELLOWSHIP PROGRAM.—

1 “(A) IN GENERAL.—Pursuant to para-
2 graph (3), a geriatric education center that re-
3 ceives an award under this subsection shall use
4 such funds to offer short-term intensive courses
5 (referred to in this subsection as a ‘fellowship’)
6 that focus on geriatrics, chronic care manage-
7 ment, and long-term care that provide supple-
8 mental training for faculty members in medical
9 schools and other health professions schools
10 with programs in psychology, pharmacy, nurs-
11 ing, social work, dentistry, public health, allied
12 health, or other health disciplines, as approved
13 by the Secretary. Such a fellowship shall be
14 open to current faculty, and appropriately
15 credentialed volunteer faculty and practitioners,
16 who do not have formal training in geriatrics,
17 to upgrade their knowledge and clinical skills
18 for the care of older adults and adults with
19 functional limitations and to enhance their
20 interdisciplinary teaching skills.

21 “(B) LOCATION.—A fellowship shall be of-
22 fered either at the geriatric education center
23 that is sponsoring the course, in collaboration
24 with other geriatric education centers, or at
25 medical schools, schools of dentistry, schools of

1 nursing, schools of pharmacy, schools of social
2 work, graduate programs in psychology, or al-
3 lied health and other health professions schools
4 approved by the Secretary with which the geri-
5 atric education centers are affiliated.

6 “(C) CME CREDIT.—Participation in a fel-
7 lowship under this paragraph shall be accepted
8 with respect to complying with continuing
9 health profession education requirements. As a
10 condition of such acceptance, the recipient shall
11 agree to subsequently provide a minimum of 18
12 hours of voluntary instructional support
13 through a geriatric education center that is pro-
14 viding clinical training to students or trainees
15 in long-term care settings.

16 “(5) ADDITIONAL REQUIRED ACTIVITIES DE-
17 SCRIBED.—Pursuant to paragraph (3), a geriatric
18 education center that receives an award under this
19 subsection shall use such funds to carry out 1 of the
20 following 2 activities.

21 “(A) FAMILY CAREGIVER AND DIRECT
22 CARE PROVIDER TRAINING.—A geriatric edu-
23 cation center that receives an award under this
24 subsection shall offer at least 2 courses each
25 year, at no charge or nominal cost, to family

1 caregivers and direct care providers that are de-
2 signed to provide practical training for sup-
3 porting frail elders and individuals with disabili-
4 ties. The Secretary shall require such Centers
5 to work with appropriate community partners
6 to develop training program content and to
7 publicize the availability of training courses in
8 their service areas. All family caregiver and di-
9 rect care provider training programs shall in-
10 clude instruction on the management of psycho-
11 logical and behavioral aspects of dementia, com-
12 munication techniques for working with individ-
13 uals who have dementia, and the appropriate,
14 safe, and effective use of medications for older
15 adults.

16 “(B) INCORPORATION OF BEST PRAC-
17 TICES.—A geriatric education center that re-
18 ceives an award under this subsection shall de-
19 velop and include material on depression and
20 other mental disorders common among older
21 adults, medication safety issues for older adults,
22 and management of the psychological and be-
23 havioral aspects of dementia and communica-
24 tion techniques with individuals who have de-

1 mentia in all training courses, where appro-
2 priate.

3 “(6) TARGETS.—A geriatric education center
4 that receives an award under this subsection shall
5 meet targets approved by the Secretary for providing
6 geriatric training to a certain number of faculty or
7 practitioners during the term of the award, as well
8 as other parameters established by the Secretary.

9 “(7) AMOUNT OF AWARD.—An award under
10 this subsection shall be in an amount of \$150,000.
11 Not more than 24 geriatric education centers may
12 receive an award under this subsection.

13 “(8) MAINTENANCE OF EFFORT.—A geriatric
14 education center that receives an award under this
15 subsection shall provide assurances to the Secretary
16 that funds provided to the geriatric education center
17 under this subsection will be used only to supple-
18 ment, not to supplant, the amount of Federal, State,
19 and local funds otherwise expended by the geriatric
20 education center.

21 “(9) AUTHORIZATION OF APPROPRIATIONS.—In
22 addition to any other funding available to carry out
23 this section, there is authorized to be appropriated
24 to carry out this subsection, \$10,800,000 for the pe-
25 riod of fiscal year 2011 through 2014.

1 “(e) GERIATRIC CAREER INCENTIVE AWARDS.—

2 “(1) IN GENERAL.—The Secretary shall award
3 grants or contracts under this section to individuals
4 described in paragraph (2) to foster greater interest
5 among a variety of health professionals in entering
6 the field of geriatrics, long-term care, and chronic
7 care management.

8 “(2) ELIGIBLE INDIVIDUALS.—To be eligible to
9 received an award under paragraph (1), an indi-
10 vidual shall—

11 “(A) be an advanced practice nurse, a clin-
12 ical social worker, a pharmacist, or student of
13 psychology who is pursuing a doctorate or other
14 advanced degree in geriatrics or related fields in
15 an accredited health professions school; and

16 “(B) submit to the Secretary an applica-
17 tion at such time, in such manner, and con-
18 taining such information as the Secretary may
19 require.

20 “(3) CONDITION OF AWARD.—As a condition of
21 receiving an award under this subsection, an indi-
22 vidual shall agree that, following completion of the
23 award period, the individual will teach or practice in
24 the field of geriatrics, long-term care, or chronic

1 care management for a minimum of 5 years under
2 guidelines set by the Secretary.

3 “(4) AUTHORIZATION OF APPROPRIATIONS.—
4 There is authorized to be appropriated to carry out
5 this subsection, \$10,000,000 for the period of fiscal
6 years 2011 through 2013.”.

7 (b) EXPANSION OF ELIGIBILITY FOR GERIATRIC
8 ACADEMIC CAREER AWARDS; PAYMENT TO INSTITU-
9 TION.—Section 753(c) of the Public Health Service Act
10 294(c) is amended—

11 (1) by redesignating paragraphs (4) and (5) as
12 paragraphs (5) and (6), respectively;

13 (2) by striking paragraph (2) through para-
14 graph (3) and inserting the following:

15 “(2) ELIGIBLE INDIVIDUALS.—To be eligible to
16 receive an Award under paragraph (1), an individual
17 shall—

18 “(A) be board certified or board eligible in
19 internal medicine, family practice, psychiatry,
20 or licensed dentistry, or have completed any re-
21 quired training in a discipline and employed in
22 an accredited health professions school that is
23 approved by the Secretary;

24 “(B) have completed an approved fellow-
25 ship program in geriatrics or have completed

1 specialty training in geriatrics as required by
2 the discipline and any addition geriatrics train-
3 ing as required by the Secretary; and

4 “(C) have a junior (non-tenured) faculty
5 appointment at an accredited (as determined by
6 the Secretary) school of medicine, osteopathic
7 medicine, nursing, social work, psychology, den-
8 tistry, pharmacy, or other allied health dis-
9 ciplines in an accredited health professions
10 school that is approved by the Secretary.

11 “(3) LIMITATIONS.—No Award under para-
12 graph (1) may be made to an eligible individual un-
13 less the individual—

14 “(A) has submitted to the Secretary an ap-
15 plication, at such time, in such manner, and
16 containing such information as the Secretary
17 may require, and the Secretary has approved
18 such application;

19 “(B) provides, in such form and manner as
20 the Secretary may require, assurances that the
21 individual will meet the service requirement de-
22 scribed in paragraph (6); and

23 “(C) provides, in such form and manner as
24 the Secretary may require, assurances that the
25 individual has a full-time faculty appointment

1 in a health professions institution and docu-
2 mented commitment from such institution to
3 spend 75 percent of the total time of such indi-
4 vidual on teaching and developing skills in
5 interdisciplinary education in geriatrics.

6 “(4) MAINTENANCE OF EFFORT.—An eligible
7 individual that receives an Award under paragraph
8 (1) shall provide assurances to the Secretary that
9 funds provided to the eligible individual under this
10 subsection will be used only to supplement, not to
11 supplant, the amount of Federal, State, and local
12 funds otherwise expended by the eligible individual.”;
13 and

14 (3) in paragraph (5), as so designated—

15 (A) in subparagraph (A)—

16 (i) by inserting “for individuals who
17 are physicians” after “this section”; and

18 (ii) by inserting after the period at
19 the end the following: “The Secretary shall
20 determine the amount of an Award under
21 this section for individuals who are not
22 physicians.”; and

23 (B) by adding at the end the following:

24 “(C) PAYMENT TO INSTITUTION.—The
25 Secretary shall make payments to institutions

1 which include schools of medicine, osteopathic
2 medicine, nursing, social work, psychology, den-
3 tistry, and pharmacy, or other allied health dis-
4 cipline in an accredited health professions
5 school that is approved by the Secretary.”.

6 (c) **COMPREHENSIVE GERIATRIC EDUCATION.**—Sec-
7 tion 855 of the Public Health Service Act (42 U.S.C. 298)
8 is amended—

9 (1) in subsection (b)—

10 (A) in paragraph (3), by striking “or” at
11 the end;

12 (B) in paragraph (4), by striking the pe-
13 riod and inserting “; or”; and

14 (C) by adding at the end the following:

15 “(5) establish traineeships for individuals who
16 are preparing for advanced education nursing de-
17 grees in geriatric nursing, long-term care, gero-psy-
18 chiatric nursing or other nursing areas that spe-
19 cialize in the care of the elderly population.”; and

20 (2) in subsection (e), by striking “2003 through
21 2007” and inserting “2010 through 2014”.

22 **SEC. 5306. MENTAL AND BEHAVIORAL HEALTH EDUCATION**
23 **AND TRAINING GRANTS.**

24 (a) **IN GENERAL.**—Part D of title VII (42 U.S.C.
25 294 et seq.) is amended by—

1 (1) striking section 757;

2 (2) redesignating section 756 (as amended by
3 section 5103) as section 757; and

4 (3) inserting after section 755 the following:

5 **“SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION**
6 **AND TRAINING GRANTS.**

7 “(a) GRANTS AUTHORIZED.—The Secretary may
8 award grants to eligible institutions of higher education
9 to support the recruitment of students for, and education
10 and clinical experience of the students in—

11 “(1) baccalaureate, master’s, and doctoral de-
12 gree programs of social work, as well as the develop-
13 ment of faculty in social work;

14 “(2) accredited master’s, doctoral, internship,
15 and post-doctoral residency programs of psychology
16 for the development and implementation of inter-
17 disciplinary training of psychology graduate students
18 for providing behavioral and mental health services,
19 including substance abuse prevention and treatment
20 services;

21 “(3) accredited institutions of higher education
22 or accredited professional training programs that are
23 establishing or expanding internships or other field
24 placement programs in child and adolescent mental
25 health in psychiatry, psychology, school psychology,

1 behavioral pediatrics, psychiatric nursing, social
2 work, school social work, substance abuse prevention
3 and treatment, marriage and family therapy, school
4 counseling, or professional counseling; and

5 “(4) State-licensed mental health nonprofit and
6 for-profit organizations to enable such organizations
7 to pay for programs for preservice or in-service
8 training of paraprofessional child and adolescent
9 mental health workers.

10 “(b) ELIGIBILITY REQUIREMENTS.—To be eligible
11 for a grant under this section, an institution shall dem-
12 onstrate—

13 “(1) participation in the institutions’ programs
14 of individuals and groups from different racial, eth-
15 nic, cultural, geographic, religious, linguistic, and
16 class backgrounds, and different genders and sexual
17 orientations;

18 “(2) knowledge and understanding of the con-
19 cerns of the individuals and groups described in sub-
20 section (a);

21 “(3) any internship or other field placement
22 program assisted under the grant will prioritize cul-
23 tural and linguistic competency;

1 “(4) the institution will provide to the Secretary
2 such data, assurances, and information as the Sec-
3 retary may require; and

4 “(5) with respect to any violation of the agree-
5 ment between the Secretary and the institution, the
6 institution will pay such liquidated damages as pre-
7 scribed by the Secretary by regulation.

8 “(c) INSTITUTIONAL REQUIREMENT.—For grants
9 authorized under subsection (a)(1), at least 4 of the grant
10 recipients shall be historically black colleges or universities
11 or other minority-serving institutions.

12 “(d) PRIORITY.—

13 “(1) In selecting the grant recipients in social
14 work under subsection (a)(1), the Secretary shall
15 give priority to applicants that—

16 “(A) are accredited by the Council on So-
17 cial Work Education;

18 “(B) have a graduation rate of not less
19 than 80 percent for social work students; and

20 “(C) exhibit an ability to recruit social
21 workers from and place social workers in areas
22 with a high need and high demand population.

23 “(2) In selecting the grant recipients in grad-
24 uate psychology under subsection (a)(2), the Sec-
25 retary shall give priority to institutions in which

1 training focuses on the needs of vulnerable groups
2 such as older adults and children, individuals with
3 mental health or substance-related disorders, victims
4 of abuse or trauma and of combat stress disorders
5 such as posttraumatic stress disorder and traumatic
6 brain injuries, homeless individuals, chronically ill
7 persons, and their families.

8 “(3) In selecting the grant recipients in train-
9 ing programs in child and adolescent mental health
10 under subsections (a)(3) and (a)(4), the Secretary
11 shall give priority to applicants that—

12 “(A) have demonstrated the ability to col-
13 lect data on the number of students trained in
14 child and adolescent mental health and the pop-
15 ulations served by such students after gradua-
16 tion or completion of preservice or in-service
17 training;

18 “(B) have demonstrated familiarity with
19 evidence-based methods in child and adolescent
20 mental health services, including substance
21 abuse prevention and treatment services;

22 “(C) have programs designed to increase
23 the number of professionals and paraprofes-
24 sionals serving high-priority populations and to
25 applicants who come from high-priority commu-

1 nities and plan to serve medically underserved
2 populations, in health professional shortage
3 areas, or in medically underserved areas;

4 “(D) offer curriculum taught collabo-
5 ratively with a family on the consumer and
6 family lived experience or the importance of
7 family-professional or family-paraprofessional
8 partnerships; and

9 “(E) provide services through a community
10 mental health program described in section
11 1913(b)(1).

12 “(e) AUTHORIZATION OF APPROPRIATION.—For the
13 fiscal years 2010 through 2013, there is authorized to be
14 appropriated to carry out this section—

15 “(1) \$8,000,000 for training in social work in
16 subsection (a)(1);

17 “(2) \$12,000,000 for training in graduate psy-
18 chology in subsection (a)(2), of which not less than
19 \$10,000,000 shall be allocated for doctoral,
20 postdoctoral, and internship level training;

21 “(3) \$10,000,000 for training in professional
22 child and adolescent mental health in subsection
23 (a)(3); and

1 “(4) \$5,000,000 for training in paraprofes-
2 sional child and adolescent work in subsection
3 (a)(4).”.

4 (b) CONFORMING AMENDMENTS.—Section 757(b)(2)
5 of the Public Health Service Act, as redesignated by sub-
6 section (a), is amended by striking “sections 751(a)(1)(A),
7 751(a)(1)(B), 753(b), 754(3)(A), and 755(b)” and insert-
8 ing “sections 751(b)(1)(A), 753(b), and 755(b)”.

9 **SEC. 5307. CULTURAL COMPETENCY, PREVENTION, AND**
10 **PUBLIC HEALTH AND INDIVIDUALS WITH DIS-**
11 **ABILITIES TRAINING.**

12 (a) TITLE VII.—Section 741 of the Public Health
13 Service Act (42 U.S.C. 293e) is amended—

14 (1) in subsection (a)—

15 (A) by striking the subsection heading and
16 inserting “CULTURAL COMPETENCY, PREVEN-
17 TION, AND PUBLIC HEALTH AND INDIVIDUALS
18 WITH DISABILITY GRANTS”; and

19 (B) in paragraph (1), by striking “for the
20 purpose of” and all that follows through the pe-
21 riod at the end and inserting “for the develop-
22 ment, evaluation, and dissemination of research,
23 demonstration projects, and model curricula for
24 cultural competency, prevention, public health
25 proficiency, reducing health disparities, and ap-

1 titude for working with individuals with disabil-
2 ities training for use in health professions
3 schools and continuing education programs, and
4 for other purposes determined as appropriate
5 by the Secretary.”; and

6 (2) by striking subsection (b) and inserting the
7 following:

8 “(b) COLLABORATION.—In carrying out subsection
9 (a), the Secretary shall collaborate with health profes-
10 sional societies, licensing and accreditation entities, health
11 professions schools, and experts in minority health and
12 cultural competency, prevention, and public health and
13 disability groups, community-based organizations, and
14 other organizations as determined appropriate by the Sec-
15 retary. The Secretary shall coordinate with curricula and
16 research and demonstration projects developed under sec-
17 tion 807.

18 “(c) DISSEMINATION.—

19 “(1) IN GENERAL.—Model curricula developed
20 under this section shall be disseminated through the
21 Internet Clearinghouse under section 270 and such
22 other means as determined appropriate by the Sec-
23 retary.

24 “(2) EVALUATION.—The Secretary shall evalu-
25 ate the adoption and the implementation of cultural

1 competency, prevention, and public health, and
2 working with individuals with a disability training
3 curricula, and the facilitate inclusion of these com-
4 petency measures in quality measurement systems as
5 appropriate.

6 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
7 is authorized to be appropriated to carry out this section
8 such sums as may be necessary for each of fiscal years
9 2010 through 2015.”.

10 (b) TITLE VIII.—Section 807 of the Public Health
11 Service Act (42 U.S.C. 296e–1) is amended—

12 (1) in subsection (a)—

13 (A) by striking the subsection heading and
14 inserting “CULTURAL COMPETENCY, PREVEN-
15 TION, AND PUBLIC HEALTH AND INDIVIDUALS
16 WITH DISABILITY GRANTS”; and

17 (B) by striking “for the purpose of” and
18 all that follows through “health care.” and in-
19 serting “for the development, evaluation, and
20 dissemination of research, demonstration
21 projects, and model curricula for cultural com-
22 petency, prevention, public health proficiency,
23 reducing health disparities, and aptitude for
24 working with individuals with disabilities train-
25 ing for use in health professions schools and

1 continuing education programs, and for other
2 purposes determined as appropriate by the Sec-
3 retary.”; and

4 (2) by redesignating subsection (b) as sub-
5 section (d);

6 (3) by inserting after subsection (a) the fol-
7 lowing:

8 “(b) COLLABORATION.—In carrying out subsection
9 (a), the Secretary shall collaborate with the entities de-
10 scribed in section 741(b). The Secretary shall coordinate
11 with curricula and research and demonstration projects
12 developed under such section 741.

13 “(c) DISSEMINATION.—Model curricula developed
14 under this section shall be disseminated and evaluated in
15 the same manner as model curricula developed under sec-
16 tion 741, as described in subsection (c) of such section.”;
17 and

18 (4) in subsection (d), as so redesignated—

19 (A) by striking “subsection (a)” and in-
20 serting “this section”; and

21 (B) by striking “2001 through 2004” and
22 inserting “2010 through 2015”.

23 **SEC. 5308. ADVANCED NURSING EDUCATION GRANTS.**

24 Section 811 of the Public Health Service Act (42
25 U.S.C. 296j) is amended—

1 (1) in subsection (c)—

2 (A) in the subsection heading, by striking

3 “AND NURSE MIDWIFERY PROGRAMS”; and

4 (B) by striking “and nurse midwifery”;

5 (2) in subsection (f)—

6 (A) by striking paragraph (2); and

7 (B) by redesignating paragraph (3) as
8 paragraph (2); and

9 (3) by redesignating subsections (d), (e), and
10 (f) as subsections (e), (f), and (g), respectively; and

11 (4) by inserting after subsection (c), the fol-
12 lowing:

13 “(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—

14 Midwifery programs that are eligible for support under

15 this section are educational programs that—

16 “(1) have as their objective the education of
17 midwives; and

18 “(2) are accredited by the American College of
19 Nurse-Midwives Accreditation Commission for Mid-
20 wifery Education.”.

21 **SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION**

22 **GRANTS.**

23 (a) IN GENERAL.—Section 831 of the Public Health

24 Service Act (42 U.S.C. 296p) is amended—

1 (1) in the section heading, by striking “**RETEN-**
2 **TION**” and inserting “**QUALITY**”;

3 (2) in subsection (a)—

4 (A) in paragraph (1), by adding “or” after
5 the semicolon;

6 (B) by striking paragraph (2); and

7 (C) by redesignating paragraph (3) as
8 paragraph (2);

9 (3) in subsection (b)(3), by striking “managed
10 care, quality improvement” and inserting “coordi-
11 nated care”;

12 (4) in subsection (g), by inserting “, as defined
13 in section 801(2),” after “school of nursing”; and

14 (5) in subsection (h), by striking “2003
15 through 2007” and inserting “2010 through 2014”.

16 (b) NURSE RETENTION GRANTS.—Title VIII of the
17 Public Health Service Act is amended by inserting after
18 section 831 (42 U.S.C. 296b) the following:

19 “**SEC. 831A. NURSE RETENTION GRANTS.**

20 “(a) RETENTION PRIORITY AREAS.—The Secretary
21 may award grants to, and enter into contracts with, eligi-
22 ble entities to enhance the nursing workforce by initiating
23 and maintaining nurse retention programs pursuant to
24 subsection (b) or (c).

1 “(b) GRANTS FOR CAREER LADDER PROGRAM.—The
2 Secretary may award grants to, and enter into contracts
3 with, eligible entities for programs—

4 “(1) to promote career advancement for individ-
5 uals including licensed practical nurses, licensed vo-
6 cational nurses, certified nurse assistants, home
7 health aides, diploma degree or associate degree
8 nurses, to become baccalaureate prepared registered
9 nurses or advanced education nurses in order to
10 meet the needs of the registered nurse workforce;

11 “(2) developing and implementing internships
12 and residency programs in collaboration with an ac-
13 credited school of nursing, as defined by section
14 801(2), to encourage mentoring and the development
15 of specialties; or

16 “(3) to assist individuals in obtaining education
17 and training required to enter the nursing profession
18 and advance within such profession.

19 “(c) ENHANCING PATIENT CARE DELIVERY SYS-
20 TEMS.—

21 “(1) GRANTS.—The Secretary may award
22 grants to eligible entities to improve the retention of
23 nurses and enhance patient care that is directly re-
24 lated to nursing activities by enhancing collaboration
25 and communication among nurses and other health

1 care professionals, and by promoting nurse involve-
2 ment in the organizational and clinical decision-mak-
3 ing processes of a health care facility.

4 “(2) PRIORITY.—In making awards of grants
5 under this subsection, the Secretary shall give pref-
6 erence to applicants that have not previously re-
7 ceived an award under this subsection (or section
8 831(c) as such section existed on the day before the
9 date of enactment of this section).

10 “(3) CONTINUATION OF AN AWARD.—The Sec-
11 retary shall make continuation of any award under
12 this subsection beyond the second year of such
13 award contingent on the recipient of such award
14 having demonstrated to the Secretary measurable
15 and substantive improvement in nurse retention or
16 patient care.

17 “(d) OTHER PRIORITY AREAS.—The Secretary may
18 award grants to, or enter into contracts with, eligible enti-
19 ties to address other areas that are of high priority to
20 nurse retention, as determined by the Secretary.

21 “(e) REPORT.—The Secretary shall submit to the
22 Congress before the end of each fiscal year a report on
23 the grants awarded and the contracts entered into under
24 this section. Each such report shall identify the overall
25 number of such grants and contracts and provide an ex-

1 planation of why each such grant or contract will meet
 2 the priority need of the nursing workforce.

3 “(f) ELIGIBLE ENTITY.—For purposes of this sec-
 4 tion, the term ‘eligible entity’ includes an accredited school
 5 of nursing, as defined by section 801(2), a health care fa-
 6 cility, or a partnership of such a school and facility.

7 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
 8 are authorized to be appropriated to carry out this section
 9 such sums as may be necessary for each of fiscal years
 10 2010 through 2012.”.

11 **SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PRO-**
 12 **GRAM.**

13 (a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Sec-
 14 tion 846(a)(3) of the Public Health Service Act (42 U.S.C.
 15 297n(a)(3)) is amended by inserting before the semicolon
 16 the following: “, or in a accredited school of nursing, as
 17 defined by section 801(2), as nurse faculty”.

18 (b) TECHNICAL AND CONFORMING AMENDMENTS.—
 19 Title VIII (42 U.S.C. 296 et seq.) is amended—

20 (1) by redesignating section 810 (relating to
 21 prohibition against discrimination by schools on the
 22 basis of sex) as section 809 and moving such section
 23 so that it follows section 808;

1 (2) in sections 835, 836, 838, 840, and 842, by
2 striking the term “this subpart” each place it ap-
3 pears and inserting “this part”;

4 (3) in section 836(h), by striking the last sen-
5 tence;

6 (4) in section 836, by redesignating subsection
7 (l) as subsection (k);

8 (5) in section 839, by striking “839” and all
9 that follows through “(a)” and inserting “839. (a)”;

10 (6) in section 835(b), by striking “841” each
11 place it appears and inserting “871”;

12 (7) by redesignating section 841 as section 871,
13 moving part F to the end of the title, and redesign-
14 ating such part as part I;

15 (8) in part G—

16 (A) by redesignating section 845 as section
17 851; and

18 (B) by redesignating part G as part F;

19 (9) in part H—

20 (A) by redesignating sections 851 and 852
21 as sections 861 and 862, respectively; and

22 (B) by redesignating part H as part G;

23 and

24 (10) in part I—

1 (A) by redesignating section 855, as
2 amended by section 5305, as section 865; and

3 (B) by redesignating part I as part H.

4 **SEC. 5311. NURSE FACULTY LOAN PROGRAM.**

5 (a) IN GENERAL.—Section 846A of the Public
6 Health Service Act (42 U.S.C. 297n–1) is amended—

7 (1) in subsection (a)—

8 (A) in the subsection heading, by striking
9 “ESTABLISHMENT” and inserting “SCHOOL OF
10 NURSING STUDENT LOAN FUND”; and

11 (B) by inserting “accredited” after “agree-
12 ment with any”;

13 (2) in subsection (c)—

14 (A) in paragraph (2), by striking
15 “\$30,000” and all that follows through the
16 semicolon and inserting “\$35,500, during fiscal
17 years 2010 and 2011 fiscal years (after fiscal
18 year 2011, such amounts shall be adjusted to
19 provide for a cost-of-attendance increase for the
20 yearly loan rate and the aggregate loan;”; and

21 (B) in paragraph (3)(A), by inserting “an
22 accredited” after “faculty member in”;

23 (3) in subsection (e), by striking “a school” and
24 inserting “an accredited school”; and

1 (4) in subsection (f), by striking “2003 through
2 2007” and inserting “2010 through 2014”.

3 (b) **ELIGIBLE INDIVIDUAL STUDENT LOAN REPAY-**
4 **MENT.**—Title VIII of the Public Health Service Act is
5 amended by inserting after section 846A (42 U.S.C.
6 297n-1) the following:

7 **“SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAY-**
8 **MENT.**

9 “(a) **IN GENERAL.**—The Secretary, acting through
10 the Administrator of the Health Resources and Services
11 Administration, may enter into an agreement with eligible
12 individuals for the repayment of education loans, in ac-
13 cordance with this section, to increase the number of
14 qualified nursing faculty.

15 “(b) **AGREEMENTS.**—Each agreement entered into
16 under this subsection shall require that the eligible indi-
17 vidual shall serve as a full-time member of the faculty of
18 an accredited school of nursing, for a total period, in the
19 aggregate, of at least 4 years during the 6-year period be-
20 ginning on the later of—

21 “(1) the date on which the individual receives
22 a master’s or doctorate nursing degree from an ac-
23 credited school of nursing; or

24 “(2) the date on which the individual enters
25 into an agreement under this subsection.

1 “(c) AGREEMENT PROVISIONS.—Agreements entered
2 into pursuant to subsection (b) shall be entered into on
3 such terms and conditions as the Secretary may deter-
4 mine, except that—

5 “(1) not more than 10 months after the date on
6 which the 6-year period described under subsection
7 (b) begins, but in no case before the individual
8 starts as a full-time member of the faculty of an ac-
9 credited school of nursing the Secretary shall begin
10 making payments, for and on behalf of that indi-
11 vidual, on the outstanding principal of, and interest
12 on, any loan of that individual obtained to pay for
13 such degree;

14 “(2) for an individual who has completed a
15 master’s in nursing or equivalent degree in nurs-
16 ing—

17 “(A) payments may not exceed \$10,000
18 per calendar year; and

19 “(B) total payments may not exceed
20 \$40,000 during the 2010 and 2011 fiscal years
21 (after fiscal year 2011, such amounts shall be
22 adjusted to provide for a cost-of-attendance in-
23 crease for the yearly loan rate and the aggre-
24 gate loan); and

1 “(3) for an individual who has completed a doc-
2 torate or equivalent degree in nursing—

3 “(A) payments may not exceed \$20,000
4 per calendar year; and

5 “(B) total payments may not exceed
6 \$80,000 during the 2010 and 2011 fiscal years
7 (adjusted for subsequent fiscal years as pro-
8 vided for in the same manner as in paragraph
9 (2)(B)).

10 “(d) BREACH OF AGREEMENT.—

11 “(1) IN GENERAL.—In the case of any agree-
12 ment made under subsection (b), the individual is
13 liable to the Federal Government for the total
14 amount paid by the Secretary under such agree-
15 ment, and for interest on such amount at the max-
16 imum legal prevailing rate, if the individual fails to
17 meet the agreement terms required under such sub-
18 section.

19 “(2) WAIVER OR SUSPENSION OF LIABILITY.—

20 In the case of an individual making an agreement
21 for purposes of paragraph (1), the Secretary shall
22 provide for the waiver or suspension of liability
23 under such paragraph if compliance by the indi-
24 vidual with the agreement involved is impossible or
25 would involve extreme hardship to the individual or

1 if enforcement of the agreement with respect to the
2 individual would be unconscionable.

3 “(3) DATE CERTAIN FOR RECOVERY.—Subject
4 to paragraph (2), any amount that the Federal Gov-
5 ernment is entitled to recover under paragraph (1)
6 shall be paid to the United States not later than the
7 expiration of the 3-year period beginning on the date
8 the United States becomes so entitled.

9 “(4) AVAILABILITY.—Amounts recovered under
10 paragraph (1) shall be available to the Secretary for
11 making loan repayments under this section and shall
12 remain available for such purpose until expended.

13 “(e) ELIGIBLE INDIVIDUAL DEFINED.—For pur-
14 poses of this section, the term ‘eligible individual’ means
15 an individual who—

16 “(1) is a United States citizen, national, or law-
17 ful permanent resident;

18 “(2) holds an unencumbered license as a reg-
19 istered nurse; and

20 “(3) has either already completed a master’s or
21 doctorate nursing program at an accredited school of
22 nursing or is currently enrolled on a full-time or
23 part-time basis in such a program.

24 “(f) PRIORITY.—For the purposes of this section and
25 section 846A, funding priority will be awarded to School

1 of Nursing Student Loans that support doctoral nursing
2 students or Individual Student Loan Repayment that sup-
3 port doctoral nursing students.

4 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 such sums as may be necessary for each of fiscal years
7 2010 through 2014.”.

8 **SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR**
9 **PARTS B THROUGH D OF TITLE VIII.**

10 Section 871 of the Public Health Service Act, as re-
11 designated and moved by section 5310, is amended to read
12 as follows:

13 **“SEC. 871. AUTHORIZATION OF APPROPRIATIONS.**

14 “For the purpose of carrying out parts B, C, and D
15 (subject to section 851(g)), there are authorized to be ap-
16 propriated \$338,000,000 for fiscal year 2010, and such
17 sums as may be necessary for each of the fiscal years 2011
18 through 2016.”.

19 **SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH**
20 **WORKFORCE.**

21 (a) IN GENERAL.—Part P of title III of the Public
22 Health Service Act (42 U.S.C. 280g et seq.) is amended
23 by adding at the end the following:

1 **“SEC. 399V. GRANTS TO PROMOTE POSITIVE HEALTH BE-**
2 **HAVIORS AND OUTCOMES.**

3 “(a) GRANTS AUTHORIZED.—The Director of the
4 Centers for Disease Control and Prevention, in collabora-
5 tion with the Secretary, shall award grants to eligible enti-
6 ties to promote positive health behaviors and outcomes for
7 populations in medically underserved communities through
8 the use of community health workers.

9 “(b) USE OF FUNDS.—Grants awarded under sub-
10 section (a) shall be used to support community health
11 workers—

12 “(1) to educate, guide, and provide outreach in
13 a community setting regarding health problems prev-
14 alent in medically underserved communities, particu-
15 larly racial and ethnic minority populations;

16 “(2) to educate and provide guidance regarding
17 effective strategies to promote positive health behav-
18 iors and discourage risky health behaviors;

19 “(3) to educate and provide outreach regarding
20 enrollment in health insurance including the Chil-
21 dren’s Health Insurance Program under title XXI of
22 the Social Security Act, Medicare under title XVIII
23 of such Act and Medicaid under title XIX of such
24 Act;

25 “(4) to identify, educate, refer, and enroll un-
26 derserved populations to appropriate healthcare

1 agencies and community-based programs and organi-
2 zations in order to increase access to quality
3 healthcare services and to eliminate duplicative care;
4 or

5 “(5) to educate, guide, and provide home visita-
6 tion services regarding maternal health and prenatal
7 care.

8 “(c) APPLICATION.—Each eligible entity that desires
9 to receive a grant under subsection (a) shall submit an
10 application to the Secretary, at such time, in such manner,
11 and accompanied by such information as the Secretary
12 may require.

13 “(d) PRIORITY.—In awarding grants under sub-
14 section (a), the Secretary shall give priority to applicants
15 that—

16 “(1) propose to target geographic areas—

17 “(A) with a high percentage of residents
18 who are eligible for health insurance but are
19 uninsured or underinsured;

20 “(B) with a high percentage of residents
21 who suffer from chronic diseases; or

22 “(C) with a high infant mortality rate;

23 “(2) have experience in providing health or
24 health-related social services to individuals who are
25 underserved with respect to such services; and

1 “(3) have documented community activity and
2 experience with community health workers.

3 “(e) COLLABORATION WITH ACADEMIC INSTITU-
4 TIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Sec-
5 retary shall encourage community health worker programs
6 receiving funds under this section to collaborate with aca-
7 demic institutions and one-stop delivery systems under
8 section 134(c) of the Workforce Investment Act of 1998.
9 Nothing in this section shall be construed to require such
10 collaboration.

11 “(f) EVIDENCE-BASED INTERVENTIONS.—The Sec-
12 retary shall encourage community health worker programs
13 receiving funding under this section to implement a proc-
14 ess or an outcome-based payment system that rewards
15 community health workers for connecting underserved
16 populations with the most appropriate services at the most
17 appropriate time. Nothing in this section shall be con-
18 strued to require such a payment.

19 “(g) QUALITY ASSURANCE AND COST EFFECTIVE-
20 NESS.—The Secretary shall establish guidelines for assur-
21 ing the quality of the training and supervision of commu-
22 nity health workers under the programs funded under this
23 section and for assuring the cost-effectiveness of such pro-
24 grams.

1 “(h) MONITORING.—The Secretary shall monitor
2 community health worker programs identified in approved
3 applications under this section and shall determine wheth-
4 er such programs are in compliance with the guidelines
5 established under subsection (g).

6 “(i) TECHNICAL ASSISTANCE.—The Secretary may
7 provide technical assistance to community health worker
8 programs identified in approved applications under this
9 section with respect to planning, developing, and operating
10 programs under the grant.

11 “(j) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated, such sums as may be
13 necessary to carry out this section for each of fiscal years
14 2010 through 2014.

15 “(k) DEFINITIONS.—In this section:

16 “(1) COMMUNITY HEALTH WORKER.—The term
17 ‘community health worker’, as defined by the De-
18 partment of Labor as Standard Occupational Classi-
19 fication [21–1094] means an individual who pro-
20 motes health or nutrition within the community in
21 which the individual resides—

22 “(A) by serving as a liaison between com-
23 munities and healthcare agencies;

24 “(B) by providing guidance and social as-
25 sistance to community residents;

1 “(C) by enhancing community residents’
2 ability to effectively communicate with
3 healthcare providers;

4 “(D) by providing culturally and linguis-
5 tically appropriate health or nutrition edu-
6 cation;

7 “(E) by advocating for individual and com-
8 munity health;

9 “(F) by providing referral and follow-up
10 services or otherwise coordinating care; and

11 “(G) by proactively identifying and enroll-
12 ing eligible individuals in Federal, State, local,
13 private or nonprofit health and human services
14 programs.

15 “(2) COMMUNITY SETTING.—The term ‘commu-
16 nity setting’ means a home or a community organi-
17 zation located in the neighborhood in which a partic-
18 ipant in the program under this section resides.

19 “(3) ELIGIBLE ENTITY.—The term ‘eligible en-
20 tity’ means a public or nonprofit private entity (in-
21 cluding a State or public subdivision of a State, a
22 public health department, a free health clinic, a hos-
23 pital, or a Federally-qualified health center (as de-
24 fined in section 1861(aa) of the Social Security
25 Act)), or a consortium of any such entities.

1 “(4) **MEDICALLY UNDERSERVED COMMUNITY.**—

2 The term ‘medically underserved community’ means
3 a community identified by a State—

4 “(A) that has a substantial number of in-
5 dividuals who are members of a medically un-
6 derserved population, as defined by section
7 330(b)(3); and

8 “(B) a significant portion of which is a
9 health professional shortage area as designated
10 under section 332.”.

11 **SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.**

12 Part E of title VII of the Public Health Service Act
13 (42 U.S.C. 294n et seq.), as amended by section 5206,
14 is further amended by adding at the end the following:

15 **“SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC**
16 **HEALTH EPIDEMIOLOGY, PUBLIC HEALTH**
17 **LABORATORY SCIENCE, PUBLIC HEALTH**
18 **INFORMATICS, AND EXPANSION OF THE EPI-**
19 **DEMIC INTELLIGENCE SERVICE.**

20 “(a) **IN GENERAL.**—The Secretary may carry out ac-
21 tivities to address documented workforce shortages in
22 State and local health departments in the critical areas
23 of applied public health epidemiology and public health
24 laboratory science and informatics and may expand the
25 Epidemic Intelligence Service.

1 “(b) SPECIFIC USES.—In carrying out subsection
2 (a), the Secretary shall provide for the expansion of exist-
3 ing fellowship programs operated through the Centers for
4 Disease Control and Prevention in a manner that is de-
5 signed to alleviate shortages of the type described in sub-
6 section (a).

7 “(c) OTHER PROGRAMS.—The Secretary may provide
8 for the expansion of other applied epidemiology training
9 programs that meet objectives similar to the objectives of
10 the programs described in subsection (b).

11 “(d) WORK OBLIGATION.—Participation in fellow-
12 ship training programs under this section shall be deemed
13 to be service for purposes of satisfying work obligations
14 stipulated in contracts under section 338I(j).

15 “(e) GENERAL SUPPORT.—Amounts may be used
16 from grants awarded under this section to expand the
17 Public Health Informatics Fellowship Program at the
18 Centers for Disease Control and Prevention to better sup-
19 port all public health systems at all levels of government.

20 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
21 are authorized to be appropriated to carry out this section
22 \$39,500,000 for each of fiscal years 2010 through 2013,
23 of which—

1 “(1) \$5,000,000 shall be made available in each
2 such fiscal year for epidemiology fellowship training
3 program activities under subsections (b) and (c);

4 “(2) \$5,000,000 shall be made available in each
5 such fiscal year for laboratory fellowship training
6 programs under subsection (b);

7 “(3) \$5,000,000 shall be made available in each
8 such fiscal year for the Public Health Informatics
9 Fellowship Program under subsection (e); and

10 “(4) \$24,500,000 shall be made available for
11 expanding the Epidemic Intelligence Service under
12 subsection (a).”.

13 **SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES**
14 **TRACK.**

15 Title II of the Public Health Service Act (42 U.S.C.
16 202 et seq.) is amended by adding at the end the fol-
17 lowing:

18 **“PART D—UNITED STATES PUBLIC HEALTH**
19 **SCIENCES TRACK**

20 **“SEC. 271. ESTABLISHMENT.**

21 “(a) UNITED STATES PUBLIC HEALTH SERVICES
22 TRACK.—

23 “(1) IN GENERAL.—There is hereby authorized
24 to be established a United States Public Health
25 Sciences Track (referred to in this part as the

1 ‘Track’), at sites to be selected by the Secretary,
2 with authority to grant appropriate advanced de-
3 grees in a manner that uniquely emphasizes team-
4 based service, public health, epidemiology, and emer-
5 gency preparedness and response. It shall be so or-
6 ganized as to graduate not less than—

7 “(A) 150 medical students annually, 10 of
8 whom shall be awarded studentships to the Uni-
9 formed Services University of Health Sciences;

10 “(B) 100 dental students annually;

11 “(C) 250 nursing students annually;

12 “(D) 100 public health students annually;

13 “(E) 100 behavioral and mental health
14 professional students annually;

15 “(F) 100 physician assistant or nurse
16 practitioner students annually; and

17 “(G) 50 pharmacy students annually.

18 “(2) LOCATIONS.—The Track shall be located
19 at existing and accredited, affiliated health profes-
20 sions education training programs at academic
21 health centers located in regions of the United
22 States determined appropriate by the Surgeon Gen-
23 eral, in consultation with the National Health Care
24 Workforce Commission established in section 5101
25 of the Patient Protection and Affordable Care Act.

1 “(b) NUMBER OF GRADUATES.—Except as provided
2 in subsection (a), the number of persons to be graduated
3 from the Track shall be prescribed by the Secretary. In
4 so prescribing the number of persons to be graduated from
5 the Track, the Secretary shall institute actions necessary
6 to ensure the maximum number of first-year enrollments
7 in the Track consistent with the academic capacity of the
8 affiliated sites and the needs of the United States for med-
9 ical, dental, and nursing personnel.

10 “(c) DEVELOPMENT.—The development of the Track
11 may be by such phases as the Secretary may prescribe
12 subject to the requirements of subsection (a).

13 “(d) INTEGRATED LONGITUDINAL PLAN.—The Sur-
14 geon General shall develop an integrated longitudinal plan
15 for health professions continuing education throughout the
16 continuum of health-related education, training, and prac-
17 tice. Training under such plan shall emphasize patient-
18 centered, interdisciplinary, and care coordination skills.
19 Experience with deployment of emergency response teams
20 shall be included during the clinical experiences.

21 “(e) FACULTY DEVELOPMENT.—The Surgeon Gen-
22 eral shall develop faculty development programs and cur-
23 ricula in decentralized venues of health care, to balance
24 urban, tertiary, and inpatient venues.

1 **“SEC. 272. ADMINISTRATION.**

2 “(a) IN GENERAL.—The business of the Track shall
3 be conducted by the Surgeon General with funds appro-
4 priated for and provided by the Department of Health and
5 Human Services. The National Health Care Workforce
6 Commission shall assist the Surgeon General in an advi-
7 sory capacity.

8 “(b) FACULTY.—

9 “(1) IN GENERAL.—The Surgeon General, after
10 considering the recommendations of the National
11 Health Care Workforce Commission, shall obtain the
12 services of such professors, instructors, and adminis-
13 trative and other employees as may be necessary to
14 operate the Track, but utilize when possible, existing
15 affiliated health professions training institutions.
16 Members of the faculty and staff shall be employed
17 under salary schedules and granted retirement and
18 other related benefits prescribed by the Secretary so
19 as to place the employees of the Track faculty on a
20 comparable basis with the employees of fully accred-
21 ited schools of the health professions within the
22 United States.

23 “(2) TITLES.—The Surgeon General may con-
24 fer academic titles, as appropriate, upon the mem-
25 bers of the faculty.

1 “(3) NONAPPLICATION OF PROVISIONS.—The
2 limitations in section 5373 of title 5, United States
3 Code, shall not apply to the authority of the Surgeon
4 General under paragraph (1) to prescribe salary
5 schedules and other related benefits.

6 “(c) AGREEMENTS.—The Surgeon General may ne-
7 gotiate agreements with agencies of the Federal Govern-
8 ment to utilize on a reimbursable basis appropriate exist-
9 ing Federal medical resources located in the United States
10 (or locations selected in accordance with section
11 271(a)(2)). Under such agreements the facilities con-
12 cerned will retain their identities and basic missions. The
13 Surgeon General may negotiate affiliation agreements
14 with accredited universities and health professions train-
15 ing institutions in the United States. Such agreements
16 may include provisions for payments for educational serv-
17 ices provided students participating in Department of
18 Health and Human Services educational programs.

19 “(d) PROGRAMS.—The Surgeon General may estab-
20 lish the following educational programs for Track stu-
21 dents:

22 “(1) Postdoctoral, postgraduate, and techno-
23 logical programs.

1 “(2) A cooperative program for medical, dental,
2 physician assistant, pharmacy, behavioral and men-
3 tal health, public health, and nursing students.

4 “(3) Other programs that the Surgeon General
5 determines necessary in order to operate the Track
6 in a cost-effective manner.

7 “(e) CONTINUING MEDICAL EDUCATION.—The Sur-
8 geon General shall establish programs in continuing med-
9 ical education for members of the health professions to
10 the end that high standards of health care may be main-
11 tained within the United States.

12 “(f) AUTHORITY OF THE SURGEON GENERAL.—

13 “(1) IN GENERAL.—The Surgeon General is au-
14 thorized—

15 “(A) to enter into contracts with, accept
16 grants from, and make grants to any nonprofit
17 entity for the purpose of carrying out coopera-
18 tive enterprises in medical, dental, physician as-
19 sistant, pharmacy, behavioral and mental
20 health, public health, and nursing research,
21 consultation, and education;

22 “(B) to enter into contracts with entities
23 under which the Surgeon General may furnish
24 the services of such professional, technical, or
25 clerical personnel as may be necessary to fulfill

1 cooperative enterprises undertaken by the
2 Track;

3 “(C) to accept, hold, administer, invest,
4 and spend any gift, devise, or bequest of per-
5 sonal property made to the Track, including
6 any gift, devise, or bequest for the support of
7 an academic chair, teaching, research, or dem-
8 onstration project;

9 “(D) to enter into agreements with entities
10 that may be utilized by the Track for the pur-
11 pose of enhancing the activities of the Track in
12 education, research, and technological applica-
13 tions of knowledge; and

14 “(E) to accept the voluntary services of
15 guest scholars and other persons.

16 “(2) LIMITATION.—The Surgeon General may
17 not enter into any contract with an entity if the con-
18 tract would obligate the Track to make outlays in
19 advance of the enactment of budget authority for
20 such outlays.

21 “(3) SCIENTISTS.—Scientists or other medical,
22 dental, or nursing personnel utilized by the Track
23 under an agreement described in paragraph (1) may
24 be appointed to any position within the Track and

1 may be permitted to perform such duties within the
2 Track as the Surgeon General may approve.

3 “(4) VOLUNTEER SERVICES.—A person who
4 provides voluntary services under the authority of
5 subparagraph (E) of paragraph (1) shall be consid-
6 ered to be an employee of the Federal Government
7 for the purposes of chapter 81 of title 5, relating to
8 compensation for work-related injuries, and to be an
9 employee of the Federal Government for the pur-
10 poses of chapter 171 of title 28, relating to tort
11 claims. Such a person who is not otherwise employed
12 by the Federal Government shall not be considered
13 to be a Federal employee for any other purpose by
14 reason of the provision of such services.

15 **“SEC. 273. STUDENTS; SELECTION; OBLIGATION.**

16 “(a) STUDENT SELECTION.—

17 “(1) IN GENERAL.—Medical, dental, physician
18 assistant, pharmacy, behavioral and mental health,
19 public health, and nursing students at the Track
20 shall be selected under procedures prescribed by the
21 Surgeon General. In so prescribing, the Surgeon
22 General shall consider the recommendations of the
23 National Health Care Workforce Commission.

24 “(2) PRIORITY.—In developing admissions pro-
25 cedures under paragraph (1), the Surgeon General

1 shall ensure that such procedures give priority to ap-
2 plicant medical, dental, physician assistant, phar-
3 macy, behavioral and mental health, public health,
4 and nursing students from rural communities and
5 underrepresented minorities.

6 “(b) CONTRACT AND SERVICE OBLIGATION.—

7 “(1) CONTRACT.—Upon being admitted to the
8 Track, a medical, dental, physician assistant, phar-
9 macy, behavioral and mental health, public health,
10 or nursing student shall enter into a written con-
11 tract with the Surgeon General that shall contain—

12 “(A) an agreement under which—

13 “(i) subject to subparagraph (B), the
14 Surgeon General agrees to provide the stu-
15 dent with tuition (or tuition remission) and
16 a student stipend (described in paragraph
17 (2)) in each school year for a period of
18 years (not to exceed 4 school years) deter-
19 mined by the student, during which period
20 the student is enrolled in the Track at an
21 affiliated or other participating health pro-
22 fessions institution pursuant to an agree-
23 ment between the Track and such institu-
24 tion; and

1 “(ii) subject to subparagraph (B), the
2 student agrees—

3 “(I) to accept the provision of
4 such tuition and student stipend to
5 the student;

6 “(II) to maintain enrollment at
7 the Track until the student completes
8 the course of study involved;

9 “(III) while enrolled in such
10 course of study, to maintain an ac-
11 ceptable level of academic standing
12 (as determined by the Surgeon Gen-
13 eral);

14 “(IV) if pursuing a degree from
15 a school of medicine or osteopathic
16 medicine, dental, public health, or
17 nursing school or a physician assist-
18 ant, pharmacy, or behavioral and
19 mental health professional program,
20 to complete a residency or internship
21 in a specialty that the Surgeon Gen-
22 eral determines is appropriate; and

23 “(V) to serve for a period of time
24 (referred to in this part as the ‘period
25 of obligated service’) within the Com-

1 missioned Corps of the Public Health
2 Service equal to 2 years for each
3 school year during which such indi-
4 vidual was enrolled at the College, re-
5 duced as provided for in paragraph
6 (3);

7 “(B) a provision that any financial obliga-
8 tion of the United States arising out of a con-
9 tract entered into under this part and any obli-
10 gation of the student which is conditioned
11 thereon, is contingent upon funds being appro-
12 priated to carry out this part;

13 “(C) a statement of the damages to which
14 the United States is entitled for the student’s
15 breach of the contract; and

16 “(D) such other statements of the rights
17 and liabilities of the Secretary and of the indi-
18 vidual, not inconsistent with the provisions of
19 this part.

20 “(2) TUITION AND STUDENT STIPEND.—

21 “(A) TUITION REMISSION RATES.—The
22 Surgeon General, based on the recommenda-
23 tions of the National Health Care Workforce
24 Commission, shall establish Federal tuition re-
25 mission rates to be used by the Track to pro-

1 vide reimbursement to affiliated and other par-
2 ticipating health professions institutions for the
3 cost of educational services provided by such in-
4 stitutions to Track students. The agreement en-
5 tered into by such participating institutions
6 under paragraph (1)(A)(i) shall contain an
7 agreement to accept as payment in full the es-
8 tablished remission rate under this subpara-
9 graph.

10 “(B) STIPEND.—The Surgeon General,
11 based on the recommendations of the National
12 Health Care Workforce Commission, shall es-
13 tablish and update Federal stipend rates for
14 payment to students under this part.

15 “(3) REDUCTIONS IN THE PERIOD OF OBLI-
16 GATED SERVICE.—The period of obligated service
17 under paragraph (1)(A)(ii)(V) shall be reduced—

18 “(A) in the case of a student who elects to
19 participate in a high-needs speciality residency
20 (as determined by the National Health Care
21 Workforce Commission), by 3 months for each
22 year of such participation (not to exceed a total
23 of 12 months); and

24 “(B) in the case of a student who, upon
25 completion of their residency, elects to practice

1 in a Federal medical facility (as defined in sec-
2 tion 781(e)) that is located in a health profes-
3 sional shortage area (as defined in section 332),
4 by 3 months for year of full-time practice in
5 such a facility (not to exceed a total of 12
6 months).

7 “(c) SECOND 2 YEARS OF SERVICE.—During the
8 third and fourth years in which a medical, dental, physi-
9 cian assistant, pharmacy, behavioral and mental health,
10 public health, or nursing student is enrolled in the Track,
11 training should be designed to prioritize clinical rotations
12 in Federal medical facilities in health professional short-
13 age areas, and emphasize a balance of hospital and com-
14 munity-based experiences, and training within inter-
15 disciplinary teams.

16 “(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST,
17 BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL,
18 PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAIN-
19 ING.—The Surgeon General shall establish provisions ap-
20 plicable with respect to dental, physician assistant, phar-
21 macy, behavioral and mental health, public health, and
22 nursing students that are comparable to those for medical
23 students under this section, including service obligations,
24 tuition support, and stipend support. The Surgeon Gen-
25 eral shall give priority to health professions training insti-

1 tutions that train medical, dental, physician assistant,
2 pharmacy, behavioral and mental health, public health,
3 and nursing students for some significant period of time
4 together, but at a minimum have a discrete and shared
5 core curriculum.

6 “(e) ELITE FEDERAL DISASTER TEAMS.—The Sur-
7 geon General, in consultation with the Secretary, the Di-
8 rector of the Centers for Disease Control and Prevention,
9 and other appropriate military and Federal government
10 agencies, shall develop criteria for the appointment of
11 highly qualified Track faculty, medical, dental, physician
12 assistant, pharmacy, behavioral and mental health, public
13 health, and nursing students, and graduates to elite Fed-
14 eral disaster preparedness teams to train and to respond
15 to public health emergencies, natural disasters, bioter-
16 rorism events, and other emergencies.

17 “(f) STUDENT DROPPED FROM TRACK IN AFFILIATE
18 SCHOOL.—A medical, dental, physician assistant, phar-
19 macy, behavioral and mental health, public health, or
20 nursing student who, under regulations prescribed by the
21 Surgeon General, is dropped from the Track in an affili-
22 ated school for deficiency in conduct or studies, or for
23 other reasons, shall be liable to the United States for all
24 tuition and stipend support provided to the student.

1 **“SEC. 274. FUNDING.**

2 “Beginning with fiscal year 2010, the Secretary shall
3 transfer from the Public Health and Social Services Emer-
4 gency Fund such sums as may be necessary to carry out
5 this part.”.

6 **Subtitle E—Supporting the**
7 **Existing Health Care Workforce**

8 **SEC. 5401. CENTERS OF EXCELLENCE.**

9 Section 736 of the Public Health Service Act (42
10 U.S.C. 293) is amended by striking subsection (h) and in-
11 serting the following:

12 “(h) FORMULA FOR ALLOCATIONS.—

13 “(1) ALLOCATIONS.—Based on the amount ap-
14 propriated under subsection (i) for a fiscal year, the
15 following subparagraphs shall apply as appropriate:

16 “(A) IN GENERAL.—If the amounts appro-
17 priated under subsection (i) for a fiscal year are
18 \$24,000,000 or less—

19 “(i) the Secretary shall make available
20 \$12,000,000 for grants under subsection
21 (a) to health professions schools that meet
22 the conditions described in subsection
23 (c)(2)(A); and

24 “(ii) and available after grants are
25 made with funds under clause (i), the Sec-
26 retary shall make available—

1 “(I) 60 percent of such amount
2 for grants under subsection (a) to
3 health professions schools that meet
4 the conditions described in paragraph
5 (3) or (4) of subsection (c) (including
6 meeting the conditions under sub-
7 section (e)); and

8 “(II) 40 percent of such amount
9 for grants under subsection (a) to
10 health professions schools that meet
11 the conditions described in subsection
12 (c)(5).

13 “(B) FUNDING IN EXCESS OF
14 \$24,000,000.—If amounts appropriated under
15 subsection (i) for a fiscal year exceed
16 \$24,000,000 but are less than \$30,000,000—

17 “(i) 80 percent of such excess
18 amounts shall be made available for grants
19 under subsection (a) to health professions
20 schools that meet the requirements de-
21 scribed in paragraph (3) or (4) of sub-
22 section (c) (including meeting conditions
23 pursuant to subsection (e)); and

24 “(ii) 20 percent of such excess
25 amount shall be made available for grants

1 under subsection (a) to health professions
2 schools that meet the conditions described
3 in subsection (c)(5).

4 “(C) FUNDING IN EXCESS OF
5 \$30,000,000.—If amounts appropriated under
6 subsection (i) for a fiscal year exceed
7 \$30,000,000 but are less than \$40,000,000, the
8 Secretary shall make available—

9 “(i) not less than \$12,000,000 for
10 grants under subsection (a) to health pro-
11 fessions schools that meet the conditions
12 described in subsection (c)(2)(A);

13 “(ii) not less than \$12,000,000 for
14 grants under subsection (a) to health pro-
15 fessions schools that meet the conditions
16 described in paragraph (3) or (4) of sub-
17 section (c) (including meeting conditions
18 pursuant to subsection (e));

19 “(iii) not less than \$6,000,000 for
20 grants under subsection (a) to health pro-
21 fessions schools that meet the conditions
22 described in subsection (c)(5); and

23 “(iv) after grants are made with
24 funds under clauses (i) through (iii), any
25 remaining excess amount for grants under

1 subsection (a) to health professions schools
2 that meet the conditions described in para-
3 graph (2)(A), (3), (4), or (5) of subsection
4 (c).

5 “(D) FUNDING IN EXCESS OF
6 \$40,000,000.—If amounts appropriated under
7 subsection (i) for a fiscal year are \$40,000,000
8 or more, the Secretary shall make available—

9 “(i) not less than \$16,000,000 for
10 grants under subsection (a) to health pro-
11 fessions schools that meet the conditions
12 described in subsection (c)(2)(A);

13 “(ii) not less than \$16,000,000 for
14 grants under subsection (a) to health pro-
15 fessions schools that meet the conditions
16 described in paragraph (3) or (4) of sub-
17 section (c) (including meeting conditions
18 pursuant to subsection (e));

19 “(iii) not less than \$8,000,000 for
20 grants under subsection (a) to health pro-
21 fessions schools that meet the conditions
22 described in subsection (c)(5); and

23 “(iv) after grants are made with
24 funds under clauses (i) through (iii), any
25 remaining funds for grants under sub-

1 section (a) to health professions schools
2 that meet the conditions described in para-
3 graph (2)(A), (3), (4), or (5) of subsection
4 (c).

5 “(2) NO LIMITATION.—Nothing in this sub-
6 section shall be construed as limiting the centers of
7 excellence referred to in this section to the des-
8 ignated amount, or to preclude such entities from
9 competing for grants under this section.

10 “(3) MAINTENANCE OF EFFORT.—

11 “(A) IN GENERAL.—With respect to activi-
12 ties for which a grant made under this part are
13 authorized to be expended, the Secretary may
14 not make such a grant to a center of excellence
15 for any fiscal year unless the center agrees to
16 maintain expenditures of non-Federal amounts
17 for such activities at a level that is not less
18 than the level of such expenditures maintained
19 by the center for the fiscal year preceding the
20 fiscal year for which the school receives such a
21 grant.

22 “(B) USE OF FEDERAL FUNDS.—With re-
23 spect to any Federal amounts received by a cen-
24 ter of excellence and available for carrying out
25 activities for which a grant under this part is

1 authorized to be expended, the center shall, be-
2 fore expending the grant, expend the Federal
3 amounts obtained from sources other than the
4 grant, unless given prior approval from the Sec-
5 retary.

6 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
7 are authorized to be appropriated to carry out this sec-
8 tion—

9 “(1) \$50,000,000 for each of the fiscal years
10 2010 through 2015; and

11 “(2) and such sums as are necessary for each
12 subsequent fiscal year.”.

13 **SEC. 5402. HEALTH CARE PROFESSIONALS TRAINING FOR**
14 **DIVERSITY.**

15 (a) LOAN REPAYMENTS AND FELLOWSHIPS REGARD-
16 ING FACULTY POSITIONS.—Section 738(a)(1) of the Pub-
17 lic Health Service Act (42 U.S.C. 293b(a)(1)) is amended
18 by striking “\$20,000 of the principal and interest of the
19 educational loans of such individuals.” and inserting
20 “\$30,000 of the principal and interest of the educational
21 loans of such individuals.”.

22 (b) SCHOLARSHIPS FOR DISADVANTAGED STU-
23 DENTS.—Section 740(a) of such Act (42 U.S.C. 293d(a))
24 is amended by striking “\$37,000,000” and all that follows
25 through “2002” and inserting “\$51,000,000 for fiscal

1 year 2010, and such sums as may be necessary for each
2 of the fiscal years 2011 through 2014”.

3 (c) REAUTHORIZATION FOR LOAN REPAYMENTS AND
4 FELLOWSHIPS REGARDING FACULTY POSITIONS.—Sec-
5 tion 740(b) of such Act (42 U.S.C. 293d(b)) is amended
6 by striking “appropriated” and all that follows through
7 the period at the end and inserting “appropriated,
8 \$5,000,000 for each of the fiscal years 2010 through
9 2014.”.

10 (d) REAUTHORIZATION FOR EDUCATIONAL ASSIST-
11 ANCE IN THE HEALTH PROFESSIONS REGARDING INDI-
12 VIDUALS FROM A DISADVANTAGED BACKGROUND.—Sec-
13 tion 740(c) of such Act (42 U.S.C. 293d(c)) is amended
14 by striking the first sentence and inserting the following:
15 “For the purpose of grants and contracts under section
16 739(a)(1), there is authorized to be appropriated
17 \$60,000,000 for fiscal year 2010 and such sums as may
18 be necessary for each of the fiscal years 2011 through
19 2014.”

20 **SEC. 5403. INTERDISCIPLINARY, COMMUNITY-BASED LINK-**
21 **AGES.**

22 (a) AREA HEALTH EDUCATION CENTERS.—Section
23 751 of the Public Health Service Act (42 U.S.C. 294a)
24 is amended to read as follows:

1 **“SEC. 751. AREA HEALTH EDUCATION CENTERS.**

2 “(a) ESTABLISHMENT OF AWARDS.—The Secretary
3 shall make the following 2 types of awards in accordance
4 with this section:

5 “(1) INFRASTRUCTURE DEVELOPMENT
6 AWARD.—The Secretary shall make awards to eligi-
7 ble entities to enable such entities to initiate health
8 care workforce educational programs or to continue
9 to carry out comparable programs that are operating
10 at the time the award is made by planning, devel-
11 oping, operating, and evaluating an area health edu-
12 cation center program.

13 “(2) POINT OF SERVICE MAINTENANCE AND
14 ENHANCEMENT AWARD.—The Secretary shall make
15 awards to eligible entities to maintain and improve
16 the effectiveness and capabilities of an existing area
17 health education center program, and make other
18 modifications to the program that are appropriate
19 due to changes in demographics, needs of the popu-
20 lations served, or other similar issues affecting the
21 area health education center program. For the pur-
22 poses of this section, the term ‘Program’ refers to
23 the area health education center program.

24 “(b) ELIGIBLE ENTITIES; APPLICATION.—

25 “(1) ELIGIBLE ENTITIES.—

1 “(A) INFRASTRUCTURE DEVELOPMENT.—
2 For purposes of subsection (a)(1), the term ‘eli-
3 gible entity’ means a school of medicine or os-
4 teopathic medicine, an incorporated consortium
5 of such schools, or the parent institutions of
6 such a school. With respect to a State in which
7 no area health education center program is in
8 operation, the Secretary may award a grant or
9 contract under subsection (a)(1) to a school of
10 nursing.

11 “(B) POINT OF SERVICE MAINTENANCE
12 AND ENHANCEMENT.—For purposes of sub-
13 section (a)(2), the term ‘eligible entity’ means
14 an entity that has received funds under this
15 section, is operating an area health education
16 center program, including an area health edu-
17 cation center or centers, and has a center or
18 centers that are no longer eligible to receive fi-
19 nancial assistance under subsection (a)(1).

20 “(2) APPLICATION.—An eligible entity desiring
21 to receive an award under this section shall submit
22 to the Secretary an application at such time, in such
23 manner, and containing such information as the Sec-
24 retary may require.

25 “(c) USE OF FUNDS.—

1 “(1) REQUIRED ACTIVITIES.—An eligible entity
2 shall use amounts awarded under a grant under sub-
3 section (a)(1) or (a)(2) to carry out the following ac-
4 tivities:

5 “(A) Develop and implement strategies, in
6 coordination with the applicable one-stop deliv-
7 ery system under section 134(c) of the Work-
8 force Investment Act of 1998, to recruit indi-
9 viduals from underrepresented minority popu-
10 lations or from disadvantaged or rural back-
11 grounds into health professions, and support
12 such individuals in attaining such careers.

13 “(B) Develop and implement strategies to
14 foster and provide community-based training
15 and education to individuals seeking careers in
16 health professions within underserved areas for
17 the purpose of developing and maintaining a di-
18 verse health care workforce that is prepared to
19 deliver high-quality care, with an emphasis on
20 primary care, in underserved areas or for health
21 disparity populations, in collaboration with
22 other Federal and State health care workforce
23 development programs, the State workforce
24 agency, and local workforce investment boards,
25 and in health care safety net sites.

1 “(C) Prepare individuals to more effec-
2 tively provide health services to underserved
3 areas and health disparity populations through
4 field placements or preceptorships in conjunc-
5 tion with community-based organizations, ac-
6 credited primary care residency training pro-
7 grams, Federally qualified health centers, rural
8 health clinics, public health departments, or
9 other appropriate facilities.

10 “(D) Conduct and participate in inter-
11 disciplinary training that involves physicians,
12 physician assistants, nurse practitioners, nurse
13 midwives, dentists, psychologists, pharmacists,
14 optometrists, community health workers, public
15 and allied health professionals, or other health
16 professionals, as practicable.

17 “(E) Deliver or facilitate continuing edu-
18 cation and information dissemination programs
19 for health care professionals, with an emphasis
20 on individuals providing care in underserved
21 areas and for health disparity populations.

22 “(F) Propose and implement effective pro-
23 gram and outcomes measurement and evalua-
24 tion strategies.

1 “(G) Establish a youth public health pro-
2 gram to expose and recruit high school students
3 into health careers, with a focus on careers in
4 public health.

5 “(2) INNOVATIVE OPPORTUNITIES.—An eligible
6 entity may use amounts awarded under a grant
7 under subsection (a)(1) or subsection (a)(2) to carry
8 out any of the following activities:

9 “(A) Develop and implement innovative
10 curricula in collaboration with community-based
11 accredited primary care residency training pro-
12 grams, Federally qualified health centers, rural
13 health clinics, behavioral and mental health fa-
14 cilities, public health departments, or other ap-
15 propriate facilities, with the goal of increasing
16 the number of primary care physicians and
17 other primary care providers prepared to serve
18 in underserved areas and health disparity popu-
19 lations.

20 “(B) Coordinate community-based
21 participatory research with academic health
22 centers, and facilitate rapid flow and dissemina-
23 tion of evidence-based health care information,
24 research results, and best practices to improve
25 quality, efficiency, and effectiveness of health

1 care and health care systems within community
2 settings.

3 “(C) Develop and implement other strate-
4 gies to address identified workforce needs and
5 increase and enhance the health care workforce
6 in the area served by the area health education
7 center program.

8 “(d) REQUIREMENTS.—

9 “(1) AREA HEALTH EDUCATION CENTER PRO-
10 GRAM.—In carrying out this section, the Secretary
11 shall ensure the following:

12 “(A) An entity that receives an award
13 under this section shall conduct at least 10 per-
14 cent of clinical education required for medical
15 students in community settings that are re-
16 moved from the primary teaching facility of the
17 contracting institution for grantees that operate
18 a school of medicine or osteopathic medicine. In
19 States in which an entity that receives an
20 award under this section is a nursing school or
21 its parent institution, the Secretary shall alter-
22 natively ensure that—

23 “(i) the nursing school conducts at
24 least 10 percent of clinical education re-
25 quired for nursing students in community

1 settings that are remote from the primary
2 teaching facility of the school; and

3 “(ii) the entity receiving the award
4 maintains a written agreement with a
5 school of medicine or osteopathic medicine
6 to place students from that school in train-
7 ing sites in the area health education cen-
8 ter program area.

9 “(B) An entity receiving funds under sub-
10 section (a)(2) does not distribute such funding
11 to a center that is eligible to receive funding
12 under subsection (a)(1).

13 “(2) AREA HEALTH EDUCATION CENTER.—The
14 Secretary shall ensure that each area health edu-
15 cation center program includes at least 1 area health
16 education center, and that each such center—

17 “(A) is a public or private organization
18 whose structure, governance, and operation is
19 independent from the awardee and the parent
20 institution of the awardee;

21 “(B) is not a school of medicine or osteo-
22 pathic medicine, the parent institution of such
23 a school, or a branch campus or other subunit
24 of a school of medicine or osteopathic medicine

1 or its parent institution, or a consortium of
2 such entities;

3 “(C) designates an underserved area or
4 population to be served by the center which is
5 in a location removed from the main location of
6 the teaching facilities of the schools partici-
7 pating in the program with such center and
8 does not duplicate, in whole or in part, the geo-
9 graphic area or population served by any other
10 center;

11 “(D) fosters networking and collaboration
12 among communities and between academic
13 health centers and community-based centers;

14 “(E) serves communities with a dem-
15 onstrated need of health professionals in part-
16 nership with academic medical centers;

17 “(F) addresses the health care workforce
18 needs of the communities served in coordination
19 with the public workforce investment system;
20 and

21 “(G) has a community-based governing or
22 advisory board that reflects the diversity of the
23 communities involved.

24 “(e) MATCHING FUNDS.—With respect to the costs
25 of operating a program through a grant under this section,

1 to be eligible for financial assistance under this section,
2 an entity shall make available (directly or through con-
3 tributions from State, county or municipal governments,
4 or the private sector) recurring non-Federal contributions
5 in cash or in kind, toward such costs in an amount that
6 is equal to not less than 50 percent of such costs. At least
7 25 percent of the total required non-Federal contributions
8 shall be in cash. An entity may apply to the Secretary
9 for a waiver of not more than 75 percent of the matching
10 fund amount required by the entity for each of the first
11 3 years the entity is funded through a grant under sub-
12 section (a)(1).

13 “(f) LIMITATION.—Not less than 75 percent of the
14 total amount provided to an area health education center
15 program under subsection (a)(1) or (a)(2) shall be allo-
16 cated to the area health education centers participating
17 in the program under this section. To provide needed flexi-
18 bility to newly funded area health education center pro-
19 grams, the Secretary may waive the requirement in the
20 sentence for the first 2 years of a new area health edu-
21 cation center program funded under subsection (a)(1).

22 “(g) AWARD.—An award to an entity under this sec-
23 tion shall be not less than \$250,000 annually per area
24 health education center included in the program involved.
25 If amounts appropriated to carry out this section are not

1 sufficient to comply with the preceding sentence, the Sec-
2 retary may reduce the per center amount provided for in
3 such sentence as necessary, provided the distribution es-
4 tablished in subsection (j)(2) is maintained.

5 “(h) PROJECT TERMS.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), the period during which payments may be
8 made under an award under subsection (a)(1) may
9 not exceed—

10 “(A) in the case of a program, 12 years;

11 or

12 “(B) in the case of a center within a pro-
13 gram, 6 years.

14 “(2) EXCEPTION.—The periods described in
15 paragraph (1) shall not apply to programs receiving
16 point of service maintenance and enhancement
17 awards under subsection (a)(2) to maintain existing
18 centers and activities.

19 “(i) INAPPLICABILITY OF PROVISION.—Notwith-
20 standing any other provision of this title, section 791(a)
21 shall not apply to an area health education center funded
22 under this section.

23 “(j) AUTHORIZATION OF APPROPRIATIONS.—

1 “(1) IN GENERAL.—There is authorized to be
2 appropriated to carry out this section \$125,000,000
3 for each of the fiscal years 2010 through 2014.

4 “(2) REQUIREMENTS.—Of the amounts appro-
5 priated for a fiscal year under paragraph (1)—

6 “(A) not more than 35 percent shall be
7 used for awards under subsection (a)(1);

8 “(B) not less than 60 percent shall be used
9 for awards under subsection (a)(2);

10 “(C) not more than 1 percent shall be used
11 for grants and contracts to implement outcomes
12 evaluation for the area health education cen-
13 ters; and

14 “(D) not more than 4 percent shall be
15 used for grants and contracts to provide tech-
16 nical assistance to entities receiving awards
17 under this section.

18 “(3) CARRYOVER FUNDS.—An entity that re-
19 ceives an award under this section may carry over
20 funds from 1 fiscal year to another without obtain-
21 ing approval from the Secretary. In no case may any
22 funds be carried over pursuant to the preceding sen-
23 tence for more than 3 years.

1 “(k) SENSE OF CONGRESS.—It is the sense of the
2 Congress that every State have an area health education
3 center program in effect under this section.”.

4 (b) CONTINUING EDUCATIONAL SUPPORT FOR
5 HEALTH PROFESSIONALS SERVING IN UNDERSERVED
6 COMMUNITIES.—Part D of title VII of the Public Health
7 Service Act (42 U.S.C. 294 et seq.) is amended by striking
8 section 752 and inserting the following:

9 **“SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR**
10 **HEALTH PROFESSIONALS SERVING IN UN-**
11 **DERSERVED COMMUNITIES.**

12 “(a) IN GENERAL.—The Secretary shall make grants
13 to, and enter into contracts with, eligible entities to im-
14 prove health care, increase retention, increase representa-
15 tion of minority faculty members, enhance the practice en-
16 vironment, and provide information dissemination and
17 educational support to reduce professional isolation
18 through the timely dissemination of research findings
19 using relevant resources.

20 “(b) ELIGIBLE ENTITIES.—For purposes of this sec-
21 tion, the term ‘eligible entity’ means an entity described
22 in section 799(b).

23 “(c) APPLICATION.—An eligible entity desiring to re-
24 ceive an award under this section shall submit to the Sec-

1 retary an application at such time, in such manner, and
2 containing such information as the Secretary may require.

3 “(d) USE OF FUNDS.—An eligible entity shall use
4 amounts awarded under a grant or contract under this
5 section to provide innovative supportive activities to en-
6 hance education through distance learning, continuing
7 educational activities, collaborative conferences, and elec-
8 tronic and telelearning activities, with priority for primary
9 care.

10 “(e) AUTHORIZATION.—There is authorized to be ap-
11 propriated to carry out this section \$5,000,000 for each
12 of the fiscal years 2010 through 2014, and such sums as
13 may be necessary for each subsequent fiscal year.”.

14 **SEC. 5404. WORKFORCE DIVERSITY GRANTS.**

15 Section 821 of the Public Health Service Act (42
16 U.S.C. 296m) is amended—

17 (1) in subsection (a)—

18 (A) by striking “The Secretary may” and
19 inserting the following:

20 “(1) AUTHORITY.—The Secretary may”;

21 (B) by striking “pre-entry preparation,
22 and retention activities” and inserting the fol-
23 lowing: “stipends for diploma or associate de-
24 gree nurses to enter a bridge or degree comple-
25 tion program, student scholarships or stipends

1 for accelerated nursing degree programs, pre-
 2 entry preparation, advanced education prepara-
 3 tion, and retention activities”; and

4 (2) in subsection (b)—

5 (A) by striking “First” and all that follows
 6 through “including the” and inserting “Na-
 7 tional Advisory Council on Nurse Education
 8 and Practice and consult with nursing associa-
 9 tions including the National Coalition of Ethnic
 10 Minority Nurse Associations,”; and

11 (B) by inserting before the period the fol-
 12 lowing: “, and other organizations determined
 13 appropriate by the Secretary”.

14 **SEC. 5405. PRIMARY CARE EXTENSION PROGRAM.**

15 Part P of title III of the Public Health Service Act
 16 (42 U.S.C. 280g et seq.), as amended by section 5313,
 17 is further amended by adding at the end the following:

18 **“SEC. 399W. PRIMARY CARE EXTENSION PROGRAM.**

19 “(a) ESTABLISHMENT, PURPOSE AND DEFINI-
 20 TION.—

21 “(1) IN GENERAL.—The Secretary, acting
 22 through the Director of the Agency for Healthcare
 23 Research and Quality, shall establish a Primary
 24 Care Extension Program.

1 “(2) PURPOSE.—The Primary Care Extension
2 Program shall provide support and assistance to pri-
3 mary care providers to educate providers about pre-
4 ventive medicine, health promotion, chronic disease
5 management, mental and behavioral health services
6 (including substance abuse prevention and treatment
7 services), and evidence-based and evidence-informed
8 therapies and techniques, in order to enable pro-
9 viders to incorporate such matters into their practice
10 and to improve community health by working with
11 community-based health connectors (referred to in
12 this section as ‘Health Extension Agents’).

13 “(3) DEFINITIONS.—In this section:

14 “(A) HEALTH EXTENSION AGENT.—The
15 term ‘Health Extension Agent’ means any local,
16 community-based health worker who facilitates
17 and provides assistance to primary care prac-
18 tices by implementing quality improvement or
19 system redesign, incorporating the principles of
20 the patient-centered medical home to provide
21 high-quality, effective, efficient, and safe pri-
22 mary care and to provide guidance to patients
23 in culturally and linguistically appropriate ways,
24 and linking practices to diverse health system
25 resources.

1 “(B) PRIMARY CARE PROVIDER.—The
2 term ‘primary care provider’ means a clinician
3 who provides integrated, accessible health care
4 services and who is accountable for addressing
5 a large majority of personal health care needs,
6 including providing preventive and health pro-
7 motion services for men, women, and children
8 of all ages, developing a sustained partnership
9 with patients, and practicing in the context of
10 family and community, as recognized by a State
11 licensing or regulatory authority, unless other-
12 wise specified in this section.

13 “(b) GRANTS TO ESTABLISH STATE HUBS AND
14 LOCAL PRIMARY CARE EXTENSION AGENCIES.—

15 “(1) GRANTS.—The Secretary shall award com-
16 petitive grants to States for the establishment of
17 State- or multistate-level primary care Primary Care
18 Extension Program State Hubs (referred to in this
19 section as ‘Hubs’).

20 “(2) COMPOSITION OF HUBS.—A Hub estab-
21 lished by a State pursuant to paragraph (1)—

22 “(A) shall consist of, at a minimum, the
23 State health department, the entity responsible
24 for administering the State Medicaid program
25 (if other than the State health department), the

1 State-level entity administering the Medicare
2 program, and the departments of 1 or more
3 health professions schools in the State that
4 train providers in primary care; and

5 “(B) may include entities such as hospital
6 associations, primary care practice-based re-
7 search networks, health professional societies,
8 State primary care associations, State licensing
9 boards, organizations with a contract with the
10 Secretary under section 1153 of the Social Se-
11 curity Act, consumer groups, and other appro-
12 priate entities.

13 “(c) STATE AND LOCAL ACTIVITIES.—

14 “(1) HUB ACTIVITIES.—Hubs established under
15 a grant under subsection (b) shall—

16 “(A) submit to the Secretary a plan to co-
17 ordinate functions with quality improvement or-
18 ganizations and area health education centers if
19 such entities are members of the Hub not de-
20 scribed in subsection (b)(2)(A);

21 “(B) contract with a county- or local-level
22 entity that shall serve as the Primary Care Ex-
23 tension Agency to administer the services de-
24 scribed in paragraph (2);

1 “(C) organize and administer grant funds
2 to county- or local-level Primary Care Extension
3 Agencies that serve a catchment area, as
4 determined by the State; and

5 “(D) organize State-wide or multistate net-
6 works of local-level Primary Care Extension
7 Agencies to share and disseminate information
8 and practices.

9 “(2) LOCAL PRIMARY CARE EXTENSION AGENCY
10 ACTIVITIES.—

11 “(A) REQUIRED ACTIVITIES.—Primary
12 Care Extension Agencies established by a Hub
13 under paragraph (1) shall—

14 “(i) assist primary care providers to
15 implement a patient-centered medical home
16 to improve the accessibility, quality, and
17 efficiency of primary care services, includ-
18 ing health homes;

19 “(ii) develop and support primary care
20 learning communities to enhance the dis-
21 semination of research findings for evi-
22 dence-based practice, assess implementa-
23 tion of practice improvement, share best
24 practices, and involve community clinicians
25 in the generation of new knowledge and

1 identification of important questions for
2 research;

3 “(iii) participate in a national network
4 of Primary Care Extension Hubs and pro-
5 pose how the Primary Care Extension
6 Agency will share and disseminate lessons
7 learned and best practices; and

8 “(iv) develop a plan for financial sus-
9 tainability involving State, local, and pri-
10 vate contributions, to provide for the re-
11 duction in Federal funds that is expected
12 after an initial 6-year period of program
13 establishment, infrastructure development,
14 and planning.

15 “(B) DISCRETIONARY ACTIVITIES.—Pri-
16 mary Care Extension Agencies established by a
17 Hub under paragraph (1) may—

18 “(i) provide technical assistance,
19 training, and organizational support for
20 community health teams established under
21 section 3602 of the Patient Protection and
22 Affordable Care Act;

23 “(ii) collect data and provision of pri-
24 mary care provider feedback from stand-
25 ardized measurements of processes and

1 outcomes to aid in continuous performance
2 improvement;

3 “(iii) collaborate with local health de-
4 partments, community health centers,
5 tribes and tribal entities, and other com-
6 munity agencies to identify community
7 health priorities and local health workforce
8 needs, and participate in community-based
9 efforts to address the social and primary
10 determinants of health, strengthen the
11 local primary care workforce, and eliminate
12 health disparities;

13 “(iv) develop measures to monitor the
14 impact of the proposed program on the
15 health of practice enrollees and of the
16 wider community served; and

17 “(v) participate in other activities, as
18 determined appropriate by the Secretary.

19 “(d) FEDERAL PROGRAM ADMINISTRATION.—

20 “(1) GRANTS; TYPES.—Grants awarded under
21 subsection (b) shall be—

22 “(A) program grants, that are awarded to
23 State or multistate entities that submit fully-de-
24 veloped plans for the implementation of a Hub,
25 for a period of 6 years; or

1 “(B) planning grants, that are awarded to
2 State or multistate entities with the goal of de-
3 veloping a plan for a Hub, for a period of 2
4 years.

5 “(2) APPLICATIONS.—To be eligible for a grant
6 under subsection (b), a State or multistate entity
7 shall submit to the Secretary an application, at such
8 time, in such manner, and containing such informa-
9 tion as the Secretary may require.

10 “(3) EVALUATION.—A State that receives a
11 grant under subsection (b) shall be evaluated at the
12 end of the grant period by an evaluation panel ap-
13 pointed by the Secretary.

14 “(4) CONTINUING SUPPORT.—After the sixth
15 year in which assistance is provided to a State under
16 a grant awarded under subsection (b), the State may
17 receive additional support under this section if the
18 State program has received satisfactory evaluations
19 with respect to program performance and the merits
20 of the State sustainability plan, as determined by
21 the Secretary.

22 “(5) LIMITATION.—A State shall not use in ex-
23 cess of 10 percent of the amount received under a
24 grant to carry out administrative activities under

1 this section. Funds awarded pursuant to this section
2 shall not be used for funding direct patient care.

3 “(e) REQUIREMENTS ON THE SECRETARY.—In car-
4 rying out this section, the Secretary shall consult with the
5 heads of other Federal agencies with demonstrated experi-
6 ence and expertise in health care and preventive medicine,
7 such as the Centers for Disease Control and Prevention,
8 the Substance Abuse and Mental Health Administration,
9 the Health Resources and Services Administration, the
10 National Institutes of Health, the Office of the National
11 Coordinator for Health Information Technology, the In-
12 dian Health Service, the Agricultural Cooperative Exten-
13 sion Service of the Department of Agriculture, and other
14 entities, as the Secretary determines appropriate.

15 “(f) AUTHORIZATION OF APPROPRIATIONS.—To
16 awards grants as provided in subsection (d), there are au-
17 thorized to be appropriated \$120,000,000 for each of fis-
18 cal years 2011 and 2012, and such sums as may be nec-
19 essary to carry out this section for each of fiscal years
20 2013 through 2014.”.

1 **Subtitle F—Strengthening Primary**
2 **Care and Other Workforce Im-**
3 **provements**

4 **SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERV-**
5 **ICES AND GENERAL SURGERY SERVICES.**

6 (a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY
7 CARE SERVICES.—

8 (1) IN GENERAL.—Section 1833 of the Social
9 Security Act (42 U.S.C. 1395l) is amended by add-
10 ing at the end the following new subsection:

11 “(x) INCENTIVE PAYMENTS FOR PRIMARY CARE
12 SERVICES.—

13 “(1) IN GENERAL.—In the case of primary care
14 services furnished on or after January 1, 2011, and
15 before January 1, 2016, by a primary care practi-
16 tioner, in addition to the amount of payment that
17 would otherwise be made for such services under this
18 part, there also shall be paid (on a monthly or quar-
19 terly basis) an amount equal to 10 percent of the
20 payment amount for the service under this part.

21 “(2) DEFINITIONS.—In this subsection:

22 “(A) PRIMARY CARE PRACTITIONER.—The
23 term ‘primary care practitioner’ means an indi-
24 vidual—

25 “(i) who—

1 “(I) is a physician (as described
2 in section 1861(r)(1)) who has a pri-
3 mary specialty designation of family
4 medicine, internal medicine, geriatric
5 medicine, or pediatric medicine; or

6 “(II) is a nurse practitioner, clin-
7 ical nurse specialist, or physician as-
8 sistant (as those terms are defined in
9 section 1861(aa)(5)); and

10 “(ii) for whom primary care services
11 accounted for at least 60 percent of the al-
12 lowed charges under this part for such
13 physician or practitioner in a prior period
14 as determined appropriate by the Sec-
15 retary.

16 “(B) PRIMARY CARE SERVICES.—The term
17 ‘primary care services’ means services identi-
18 fied, as of January 1, 2009, by the following
19 HCPCS codes (and as subsequently modified by
20 the Secretary):

21 “(i) 99201 through 99215.

22 “(ii) 99304 through 99340.

23 “(iii) 99341 through 99350.

24 “(3) COORDINATION WITH OTHER PAY-
25 MENTS.—The amount of the additional payment for

1 a service under this subsection and subsection (m)
2 shall be determined without regard to any additional
3 payment for the service under subsection (m) and
4 this subsection, respectively.

5 “(4) LIMITATION ON REVIEW.—There shall be
6 no administrative or judicial review under section
7 1869, 1878, or otherwise, respecting the identifica-
8 tion of primary care practitioners under this sub-
9 section.”.

10 (2) CONFORMING AMENDMENT.—Section
11 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
12 1395m(g)(2)(B)) is amended by adding at the end
13 the following sentence: “Section 1833(x) shall not be
14 taken into account in determining the amounts that
15 would otherwise be paid pursuant to the preceding
16 sentence.”.

17 (b) INCENTIVE PAYMENT PROGRAM FOR MAJOR
18 SURGICAL PROCEDURES FURNISHED IN HEALTH PRO-
19 FESSIONAL SHORTAGE AREAS.—

20 (1) IN GENERAL.—Section 1833 of the Social
21 Security Act (42 U.S.C. 1395l), as amended by sub-
22 section (a)(1), is amended by adding at the end the
23 following new subsection:

1 “(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL
2 PROCEDURES FURNISHED IN HEALTH PROFESSIONAL
3 SHORTAGE AREAS.—

4 “(1) IN GENERAL.—In the case of major sur-
5 gical procedures furnished on or after January 1,
6 2011, and before January 1, 2016, by a general sur-
7 geon in an area that is designated (under section
8 332(a)(1)(A) of the Public Health Service Act) as a
9 health professional shortage area as identified by the
10 Secretary prior to the beginning of the year involved,
11 in addition to the amount of payment that would
12 otherwise be made for such services under this part,
13 there also shall be paid (on a monthly or quarterly
14 basis) an amount equal to 10 percent of the pay-
15 ment amount for the service under this part.

16 “(2) DEFINITIONS.—In this subsection:

17 “(A) GENERAL SURGEON.—In this sub-
18 section, the term ‘general surgeon’ means a
19 physician (as described in section 1861(r)(1))
20 who has designated CMS specialty code 02–
21 General Surgery as their primary specialty code
22 in the physician’s enrollment under section
23 1866(j).

24 “(B) MAJOR SURGICAL PROCEDURES.—
25 The term ‘major surgical procedures’ means

1 physicians' services which are surgical proce-
2 dures for which a 10-day or 90-day global pe-
3 riod is used for payment under the fee schedule
4 under section 1848(b).

5 “(3) COORDINATION WITH OTHER PAY-
6 MENTS.—The amount of the additional payment for
7 a service under this subsection and subsection (m)
8 shall be determined without regard to any additional
9 payment for the service under subsection (m) and
10 this subsection, respectively.

11 “(4) APPLICATION.—The provisions of para-
12 graph (2) and (4) of subsection (m) shall apply to
13 the determination of additional payments under this
14 subsection in the same manner as such provisions
15 apply to the determination of additional payments
16 under subsection (m).”.

17 (2) CONFORMING AMENDMENT.—Section
18 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
19 1395m(g)(2)(B)), as amended by subsection (a)(2),
20 is amended by striking “Section 1833(x)” and in-
21 sserting “Subsections (x) and (y) of section 1833” in
22 the last sentence.

23 (c) BUDGET-NEUTRALITY ADJUSTMENT.—Section
24 1848(c)(2)(B) of the Social Security Act (42 U.S.C.

1 1395w-4(c)(2)(B)) is amended by adding at the end the
2 following new clause:

3 “(vii) ADJUSTMENT FOR CERTAIN
4 PHYSICIAN INCENTIVE PAYMENTS.—Fifty
5 percent of the additional expenditures
6 under this part attributable to subsections
7 (x) and (y) of section 1833 for a year (as
8 estimated by the Secretary) shall be taken
9 into account in applying clause (ii)(II) for
10 2011 and subsequent years. In lieu of ap-
11 plying the budget-neutrality adjustments
12 required under clause (ii)(II) to relative
13 value units to account for such costs for
14 the year, the Secretary shall apply such
15 budget-neutrality adjustments to the con-
16 version factor otherwise determined for the
17 year. For 2011 and subsequent years, the
18 Secretary shall increase the incentive pay-
19 ment otherwise applicable under section
20 1833(m) by a percent estimated to be
21 equal to the additional expenditures esti-
22 mated under the first sentence of this
23 clause for such year that is applicable to
24 physicians who primarily furnish services
25 in areas designated (under section

1 332(a)(1)(A) of the Public Health Service
2 Act) as health professional shortage
3 areas.”.

4 **SEC. 5502. MEDICARE FEDERALLY QUALIFIED HEALTH**
5 **CENTER IMPROVEMENTS.**

6 (a) EXPANSION OF MEDICARE-COVERED PREVEN-
7 TIVE SERVICES AT FEDERALLY QUALIFIED HEALTH
8 CENTERS.—

9 (1) IN GENERAL.—Section 1861(aa)(3)(A) of
10 the Social Security Act (42 U.S.C. 1395w
11 (aa)(3)(A)) is amended to read as follows:

12 “(A) services of the type described sub-
13 paragraphs (A) through (C) of paragraph (1)
14 and preventive services (as defined in section
15 1861(ddd)(3)); and”.

16 (2) EFFECTIVE DATE.—The amendment made
17 by paragraph (1) shall apply to services furnished on
18 or after January 1, 2011.

19 (b) PROSPECTIVE PAYMENT SYSTEM FOR FEDER-
20 ALLY QUALIFIED HEALTH CENTERS.—Section 1834 of
21 the Social Security Act (42 U.S.C. 1395m) is amended
22 by adding at the end the following new subsection:

23 “(n) DEVELOPMENT AND IMPLEMENTATION OF PRO-
24 SPECTIVE PAYMENT SYSTEM.—

25 “(1) DEVELOPMENT.—

1 “(A) IN GENERAL.—The Secretary shall
2 develop a prospective payment system for pay-
3 ment for Federally qualified health services fur-
4 nished by Federally qualified health centers
5 under this title. Such system shall include a
6 process for appropriately describing the services
7 furnished by Federally qualified health centers.

8 “(B) COLLECTION OF DATA AND EVALUA-
9 TION.—The Secretary shall require Federally
10 qualified health centers to submit to the Sec-
11 retary such information as the Secretary may
12 require in order to develop and implement the
13 prospective payment system under this para-
14 graph and paragraph (2), respectively, including
15 the reporting of services using HCPCS codes.

16 “(2) IMPLEMENTATION.—

17 “(A) IN GENERAL.—Notwithstanding sec-
18 tion 1833(a)(3)(B), the Secretary shall provide,
19 for cost reporting periods beginning on or after
20 October 1, 2014, for payments for Federally
21 qualified health services furnished by Federally
22 qualified health centers under this title in ac-
23 cordance with the prospective payment system
24 developed by the Secretary under paragraph
25 (1).

1 “(B) PAYMENTS.—

2 “(i) INITIAL PAYMENTS.—The Sec-
3 retary shall implement such prospective
4 payment system so that the estimated
5 amount of expenditures under this title for
6 Federally qualified health services in the
7 first year that the prospective payment
8 system is implemented is equal to 103 per-
9 cent of the estimated amount of expendi-
10 tures under this title that would have oc-
11 curred for such services in such year if the
12 system had not been implemented.

13 “(ii) PAYMENTS IN SUBSEQUENT
14 YEARS.—In the year after the first year of
15 implementation of such system, and in
16 each subsequent year, the payment rate for
17 Federally qualified health services fur-
18 nished in the year shall be equal to the
19 payment rate established for such services
20 furnished in the preceding year under this
21 subparagraph increased by the percentage
22 increase in the MEI (as defined in
23 1842(i)(3)) for the year involved.”.

1 **SEC. 5503. DISTRIBUTION OF ADDITIONAL RESIDENCY PO-**
2 **SITIONS.**

3 (a) IN GENERAL.—Section 1886(h) of the Social Se-
4 curity Act (42 U.S.C. 1395ww(h)) is amended—

5 (1) in paragraph (4)(F)(i), by striking “para-
6 graph (7)” and inserting “paragraphs (7) and (8)”;

7 (2) in paragraph (4)(H)(i), by striking “para-
8 graph (7)” and inserting “paragraphs (7) and (8)”;

9 (3) in paragraph (7)(E), by inserting “or para-
10 graph (8)” before the period at the end; and

11 (4) by adding at the end the following new
12 paragraph:

13 “(8) DISTRIBUTION OF ADDITIONAL RESIDENCY
14 POSITIONS.—

15 “(A) REDUCTIONS IN LIMIT BASED ON UN-
16 USED POSITIONS.—

17 “(i) IN GENERAL.—Except as pro-
18 vided in clause (ii), if a hospital’s reference
19 resident level (as defined in subparagraph
20 (H)(i)) is less than the otherwise applica-
21 ble resident limit (as defined in subpara-
22 graph (H)(iii)), effective for portions of
23 cost reporting periods occurring on or after
24 July 1, 2011, the otherwise applicable resi-
25 dent limit shall be reduced by 65 percent
26 of the difference between such otherwise

1 applicable resident limit and such reference
2 resident level.

3 “(ii) EXCEPTIONS.—This subpara-
4 graph shall not apply to—

5 “(I) a hospital located in a rural
6 area (as defined in subsection
7 (d)(2)(D)(ii)) with fewer than 250
8 acute care inpatient beds;

9 “(II) a hospital that was part of
10 a qualifying entity which had a vol-
11 untary residency reduction plan ap-
12 proved under paragraph (6)(B) or
13 under the authority of section 402 of
14 Public Law 90–248, if the hospital
15 demonstrates to the Secretary that it
16 has a specified plan in place for filling
17 the unused positions by not later than
18 2 years after the date of enactment of
19 this paragraph; or

20 “(III) a hospital described in
21 paragraph (4)(H)(v).

22 “(B) DISTRIBUTION.—

23 “(i) IN GENERAL.—The Secretary
24 shall increase the otherwise applicable resi-
25 dent limit for each qualifying hospital that

1 submits an application under this subpara-
2 graph by such number as the Secretary
3 may approve for portions of cost reporting
4 periods occurring on or after July 1, 2011.
5 The aggregate number of increases in the
6 otherwise applicable resident limit under
7 this subparagraph shall be equal to the ag-
8 gregate reduction in such limits attrib-
9 utable to subparagraph (A) (as estimated
10 by the Secretary).

11 “(ii) REQUIREMENTS.—Subject to
12 clause (iii), a hospital that receives an in-
13 crease in the otherwise applicable resident
14 limit under this subparagraph shall ensure,
15 during the 5-year period beginning on the
16 date of such increase, that—

17 “(I) the number of full-time
18 equivalent primary care residents, as
19 defined in paragraph (5)(H) (as de-
20 termined by the Secretary), excluding
21 any additional positions under sub-
22 clause (II), is not less than the aver-
23 age number of full-time equivalent
24 primary care residents (as so deter-
25 mined) during the 3 most recent cost

1 reporting periods ending prior to the
2 date of enactment of this paragraph;
3 and

4 “(II) not less than 75 percent of
5 the positions attributable to such in-
6 crease are in a primary care or gen-
7 eral surgery residency (as determined
8 by the Secretary).

9 The Secretary may determine whether a
10 hospital has met the requirements under
11 this clause during such 5-year period in
12 such manner and at such time as the Sec-
13 retary determines appropriate, including at
14 the end of such 5-year period.

15 “(iii) REDISTRIBUTION OF POSITIONS
16 IF HOSPITAL NO LONGER MEETS CERTAIN
17 REQUIREMENTS.—In the case where the
18 Secretary determines that a hospital de-
19 scribed in clause (ii) does not meet either
20 of the requirements under subclause (I) or
21 (II) of such clause, the Secretary shall—

22 “(I) reduce the otherwise applica-
23 ble resident limit of the hospital by
24 the amount by which such limit was
25 increased under this paragraph; and

1 “(II) provide for the distribution
2 of positions attributable to such re-
3 duction in accordance with the re-
4 quirements of this paragraph.

5 “(C) CONSIDERATIONS IN REDISTRIBU-
6 TION.—In determining for which hospitals the
7 increase in the otherwise applicable resident
8 limit is provided under subparagraph (B), the
9 Secretary shall take into account—

10 “(i) the demonstration likelihood of
11 the hospital filling the positions made
12 available under this paragraph within the
13 first 3 cost reporting periods beginning on
14 or after July 1, 2011, as determined by
15 the Secretary; and

16 “(ii) whether the hospital has an ac-
17 credited rural training track (as described
18 in paragraph (4)(H)(iv)).

19 “(D) PRIORITY FOR CERTAIN AREAS.—In
20 determining for which hospitals the increase in
21 the otherwise applicable resident limit is pro-
22 vided under subparagraph (B), subject to sub-
23 paragraph (E), the Secretary shall distribute
24 the increase to hospitals based on the following
25 factors:

1 “(i) Whether the hospital is located in
2 a State with a resident-to-population ratio
3 in the lowest quartile (as determined by
4 the Secretary).

5 “(ii) Whether the hospital is located
6 in a State, a territory of the United States,
7 or the District of Columbia that is among
8 the top 10 States, territories, or Districts
9 in terms of the ratio of—

10 “(I) the total population of the
11 State, territory, or District living in
12 an area designated (under such sec-
13 tion 332(a)(1)(A)) as a health profes-
14 sional shortage area (as of the date of
15 enactment of this paragraph); to

16 “(II) the total population of the
17 State, territory, or District (as deter-
18 mined by the Secretary based on the
19 most recent available population data
20 published by the Bureau of the Cen-
21 sus).

22 “(iii) Whether the hospital is located
23 in a rural area (as defined in subsection
24 (d)(2)(D)(ii)).

1 “(E) RESERVATION OF POSITIONS FOR
2 CERTAIN HOSPITALS.—

3 “(i) IN GENERAL.—Subject to clause
4 (ii), the Secretary shall reserve the posi-
5 tions available for distribution under this
6 paragraph as follows:

7 “(I) 70 percent of such positions
8 for distribution to hospitals described
9 in clause (i) of subparagraph (D).

10 “(II) 30 percent of such positions
11 for distribution to hospitals described
12 in clause (ii) and (iii) of such sub-
13 paragraph.

14 “(ii) EXCEPTION IF POSITIONS NOT
15 REDISTRIBUTED BY JULY 1, 2011.—In the
16 case where the Secretary does not dis-
17 tribute positions to hospitals in accordance
18 with clause (i) by July 1, 2011, the Sec-
19 retary shall distribute such positions to
20 other hospitals in accordance with the con-
21 siderations described in subparagraph (C)
22 and the priority described in subparagraph
23 (D).

1 “(F) LIMITATION.—A hospital may not re-
2 ceive more than 75 full-time equivalent addi-
3 tional residency positions under this paragraph.

4 “(G) APPLICATION OF PER RESIDENT
5 AMOUNTS FOR PRIMARY CARE AND NONPRI-
6 MARY CARE.—With respect to additional resi-
7 dency positions in a hospital attributable to the
8 increase provided under this paragraph, the ap-
9 proved FTE per resident amounts are deemed
10 to be equal to the hospital per resident amounts
11 for primary care and nonprimary care com-
12 puted under paragraph (2)(D) for that hospital.

13 “(H) DEFINITIONS.—In this paragraph:

14 “(i) REFERENCE RESIDENT LEVEL.—
15 The term ‘reference resident level’ means,
16 with respect to a hospital, the highest resi-
17 dent level for any of the 3 most recent cost
18 reporting periods (ending before the date
19 of the enactment of this paragraph) of the
20 hospital for which a cost report has been
21 settled (or, if not, submitted (subject to
22 audit)), as determined by the Secretary.

23 “(ii) RESIDENT LEVEL.—The term
24 ‘resident level’ has the meaning given such
25 term in paragraph (7)(C)(i).

1 “(iii) OTHERWISE APPLICABLE RESI-
2 DENT LIMIT.—The term ‘otherwise appli-
3 cable resident limit’ means, with respect to
4 a hospital, the limit otherwise applicable
5 under subparagraphs (F)(i) and (H) of
6 paragraph (4) on the resident level for the
7 hospital determined without regard to this
8 paragraph but taking into account para-
9 graph (7)(A).”.

10 (b) IME.—

11 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
12 the Social Security Act (42 U.S.C.
13 1395ww(d)(5)(B)(v)), in the second sentence, is
14 amended—

15 (A) by striking “subsection (h)(7)” and in-
16 serting “subsections (h)(7) and (h)(8)”; and

17 (B) by striking “it applies” and inserting
18 “they apply”.

19 (2) CONFORMING AMENDMENT.—Section
20 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
21 1395ww(d)(5)(B)) is amended by adding at the end
22 the following clause:

23 “(x) For discharges occurring on or after July
24 1, 2011, insofar as an additional payment amount
25 under this subparagraph is attributable to resident

1 positions distributed to a hospital under subsection
2 (h)(8)(B), the indirect teaching adjustment factor
3 shall be computed in the same manner as provided
4 under clause (ii) with respect to such resident posi-
5 tions.”.

6 (c) CONFORMING AMENDMENT.—Section 422(b)(2)
7 of the Medicare Prescription Drug, Improvement, and
8 Modernization Act of 2003 (Public Law 108–173) is
9 amended by striking “section 1886(h)(7)” and all that fol-
10 lows and inserting “paragraphs (7) and (8) of subsection
11 (h) of section 1886 of the Social Security Act”.

12 **SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER**
13 **SETTINGS.**

14 (a) GME.—Section 1886(h)(4)(E) of the Social Se-
15 curity Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

16 (1) by striking “shall be counted and that all
17 the time” and inserting “shall be counted and
18 that—

19 “(i) effective for cost reporting peri-
20 ods beginning before July 1, 2010, all the
21 time;”;

22 (2) in clause (i), as inserted by paragraph (1),
23 by striking the period at the end and inserting “;
24 and”;

1 (3) by inserting after clause (i), as so inserted,
2 the following new clause:

3 “(ii) effective for cost reporting peri-
4 ods beginning on or after July 1, 2010, all
5 the time so spent by a resident shall be
6 counted towards the determination of full-
7 time equivalency, without regard to the
8 setting in which the activities are per-
9 formed, if a hospital incurs the costs of the
10 stipends and fringe benefits of the resident
11 during the time the resident spends in that
12 setting. If more than one hospital incurs
13 these costs, either directly or through a
14 third party, such hospitals shall count a
15 proportional share of the time, as deter-
16 mined by written agreement between the
17 hospitals, that a resident spends training
18 in that setting.”; and

19 (4) by adding at the end the following flush
20 sentence:

21 “Any hospital claiming under this subpara-
22 graph for time spent in a nonprovider setting
23 shall maintain and make available to the Sec-
24 retary records regarding the amount of such
25 time and such amount in comparison with

1 amounts of such time in such base year as the
2 Secretary shall specify.”.

3 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
4 Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

5 (1) by striking “(iv) Effective for discharges oc-
6 ccurring on or after October 1, 1997” and inserting
7 “(iv)(I) Effective for discharges occurring on or
8 after October 1, 1997, and before July 1, 2010”;
9 and

10 (2) by inserting after clause (I), as inserted by
11 paragraph (1), the following new subparagraph:

12 “(II) Effective for discharges occurring on or
13 after July 1, 2010, all the time spent by an intern
14 or resident in patient care activities in a nonprovider
15 setting shall be counted towards the determination
16 of full-time equivalency if a hospital incurs the costs
17 of the stipends and fringe benefits of the intern or
18 resident during the time the intern or resident
19 spends in that setting. If more than one hospital in-
20 curs these costs, either directly or through a third
21 party, such hospitals shall count a proportional
22 share of the time, as determined by written agree-
23 ment between the hospitals, that a resident spends
24 training in that setting.”.

1 (c) APPLICATION.—The amendments made by this
 2 section shall not be applied in a manner that requires re-
 3 opening of any settled hospital cost reports as to which
 4 there is not a jurisdictionally proper appeal pending as
 5 of the date of the enactment of this Act on the issue of
 6 payment for indirect costs of medical education under sec-
 7 tion 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
 8 1395ww(d)(5)(B)) or for direct graduate medical edu-
 9 cation costs under section 1886(h) of such Act (42 U.S.C.
 10 1395ww(h)).

11 **SEC. 5505. RULES FOR COUNTING RESIDENT TIME FOR DI-**
 12 **DACTIC AND SCHOLARLY ACTIVITIES AND**
 13 **OTHER ACTIVITIES.**

14 (a) GME.—Section 1886(h) of the Social Security
 15 Act (42 U.S.C. 1395ww(h)), as amended by section 5504,
 16 is amended—

17 (1) in paragraph (4)—

18 (A) in subparagraph (E), by striking
 19 “Such rules” and inserting “Subject to sub-
 20 paragraphs (J) and (K), such rules”; and

21 (B) by adding at the end the following new
 22 subparagraphs:

23 “(J) TREATMENT OF CERTAIN NONPRO-
 24 VIDER AND DIDACTIC ACTIVITIES.—Such rules
 25 shall provide that all time spent by an intern or

1 resident in an approved medical residency train-
2 ing program in a nonprovider setting that is
3 primarily engaged in furnishing patient care (as
4 defined in paragraph (5)(K)) in non-patient
5 care activities, such as didactic conferences and
6 seminars, but not including research not associ-
7 ated with the treatment or diagnosis of a par-
8 ticular patient, as such time and activities are
9 defined by the Secretary, shall be counted to-
10 ward the determination of full-time equivalency.

11 “(K) TREATMENT OF CERTAIN OTHER AC-
12 TIVITIES.—In determining the hospital’s num-
13 ber of full-time equivalent residents for pur-
14 poses of this subsection, all the time that is
15 spent by an intern or resident in an approved
16 medical residency training program on vacation,
17 sick leave, or other approved leave, as such time
18 is defined by the Secretary, and that does not
19 prolong the total time the resident is partici-
20 pating in the approved program beyond the nor-
21 mal duration of the program shall be counted
22 toward the determination of full-time equiva-
23 lency.”; and

24 (2) in paragraph (5), by adding at the end the
25 following new subparagraph:

1 “(K) NONPROVIDER SETTING THAT IS PRI-
2 MARILY ENGAGED IN FURNISHING PATIENT
3 CARE.—The term ‘nonprovider setting that is
4 primarily engaged in furnishing patient care’
5 means a nonprovider setting in which the pri-
6 mary activity is the care and treatment of pa-
7 tients, as defined by the Secretary.”.

8 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
9 of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by
10 adding at the end the following new clause:

11 “(x)(I) The provisions of subpara-
12 graph (K) of subsection (h)(4) shall apply
13 under this subparagraph in the same man-
14 ner as they apply under such subsection.

15 “(II) In determining the hospital’s
16 number of full-time equivalent residents
17 for purposes of this subparagraph, all the
18 time spent by an intern or resident in an
19 approved medical residency training pro-
20 gram in non-patient care activities, such as
21 didactic conferences and seminars, as such
22 time and activities are defined by the Sec-
23 retary, that occurs in the hospital shall be
24 counted toward the determination of full-
25 time equivalency if the hospital—

1 “(aa) is recognized as a sub-
2 section (d) hospital;

3 “(bb) is recognized as a sub-
4 section (d) Puerto Rico hospital;

5 “(cc) is reimbursed under a reim-
6 bursement system authorized under
7 section 1814(b)(3); or

8 “(dd) is a provider-based hospital
9 outpatient department.

10 “(III) In determining the hospital’s
11 number of full-time equivalent residents
12 for purposes of this subparagraph, all the
13 time spent by an intern or resident in an
14 approved medical residency training pro-
15 gram in research activities that are not as-
16 sociated with the treatment or diagnosis of
17 a particular patient, as such time and ac-
18 tivities are defined by the Secretary, shall
19 not be counted toward the determination of
20 full-time equivalency.”.

21 (c) EFFECTIVE DATES.—

22 (1) IN GENERAL.—Except as otherwise pro-
23 vided, the Secretary of Health and Human Services
24 shall implement the amendments made by this sec-

1 tion in a manner so as to apply to cost reporting pe-
 2 riods beginning on or after January 1, 1983.

3 (2) GME.—Section 1886(h)(4)(J) of the Social
 4 Security Act, as added by subsection (a)(1)(B), shall
 5 apply to cost reporting periods beginning on or after
 6 July 1, 2009.

7 (3) IME.—Section 1886(d)(5)(B)(x)(III) of the
 8 Social Security Act, as added by subsection (b), shall
 9 apply to cost reporting periods beginning on or after
 10 October 1, 2001. Such section, as so added, shall
 11 not give rise to any inference as to how the law in
 12 effect prior to such date should be interpreted.

13 **SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS**
 14 **FROM CLOSED HOSPITALS.**

15 (a) GME.—Section 1886(h)(4)(H) of the Social Se-
 16 curity Act (42 U.S.C. Section 1395ww(h)(4)(H)) is
 17 amended by adding at the end the following new clause:

18 “(vi) REDISTRIBUTION OF RESIDENCY
 19 SLOTS AFTER A HOSPITAL CLOSES.—

20 “(I) IN GENERAL.—Subject to
 21 the succeeding provisions of this
 22 clause, the Secretary shall, by regula-
 23 tion, establish a process under which,
 24 in the case where a hospital (other
 25 than a hospital described in clause

1 (v)) with an approved medical resi-
2 dency program closes on or after a
3 date that is 2 years before the date of
4 enactment of this clause, the Sec-
5 retary shall increase the otherwise ap-
6 plicable resident limit under this para-
7 graph for other hospitals in accord-
8 ance with this clause.

9 “(II) PRIORITY FOR HOSPITALS
10 IN CERTAIN AREAS.—Subject to the
11 succeeding provisions of this clause, in
12 determining for which hospitals the
13 increase in the otherwise applicable
14 resident limit is provided under such
15 process, the Secretary shall distribute
16 the increase to hospitals in the fol-
17 lowing priority order (with preference
18 given within each category to hos-
19 pitals that are members of the same
20 affiliated group (as defined by the
21 Secretary under clause (ii)) as the
22 closed hospital):

23 “(aa) First, to hospitals lo-
24 cated in the same core-based sta-
25 tistical area as, or a core-based

1 statistical area contiguous to, the
2 hospital that closed.

3 “(bb) Second, to hospitals
4 located in the same State as the
5 hospital that closed.

6 “(cc) Third, to hospitals lo-
7 cated in the same region of the
8 country as the hospital that
9 closed.

10 “(dd) Fourth, only if the
11 Secretary is not able to distribute
12 the increase to hospitals de-
13 scribed in item (cc), to qualifying
14 hospitals in accordance with the
15 provisions of paragraph (8).

16 “(III) REQUIREMENT HOSPITAL
17 LIKELY TO FILL POSITION WITHIN
18 CERTAIN TIME PERIOD.—The Sec-
19 retary may only increase the otherwise
20 applicable resident limit of a hospital
21 under such process if the Secretary
22 determines the hospital has dem-
23 onstrated a likelihood of filling the po-
24 sitions made available under this
25 clause within 3 years.

1 “(IV) LIMITATION.—The aggregate
2 number of increases in the other-
3 wise applicable resident limits for hos-
4 pitals under this clause shall be equal
5 to the number of resident positions in
6 the approved medical residency pro-
7 grams that closed on or after the date
8 described in subclause (I).

9 “(V) ADMINISTRATION.—Chapter
10 35 of title 44, United States Code,
11 shall not apply to the implementation
12 of this clause.”.

13 (b) IME.—Section 1886(d)(5)(B)(v) of the Social Se-
14 curity Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second
15 sentence, as amended by section 5503, is amended by
16 striking “subsections (h)(7) and (h)(8)” and inserting
17 “subsections (h)(4)(H)(vi), (h)(7), and (h)(8)”.

18 (c) APPLICATION.—The amendments made by this
19 section shall not be applied in a manner that requires re-
20 opening of any settled hospital cost reports as to which
21 there is not a jurisdictionally proper appeal pending as
22 of the date of the enactment of this Act on the issue of
23 payment for indirect costs of medical education under sec-
24 tion 1886(d)(5)(B) of the Social Security Act (42 U.S.C.
25 1395ww(d)(5)(B)) or for direct graduate medical edu-

1 cation costs under section 1886(h) of such Act (42 U.S.C.
2 Section 1395ww(h)).

3 (d) EFFECT ON TEMPORARY FTE CAP ADJUST-
4 MENTS.—The Secretary of Health and Human Services
5 shall give consideration to the effect of the amendments
6 made by this section on any temporary adjustment to a
7 hospital’s FTE cap under section 413.79(h) of title 42,
8 Code of Federal Regulations (as in effect on the date of
9 enactment of this Act) in order to ensure that there is
10 no duplication of FTE slots. Such amendments shall not
11 affect the application of section 1886(h)(4)(H)(v) of the
12 Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

13 (e) CONFORMING AMENDMENT.—Section
14 1886(h)(7)(E) of the Social Security Act (42 U.S.C.
15 1395ww(h)(7)(E)), as amended by section 5503(a), is
16 amended by striking “paragraph or paragraph (8)” and
17 inserting “this paragraph, paragraph (8), or paragraph
18 (4)(H)(vi)”.

19 **SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS**
20 **HEALTH PROFESSIONS WORKFORCE NEEDS;**
21 **EXTENSION OF FAMILY-TO-FAMILY HEALTH**
22 **INFORMATION CENTERS.**

23 (a) AUTHORITY TO CONDUCT DEMONSTRATION
24 PROJECTS.—Title XX of the Social Security Act (42

1 U.S.C. 1397 et seq.) is amended by adding at the end
2 the following:

3 **“SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS**
4 **HEALTH PROFESSIONS WORKFORCE NEEDS.**

5 “(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-
6 INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDU-
7 CATION, TRAINING, AND CAREER ADVANCEMENT TO AD-
8 DRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

9 “(1) AUTHORITY TO AWARD GRANTS.—The
10 Secretary, in consultation with the Secretary of
11 Labor, shall award grants to eligible entities to con-
12 duct demonstration projects that are designed to
13 provide eligible individuals with the opportunity to
14 obtain education and training for occupations in the
15 health care field that pay well and are expected to
16 either experience labor shortages or be in high de-
17 mand.

18 “(2) REQUIREMENTS.—

19 “(A) AID AND SUPPORTIVE SERVICES.—

20 “(i) IN GENERAL.—A demonstration
21 project conducted by an eligible entity
22 awarded a grant under this section shall, if
23 appropriate, provide eligible individuals
24 participating in the project with financial

1 aid, child care, case management, and
2 other supportive services.

3 “(ii) TREATMENT.—Any aid, services,
4 or incentives provided to an eligible bene-
5 ficiary participating in a demonstration
6 project under this section shall not be con-
7 sidered income, and shall not be taken into
8 account for purposes of determining the in-
9 dividual’s eligibility for, or amount of, ben-
10 efits under any means-tested program.

11 “(B) CONSULTATION AND COORDINA-
12 TION.—An eligible entity applying for a grant
13 to carry out a demonstration project under this
14 section shall demonstrate in the application that
15 the entity has consulted with the State agency
16 responsible for administering the State TANF
17 program, the local workforce investment board
18 in the area in which the project is to be con-
19 ducted (unless the applicant is such board), the
20 State workforce investment board established
21 under section 111 of the Workforce Investment
22 Act of 1998, and the State Apprenticeship
23 Agency recognized under the Act of August 16,
24 1937 (commonly known as the ‘National Ap-
25 prenticeship Act’) (or if no agency has been rec-

1 ognized in the State, the Office of Apprentice-
2 ship of the Department of Labor) and that the
3 project will be carried out in coordination with
4 such entities.

5 “(C) ASSURANCE OF OPPORTUNITIES FOR
6 INDIAN POPULATIONS.—The Secretary shall
7 award at least 3 grants under this subsection to
8 an eligible entity that is an Indian tribe, tribal
9 organization, or Tribal College or University.

10 “(3) REPORTS AND EVALUATION.—

11 “(A) ELIGIBLE ENTITIES.—An eligible en-
12 tity awarded a grant to conduct a demonstra-
13 tion project under this subsection shall submit
14 interim reports to the Secretary on the activi-
15 ties carried out under the project and a final
16 report on such activities upon the conclusion of
17 the entities’ participation in the project. Such
18 reports shall include assessments of the effec-
19 tiveness of such activities with respect to im-
20 proving outcomes for the eligible individuals
21 participating in the project and with respect to
22 addressing health professions workforce needs
23 in the areas in which the project is conducted.

24 “(B) EVALUATION.—The Secretary shall,
25 by grant, contract, or interagency agreement,

1 evaluate the demonstration projects conducted
2 under this subsection. Such evaluation shall in-
3 clude identification of successful activities for
4 creating opportunities for developing and sus-
5 taining, particularly with respect to low-income
6 individuals and other entry-level workers, a
7 health professions workforce that has accessible
8 entry points, that meets high standards for edu-
9 cation, training, certification, and professional
10 development, and that provides increased wages
11 and affordable benefits, including health care
12 coverage, that are responsive to the workforce’s
13 needs.

14 “(C) REPORT TO CONGRESS.—The Sec-
15 retary shall submit interim reports and, based
16 on the evaluation conducted under subpara-
17 graph (B), a final report to Congress on the
18 demonstration projects conducted under this
19 subsection.

20 “(4) DEFINITIONS.—In this subsection:

21 “(A) ELIGIBLE ENTITY.—The term ‘eligi-
22 ble entity’ means a State, an Indian tribe or
23 tribal organization, an institution of higher edu-
24 cation, a local workforce investment board es-
25 tablished under section 117 of the Workforce

1 Investment Act of 1998, a sponsor of an ap-
2 prenticeship program registered under the Na-
3 tional Apprenticeship Act or a community-based
4 organization.

5 “(B) ELIGIBLE INDIVIDUAL.—

6 “(i) IN GENERAL.—The term ‘eligible
7 individual’ means a individual receiving as-
8 sistance under the State TANF program.

9 “(ii) OTHER LOW-INCOME INDIVID-
10 UALS.—Such term may include other low-
11 income individuals described by the eligible
12 entity in its application for a grant under
13 this section.

14 “(C) INDIAN TRIBE; TRIBAL ORGANIZA-
15 TION.—The terms ‘Indian tribe’ and ‘tribal or-
16 ganization’ have the meaning given such terms
17 in section 4 of the Indian Self-Determination
18 and Education Assistance Act (25 U.S.C.
19 450b).

20 “(D) INSTITUTION OF HIGHER EDU-
21 CATION.—The term ‘institution of higher edu-
22 cation’ has the meaning given that term in sec-
23 tion 101 of the Higher Education Act of 1965
24 (20 U.S.C. 1001).

1 “(E) STATE.—The term ‘State’ means
2 each of the 50 States, the District of Columbia,
3 the Commonwealth of Puerto Rico, the United
4 States Virgin Islands, Guam, and American
5 Samoa.

6 “(F) STATE TANF PROGRAM.—The term
7 ‘State TANF program’ means the temporary
8 assistance for needy families program funded
9 under part A of title IV.

10 “(G) TRIBAL COLLEGE OR UNIVERSITY.—
11 The term ‘Tribal College or University’ has the
12 meaning given that term in section 316(b) of
13 the Higher Education Act of 1965 (20 U.S.C.
14 1059c(b)).

15 “(b) DEMONSTRATION PROJECT TO DEVELOP
16 TRAINING AND CERTIFICATION PROGRAMS FOR PER-
17 SONAL OR HOME CARE AIDES.—

18 “(1) AUTHORITY TO AWARD GRANTS.—Not
19 later than 18 months after the date of enactment of
20 this section, the Secretary shall award grants to eli-
21 gible entities that are States to conduct demonstra-
22 tion projects for purposes of developing core training
23 competencies and certification programs for personal
24 or home care aides. The Secretary shall—

1 “(A) evaluate the efficacy of the core train-
2 ing competencies described in paragraph (3)(A)
3 for newly hired personal or home care aides and
4 the methods used by States to implement such
5 core training competencies in accordance with
6 the issues specified in paragraph (3)(B); and

7 “(B) ensure that the number of hours of
8 training provided by States under the dem-
9 onstration project with respect to such core
10 training competencies are not less than the
11 number of hours of training required under any
12 applicable State or Federal law or regulation.

13 “(2) DURATION.—A demonstration project shall
14 be conducted under this subsection for not less than
15 3 years.

16 “(3) CORE TRAINING COMPETENCIES FOR PER-
17 SONAL OR HOME CARE AIDES.—

18 “(A) IN GENERAL.—The core training
19 competencies for personal or home care aides
20 described in this subparagraph include com-
21 petencies with respect to the following areas:

22 “(i) The role of the personal or home
23 care aide (including differences between a
24 personal or home care aide employed by an
25 agency and a personal or home care aide

1 employed directly by the health care con-
2 sumer or an independent provider).

3 “(ii) Consumer rights, ethics, and
4 confidentiality (including the role of proxy
5 decision-makers in the case where a health
6 care consumer has impaired decision-mak-
7 ing capacity).

8 “(iii) Communication, cultural and
9 linguistic competence and sensitivity, prob-
10 lem solving, behavior management, and re-
11 lationship skills.

12 “(iv) Personal care skills.

13 “(v) Health care support.

14 “(vi) Nutritional support.

15 “(vii) Infection control.

16 “(viii) Safety and emergency training.

17 “(ix) Training specific to an indi-
18 vidual consumer’s needs (including older
19 individuals, younger individuals with dis-
20 abilities, individuals with developmental
21 disabilities, individuals with dementia, and
22 individuals with mental and behavioral
23 health needs).

24 “(x) Self-Care.

1 “(B) IMPLEMENTATION.—The implemen-
2 tation issues specified in this subparagraph in-
3 clude the following:

4 “(i) The length of the training.

5 “(ii) The appropriate trainer to stu-
6 dent ratio.

7 “(iii) The amount of instruction time
8 spent in the classroom as compared to on-
9 site in the home or a facility.

10 “(iv) Trainer qualifications.

11 “(v) Content for a ‘hands-on’ and
12 written certification exam.

13 “(vi) Continuing education require-
14 ments.

15 “(4) APPLICATION AND SELECTION CRI-
16 TERIA.—

17 “(A) IN GENERAL.—

18 “(i) NUMBER OF STATES.—The Sec-
19 retary shall enter into agreements with not
20 more than 6 States to conduct demonstra-
21 tion projects under this subsection.

22 “(ii) REQUIREMENTS FOR STATES.—
23 An agreement entered into under clause (i)
24 shall require that a participating State—

1 “(I) implement the core training
2 competencies described in paragraph
3 (3)(A); and

4 “(II) develop written materials
5 and protocols for such core training
6 competencies, including the develop-
7 ment of a certification test for per-
8 sonal or home care aides who have
9 completed such training competencies.

10 “(iii) CONSULTATION AND COLLABO-
11 RATION WITH COMMUNITY AND VOCA-
12 TIONAL COLLEGES.—The Secretary shall
13 encourage participating States to consult
14 with community and vocational colleges re-
15 garding the development of curricula to
16 implement the project with respect to ac-
17 tivities, as applicable, which may include
18 consideration of such colleges as partners
19 in such implementation.

20 “(B) APPLICATION AND ELIGIBILITY.—A
21 State seeking to participate in the project
22 shall—

23 “(i) submit an application to the Sec-
24 retary containing such information and at
25 such time as the Secretary may specify;

1 “(ii) meet the selection criteria estab-
2 lished under subparagraph (C); and

3 “(iii) meet such additional criteria as
4 the Secretary may specify.

5 “(C) SELECTION CRITERIA.—In selecting
6 States to participate in the program, the Sec-
7 retary shall establish criteria to ensure (if appli-
8 cable with respect to the activities involved)—

9 “(i) geographic and demographic di-
10 versity;

11 “(ii) that participating States offer
12 medical assistance for personal care serv-
13 ices under the State Medicaid plan;

14 “(iii) that the existing training stand-
15 ards for personal or home care aides in
16 each participating State—

17 “(I) are different from such
18 standards in the other participating
19 States; and

20 “(II) are different from the core
21 training competencies described in
22 paragraph (3)(A);

23 “(iv) that participating States do not
24 reduce the number of hours of training re-
25 quired under applicable State law or regu-

1 lation after being selected to participate in
2 the project; and

3 “(v) that participating States recruit
4 a minimum number of eligible health and
5 long-term care providers to participate in
6 the project.

7 “(D) TECHNICAL ASSISTANCE.—The Sec-
8 retary shall provide technical assistance to
9 States in developing written materials and pro-
10 tocols for such core training competencies.

11 “(5) EVALUATION AND REPORT.—

12 “(A) EVALUATION.—The Secretary shall
13 develop an experimental or control group test-
14 ing protocol in consultation with an inde-
15 pendent evaluation contractor selected by the
16 Secretary. Such contractor shall evaluate—

17 “(i) the impact of core training com-
18 petencies described in paragraph (3)(A),
19 including curricula developed to implement
20 such core training competencies, for per-
21 sonal or home care aides within each par-
22 ticipating State on job satisfaction, mas-
23 tery of job skills, beneficiary and family
24 caregiver satisfaction with services, and ad-
25 ditional measures determined by the Sec-

1 retary in consultation with the expert
2 panel;

3 “(ii) the impact of providing such core
4 training competencies on the existing
5 training infrastructure and resources of
6 States; and

7 “(iii) whether a minimum number of
8 hours of initial training should be required
9 for personal or home care aides and, if so,
10 what minimum number of hours should be
11 required.

12 “(B) REPORTS.—

13 “(i) REPORT ON INITIAL IMPLEMEN-
14 TATION.—Not later than 2 years after the
15 date of enactment of this section, the Sec-
16 retary shall submit to Congress a report on
17 the initial implementation of activities con-
18 ducted under the demonstration project,
19 including any available results of the eval-
20 uation conducted under subparagraph (A)
21 with respect to such activities, together
22 with such recommendations for legislation
23 or administrative action as the Secretary
24 determines appropriate.

1 “(ii) FINAL REPORT.—Not later than
2 1 year after the completion of the dem-
3 onstration project, the Secretary shall sub-
4 mit to Congress a report containing the re-
5 sults of the evaluation conducted under
6 subparagraph (A), together with such rec-
7 ommendations for legislation or adminis-
8 trative action as the Secretary determines
9 appropriate.

10 “(6) DEFINITIONS.—In this subsection:

11 “(A) ELIGIBLE HEALTH AND LONG-TERM
12 CARE PROVIDER.—The term ‘eligible health and
13 long-term care provider’ means a personal or
14 home care agency (including personal or home
15 care public authorities), a nursing home, a
16 home health agency (as defined in section
17 1861(o)), or any other health care provider the
18 Secretary determines appropriate which—

19 “(i) is licensed or authorized to pro-
20 vide services in a participating State; and

21 “(ii) receives payment for services
22 under title XIX.

23 “(B) PERSONAL CARE SERVICES.—The
24 term ‘personal care services’ has the meaning
25 given such term for purposes of title XIX.

1 “(C) PERSONAL OR HOME CARE AIDE.—

2 The term ‘personal or home care aide’ means
3 an individual who helps individuals who are el-
4 derly, disabled, ill, or mentally disabled (includ-
5 ing an individual with Alzheimer’s disease or
6 other dementia) to live in their own home or a
7 residential care facility (such as a nursing
8 home, assisted living facility, or any other facil-
9 ity the Secretary determines appropriate) by
10 providing routine personal care services and
11 other appropriate services to the individual.

12 “(D) STATE.—The term ‘State’ has the
13 meaning given that term for purposes of title
14 XIX.

15 “(e) FUNDING.—

16 “(1) IN GENERAL.—Subject to paragraph (2),
17 out of any funds in the Treasury not otherwise ap-
18 propriated, there are appropriated to the Secretary
19 to carry out subsections (a) and (b), \$85,000,000
20 for each of fiscal years 2010 through 2014.

21 “(2) TRAINING AND CERTIFICATION PROGRAMS
22 FOR PERSONAL AND HOME CARE AIDES.—With re-
23 spect to the demonstration projects under subsection
24 (b), the Secretary shall use \$5,000,000 of the
25 amount appropriated under paragraph (1) for each

1 of fiscal years 2010 through 2012 to carry out such
2 projects. No funds appropriated under paragraph
3 (1) shall be used to carry out demonstration projects
4 under subsection (b) after fiscal year 2012.

5 “(d) NONAPPLICATION.—

6 “(1) IN GENERAL.—Except as provided in para-
7 graph (2), the preceding sections of this title shall
8 not apply to grant awarded under this section.

9 “(2) LIMITATIONS ON USE OF GRANTS.—Sec-
10 tion 2005(a) (other than paragraph (6)) shall apply
11 to a grant awarded under this section to the same
12 extent and in the same manner as such section ap-
13 plies to payments to States under this title.”.

14 (b) EXTENSION OF FAMILY-TO-FAMILY HEALTH IN-
15 FORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the
16 Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is
17 amended by striking “fiscal year 2009” and inserting
18 “each of fiscal years 2009 through 2012”.

19 **SEC. 5508. INCREASING TEACHING CAPACITY.**

20 (a) TEACHING HEALTH CENTERS TRAINING AND
21 ENHANCEMENT.—Part C of title VII of the Public Health
22 Service Act (42 U.S.C. 293k et. seq.), as amended by sec-
23 tion 5303, is further amended by inserting after section
24 749 the following:

1 **“SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT**
2 **GRANTS.**

3 “(a) PROGRAM AUTHORIZED.—The Secretary may
4 award grants under this section to teaching health centers
5 for the purpose of establishing new accredited or expanded
6 primary care residency programs.

7 “(b) AMOUNT AND DURATION.—Grants awarded
8 under this section shall be for a term of not more than
9 3 years and the maximum award may not be more than
10 \$500,000.

11 “(c) USE OF FUNDS.—Amounts provided under a
12 grant under this section shall be used to cover the costs
13 of—

14 “(1) establishing or expanding a primary care
15 residency training program described in subsection
16 (a), including costs associated with—

17 “(A) curriculum development;

18 “(B) recruitment, training and retention of
19 residents and faculty:

20 “(C) accreditation by the Accreditation
21 Council for Graduate Medical Education
22 (ACGME), the American Dental Association
23 (ADA), or the American Osteopathic Associa-
24 tion (AOA); and

25 “(D) faculty salaries during the develop-
26 ment phase; and

1 “(2) technical assistance provided by an eligible
2 entity.

3 “(d) APPLICATION.—A teaching health center seek-
4 ing a grant under this section shall submit an application
5 to the Secretary at such time, in such manner, and con-
6 taining such information as the Secretary may require.

7 “(e) PREFERENCE FOR CERTAIN APPLICATIONS.—In
8 selecting recipients for grants under this section, the Sec-
9 retary shall give preference to any such application that
10 documents an existing affiliation agreement with an area
11 health education center program as defined in sections
12 751 and 799B.

13 “(f) DEFINITIONS.—In this section:

14 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
15 tity’ means an organization capable of providing
16 technical assistance including an area health edu-
17 cation center program as defined in sections 751
18 and 799B.

19 “(2) PRIMARY CARE RESIDENCY PROGRAM.—
20 The term ‘primary care residency program’ means
21 an approved graduate medical residency training
22 program (as defined in section 340H) in family med-
23 icine, internal medicine, pediatrics, internal medi-
24 cine-pediatrics, obstetrics and gynecology, psychi-

1 atry, general dentistry, pediatric dentistry, and geri-
2 atrics.

3 “(3) TEACHING HEALTH CENTER.—

4 “(A) IN GENERAL.—The term ‘teaching
5 health center’ means an entity that—

6 “(i) is a community based, ambula-
7 tory patient care center; and

8 “(ii) operates a primary care resi-
9 dency program.

10 “(B) INCLUSION OF CERTAIN ENTITIES.—

11 Such term includes the following:

12 “(i) A Federally qualified health cen-
13 ter (as defined in section 1905(l)(2)(B), of
14 the Social Security Act).

15 “(ii) A community mental health cen-
16 ter (as defined in section 1861(ff)(3)(B) of
17 the Social Security Act).

18 “(iii) A rural health clinic, as defined
19 in section 1861(aa) of the Social Security
20 Act.

21 “(iv) A health center operated by the
22 Indian Health Service, an Indian tribe or
23 tribal organization, or an urban Indian or-
24 ganization (as defined in section 4 of the
25 Indian Health Care Improvement Act).

1 “(v) An entity receiving funds under
2 title X of the Public Health Service Act.

3 “(g) AUTHORIZATION OF APPROPRIATIONS.—There
4 is authorized to be appropriated, \$25,000,000 for fiscal
5 year 2010, \$50,000,000 for fiscal year 2011, \$50,000,000
6 for fiscal year 2012, and such sums as may be necessary
7 for each fiscal year thereafter to carry out this section.
8 Not to exceed \$5,000,000 annually may be used for tech-
9 nical assistance program grants.”.

10 (b) NATIONAL HEALTH SERVICE CORPS TEACHING
11 CAPACITY.—Section 338C(a) of the Public Health Service
12 Act (42 U.S.C. 254m(a)) is amended to read as follows:

13 “(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—
14 Except as provided in section 338D, each individual who
15 has entered into a written contract with the Secretary
16 under section 338A or 338B shall provide service in the
17 full-time clinical practice of such individual’s profession as
18 a member of the Corps for the period of obligated service
19 provided in such contract. For the purpose of calculating
20 time spent in full-time clinical practice under this sub-
21 section, up to 50 percent of time spent teaching by a mem-
22 ber of the Corps may be counted toward his or her service
23 obligation.”.

24 (c) PAYMENTS TO QUALIFIED TEACHING HEALTH
25 CENTERS.—Part D of title III of the Public Health Serv-

1 ice Act (42 U.S.C. 254b et seq.) is amended by adding
2 at the end the following:

3 **“Subpart XI—Support of Graduate Medical**

4 **Education in Qualified Teaching Health Centers**

5 **“SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING**

6 **HEALTH CENTERS THAT OPERATE GRAD-**

7 **UATE MEDICAL EDUCATION PROGRAMS.**

8 “(a) PAYMENTS.—Subject to subsection (h)(2), the
9 Secretary shall make payments under this section for di-
10 rect expenses and for indirect expenses to qualified teach-
11 ing health centers that are listed as sponsoring institutions
12 by the relevant accrediting body for expansion of existing
13 or establishment of new approved graduate medical resi-
14 dency training programs.

15 “(b) AMOUNT OF PAYMENTS.—

16 “(1) IN GENERAL.—Subject to paragraph (2),
17 the amounts payable under this section to qualified
18 teaching health centers for an approved graduate
19 medical residency training program for a fiscal year
20 are each of the following amounts:

21 “(A) DIRECT EXPENSE AMOUNT.—The
22 amount determined under subsection (c) for di-
23 rect expenses associated with sponsoring ap-
24 proved graduate medical residency training pro-
25 grams.

1 “(B) INDIRECT EXPENSE AMOUNT.—The
2 amount determined under subsection (d) for in-
3 direct expenses associated with the additional
4 costs relating to teaching residents in such pro-
5 grams.

6 “(2) CAPPED AMOUNT.—

7 “(A) IN GENERAL.—The total of the pay-
8 ments made to qualified teaching health centers
9 under paragraph (1)(A) or paragraph (1)(B) in
10 a fiscal year shall not exceed the amount of
11 funds appropriated under subsection (g) for
12 such payments for that fiscal year.

13 “(B) LIMITATION.—The Secretary shall
14 limit the funding of full-time equivalent resi-
15 dents in order to ensure the direct and indirect
16 payments as determined under subsection (c)
17 and (d) do not exceed the total amount of funds
18 appropriated in a fiscal year under subsection
19 (g).

20 “(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE
21 MEDICAL EDUCATION.—

22 “(1) IN GENERAL.—The amount determined
23 under this subsection for payments to qualified
24 teaching health centers for direct graduate expenses
25 relating to approved graduate medical residency

1 training programs for a fiscal year is equal to the
2 product of—

3 “(A) the updated national per resident
4 amount for direct graduate medical education,
5 as determined under paragraph (2); and

6 “(B) the average number of full-time
7 equivalent residents in the teaching health cen-
8 ter’s graduate approved medical residency train-
9 ing programs as determined under section
10 1886(h)(4) of the Social Security Act (without
11 regard to the limitation under subparagraph
12 (F) of such section) during the fiscal year.

13 “(2) UPDATED NATIONAL PER RESIDENT
14 AMOUNT FOR DIRECT GRADUATE MEDICAL EDU-
15 CATION.—The updated per resident amount for di-
16 rect graduate medical education for a qualified
17 teaching health center for a fiscal year is an amount
18 determined as follows:

19 “(A) DETERMINATION OF QUALIFIED
20 TEACHING HEALTH CENTER PER RESIDENT
21 AMOUNT.—The Secretary shall compute for
22 each individual qualified teaching health center
23 a per resident amount—

24 “(i) by dividing the national average
25 per resident amount computed under sec-

1 tion 340E(c)(2)(D) into a wage-related
2 portion and a non-wage related portion by
3 applying the proportion determined under
4 subparagraph (B);

5 “(ii) by multiplying the wage-related
6 portion by the factor applied under section
7 1886(d)(3)(E) of the Social Security Act
8 (but without application of section 4410 of
9 the Balanced Budget Act of 1997 (42
10 U.S.C. 1395ww note)) during the pre-
11 ceding fiscal year for the teaching health
12 center’s area; and

13 “(iii) by adding the non-wage-related
14 portion to the amount computed under
15 clause (ii).

16 “(B) UPDATING RATE.—The Secretary
17 shall update such per resident amount for each
18 such qualified teaching health center as deter-
19 mined appropriate by the Secretary.

20 “(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL
21 EDUCATION.—

22 “(1) IN GENERAL.—The amount determined
23 under this subsection for payments to qualified
24 teaching health centers for indirect expenses associ-
25 ated with the additional costs of teaching residents

1 for a fiscal year is equal to an amount determined
2 appropriate by the Secretary.

3 “(2) FACTORS.—In determining the amount
4 under paragraph (1), the Secretary shall—

5 “(A) evaluate indirect training costs rel-
6 ative to supporting a primary care residency
7 program in qualified teaching health centers;
8 and

9 “(B) based on this evaluation, assure that
10 the aggregate of the payments for indirect ex-
11 penses under this section and the payments for
12 direct graduate medical education as deter-
13 mined under subsection (c) in a fiscal year do
14 not exceed the amount appropriated for such
15 expenses as determined in subsection (g).

16 “(3) INTERIM PAYMENT.—Before the Secretary
17 makes a payment under this subsection pursuant to
18 a determination of indirect expenses under para-
19 graph (1), the Secretary may provide to qualified
20 teaching health centers a payment, in addition to
21 any payment made under subsection (c), for ex-
22 pected indirect expenses associated with the addi-
23 tional costs of teaching residents for a fiscal year,
24 based on an estimate by the Secretary.

1 “(e) CLARIFICATION REGARDING RELATIONSHIP TO
2 OTHER PAYMENTS FOR GRADUATE MEDICAL EDU-
3 CATION.—Payments under this section—

4 “(1) shall be in addition to any payments—

5 “(A) for the indirect costs of medical edu-
6 cation under section 1886(d)(5)(B) of the So-
7 cial Security Act;

8 “(B) for direct graduate medical education
9 costs under section 1886(h) of such Act; and

10 “(C) for direct costs of medical education
11 under section 1886(k) of such Act;

12 “(2) shall not be taken into account in applying
13 the limitation on the number of total full-time equiv-
14 alent residents under subparagraphs (F) and (G) of
15 section 1886(h)(4) of such Act and clauses (v),
16 (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such
17 Act for the portion of time that a resident rotates
18 to a hospital; and

19 “(3) shall not include the time in which a resi-
20 dent is counted toward full-time equivalency by a
21 hospital under paragraph (2) or under section
22 1886(d)(5)(B)(iv) of the Social Security Act, section
23 1886(h)(4)(E) of such Act, or section 340E of this
24 Act.

1 “(f) RECONCILIATION.—The Secretary shall deter-
2 mine any changes to the number of residents reported by
3 a hospital in the application of the hospital for the current
4 fiscal year to determine the final amount payable to the
5 hospital for the current fiscal year for both direct expense
6 and indirect expense amounts. Based on such determina-
7 tion, the Secretary shall recoup any overpayments made
8 to pay any balance due to the extent possible. The final
9 amount so determined shall be considered a final inter-
10 mediary determination for the purposes of section 1878
11 of the Social Security Act and shall be subject to adminis-
12 trative and judicial review under that section in the same
13 manner as the amount of payment under section 1186(d)
14 of such Act is subject to review under such section.

15 “(g) FUNDING.—To carry out this section, there are
16 appropriated such sums as may be necessary, not to ex-
17 ceed \$230,000,000, for the period of fiscal years 2011
18 through 2015.

19 “(h) ANNUAL REPORTING REQUIRED.—

20 “(1) ANNUAL REPORT.—The report required
21 under this paragraph for a qualified teaching health
22 center for a fiscal year is a report that includes (in
23 a form and manner specified by the Secretary) the
24 following information for the residency academic
25 year completed immediately prior to such fiscal year:

1 “(A) The types of primary care resident
2 approved training programs that the qualified
3 teaching health center provided for residents.

4 “(B) The number of approved training po-
5 sitions for residents described in paragraph (4).

6 “(C) The number of residents described in
7 paragraph (4) who completed their residency
8 training at the end of such residency academic
9 year and care for vulnerable populations living
10 in underserved areas.

11 “(D) Other information as deemed appro-
12 priate by the Secretary.

13 “(2) AUDIT AUTHORITY; LIMITATION ON PAY-
14 MENT.—

15 “(A) AUDIT AUTHORITY.—The Secretary
16 may audit a qualified teaching health center to
17 ensure the accuracy and completeness of the in-
18 formation submitted in a report under para-
19 graph (1).

20 “(B) LIMITATION ON PAYMENT.—A teach-
21 ing health center may only receive payment in
22 a cost reporting period for a number of such
23 resident positions that is greater than the base
24 level of primary care resident positions, as de-
25 termined by the Secretary. For purposes of this

1 subparagraph, the ‘base level of primary care
2 residents’ for a teaching health center is the
3 level of such residents as of a base period.

4 “(3) REDUCTION IN PAYMENT FOR FAILURE TO
5 REPORT.—

6 “(A) IN GENERAL.—The amount payable
7 under this section to a qualified teaching health
8 center for a fiscal year shall be reduced by at
9 least 25 percent if the Secretary determines
10 that—

11 “(i) the qualified teaching health cen-
12 ter has failed to provide the Secretary, as
13 an addendum to the qualified teaching
14 health center’s application under this sec-
15 tion for such fiscal year, the report re-
16 quired under paragraph (1) for the pre-
17 vious fiscal year; or

18 “(ii) such report fails to provide com-
19 plete and accurate information required
20 under any subparagraph of such para-
21 graph.

22 “(B) NOTICE AND OPPORTUNITY TO PRO-
23 VIDE ACCURATE AND MISSING INFORMATION.—
24 Before imposing a reduction under subpara-
25 graph (A) on the basis of a qualified teaching

1 health center's failure to provide complete and
2 accurate information described in subparagraph
3 (A)(ii), the Secretary shall provide notice to the
4 teaching health center of such failure and the
5 Secretary's intention to impose such reduction
6 and shall provide the teaching health center
7 with the opportunity to provide the required in-
8 formation within the period of 30 days begin-
9 ning on the date of such notice. If the teaching
10 health center provides such information within
11 such period, no reduction shall be made under
12 subparagraph (A) on the basis of the previous
13 failure to provide such information.

14 “(4) RESIDENTS.—The residents described in
15 this paragraph are those who are in part-time or
16 full-time equivalent resident training positions at a
17 qualified teaching health center in any approved
18 graduate medical residency training program.

19 “(i) REGULATIONS.—The Secretary shall promulgate
20 regulations to carry out this section.

21 “(j) DEFINITIONS.—In this section:

22 “(1) APPROVED GRADUATE MEDICAL RESI-
23 DENCY TRAINING PROGRAM.—The term ‘approved
24 graduate medical residency training program’ means

1 a residency or other postgraduate medical training
2 program—

3 “(A) participation in which may be count-
4 ed toward certification in a specialty or sub-
5 specialty and includes formal postgraduate
6 training programs in geriatric medicine ap-
7 proved by the Secretary; and

8 “(B) that meets criteria for accreditation
9 (as established by the Accreditation Council for
10 Graduate Medical Education, the American Os-
11 teopathic Association, or the American Dental
12 Association).

13 “(2) PRIMARY CARE RESIDENCY PROGRAM.—
14 The term ‘primary care residency program’ has the
15 meaning given that term in section 749A.

16 “(3) QUALIFIED TEACHING HEALTH CENTER.—
17 The term ‘qualified teaching health center’ has the
18 meaning given the term ‘teaching health center’ in
19 section 749A.”.

20 **SEC. 5509. GRADUATE NURSE EDUCATION DEMONSTRATION.**
21 **TION.**

22 (a) IN GENERAL.—

23 (1) ESTABLISHMENT.—

24 (A) IN GENERAL.—The Secretary shall es-
25 tablish a graduate nurse education demonstra-

1 tion under title XVIII of the Social Security
2 Act (42 U.S.C. 1395 et seq.) under which an el-
3 igible hospital may receive payment for the hos-
4 pital's reasonable costs (described in paragraph
5 (2)) for the provision of qualified clinical train-
6 ing to advance practice nurses.

7 (B) NUMBER.—The demonstration shall
8 include up to 5 eligible hospitals.

9 (C) WRITTEN AGREEMENTS.—Eligible hos-
10 pitals selected to participate in the demonstra-
11 tion shall enter into written agreements pursu-
12 ant to subsection (b) in order to reimburse the
13 eligible partners of the hospital the share of the
14 costs attributable to each partner.

15 (2) COSTS DESCRIBED.—

16 (A) IN GENERAL.—Subject to subpara-
17 graph (B) and subsection (d), the costs de-
18 scribed in this paragraph are the reasonable
19 costs (as described in section 1861(v) of the So-
20 cial Security Act (42 U.S.C. 1395x(v))) of each
21 eligible hospital for the clinical training costs
22 (as determined by the Secretary) that are at-
23 tributable to providing advanced practice reg-
24 istered nurses with qualified training.

1 (B) LIMITATION.—With respect to a year,
2 the amount reimbursed under subparagraph (A)
3 may not exceed the amount of costs described
4 in subparagraph (A) that are attributable to an
5 increase in the number of advanced practice
6 registered nurses enrolled in a program that
7 provides qualified training during the year and
8 for which the hospital is being reimbursed
9 under the demonstration, as compared to the
10 average number of advanced practice registered
11 nurses who graduated in each year during the
12 period beginning on January 1, 2006, and end-
13 ing on December 31, 2010 (as determined by
14 the Secretary) from the graduate nursing edu-
15 cation program operated by the applicable
16 school of nursing that is an eligible partner of
17 the hospital for purposes of the demonstration.

18 (3) WAIVER AUTHORITY.—The Secretary may
19 waive such requirements of titles XI and XVIII of
20 the Social Security Act as may be necessary to carry
21 out the demonstration.

22 (4) ADMINISTRATION.—Chapter 35 of title 44,
23 United States Code, shall not apply to the imple-
24 mentation of this section.

1 (b) WRITTEN AGREEMENTS WITH ELIGIBLE PART-
2 NERS.—No payment shall be made under this section to
3 an eligible hospital unless such hospital has in effect a
4 written agreement with the eligible partners of the hos-
5 pital. Such written agreement shall describe, at a min-
6 imum—

7 (1) the obligations of the eligible partners with
8 respect to the provision of qualified training; and

9 (2) the obligation of the eligible hospital to re-
10 imburse such eligible partners applicable (in a timely
11 manner) for the costs of such qualified training at-
12 tributable to partner.

13 (c) EVALUATION.—Not later than October 17, 2017,
14 the Secretary shall submit to Congress a report on the
15 demonstration. Such report shall include an analysis of the
16 following:

17 (1) The growth in the number of advanced
18 practice registered nurses with respect to a specific
19 base year as a result of the demonstration.

20 (2) The growth for each of the specialties de-
21 scribed in subparagraphs (A) through (D) of sub-
22 section (e)(1).

23 (3) The costs to the Medicare program under
24 title XVIII of the Social Security Act as a result of
25 the demonstration.

1 (4) Other items the Secretary determines ap-
2 propriate and relevant.

3 (d) FUNDING.—

4 (1) IN GENERAL.—There is hereby appro-
5 priated to the Secretary, out of any funds in the
6 Treasury not otherwise appropriated, \$50,000,000
7 for each of fiscal years 2012 through 2015 to carry
8 out this section, including the design, implementa-
9 tion, monitoring, and evaluation of the demonstra-
10 tion.

11 (2) PRORATION.—If the aggregate payments to
12 eligible hospitals under the demonstration exceed
13 \$50,000,000 for a fiscal year described in paragraph
14 (1), the Secretary shall prorate the payment
15 amounts to each eligible hospital in order to ensure
16 that the aggregate payments do not exceed such
17 amount.

18 (3) WITHOUT FISCAL YEAR LIMITATION.—
19 Amounts appropriated under this subsection shall
20 remain available without fiscal year limitation.

21 (e) DEFINITIONS.—In this section:

22 (1) ADVANCED PRACTICE REGISTERED
23 NURSE.—The term “advanced practice registered
24 nurse” includes the following:

1 (A) A clinical nurse specialist (as defined
2 in subsection (aa)(5) of section 1861 of the So-
3 cial Security Act (42 U.S.C. 1395x)).

4 (B) A nurse practitioner (as defined in
5 such subsection).

6 (C) A certified registered nurse anesthetist
7 (as defined in subsection (bb)(2) of such sec-
8 tion).

9 (D) A certified nurse-midwife (as defined
10 in subsection (gg)(2) of such section).

11 (2) APPLICABLE NON-HOSPITAL COMMUNITY-
12 BASED CARE SETTING.—The term “applicable non-
13 hospital community-based care setting” means a
14 non-hospital community-based care setting which
15 has entered into a written agreement (as described
16 in subsection (b)) with the eligible hospital partici-
17 pating in the demonstration. Such settings include
18 Federally qualified health centers, rural health clin-
19 ics, and other non-hospital settings as determined
20 appropriate by the Secretary.

21 (3) APPLICABLE SCHOOL OF NURSING.—The
22 term “applicable school of nursing” means an ac-
23 credited school of nursing (as defined in section 801
24 of the Public Health Service Act) which has entered
25 into a written agreement (as described in subsection

1 (b)) with the eligible hospital participating in the
2 demonstration.

3 (4) DEMONSTRATION.—The term “demonstra-
4 tion” means the graduate nurse education dem-
5 onstration established under subsection (a).

6 (5) ELIGIBLE HOSPITAL.—The term “eligible
7 hospital” means a hospital (as defined in subsection
8 (e) of section 1861 of the Social Security Act (42
9 U.S.C. 1395x)) or a critical access hospital (as de-
10 fined in subsection (mm)(1) of such section) that
11 has a written agreement in place with—

12 (A) 1 or more applicable schools of nurs-
13 ing; and

14 (B) 2 or more applicable non-hospital com-
15 munity-based care settings.

16 (6) ELIGIBLE PARTNERS.—The term “eligible
17 partners” includes the following:

18 (A) An applicable non-hospital community-
19 based care setting.

20 (B) An applicable school of nursing.

21 (7) QUALIFIED TRAINING.—

22 (A) IN GENERAL.—The term “qualified
23 training” means training—

24 (i) that provides an advanced practice
25 registered nurse with the clinical skills nec-

1 essary to provide primary care, preventive
2 care, transitional care, chronic care man-
3 agement, and other services appropriate
4 for individuals entitled to, or enrolled for,
5 benefits under part A of title XVIII of the
6 Social Security Act, or enrolled under part
7 B of such title; and

8 (ii) subject to subparagraph (B), at
9 least half of which is provided in a non-
10 hospital community-based care setting.

11 (B) WAIVER OF REQUIREMENT HALF OF
12 TRAINING BE PROVIDED IN NON-HOSPITAL
13 COMMUNITY-BASED CARE SETTING IN CERTAIN
14 AREAS.—The Secretary may waive the require-
15 ment under subparagraph (A)(ii) with respect
16 to eligible hospitals located in rural or medically
17 underserved areas.

18 (8) SECRETARY.—The term “Secretary” means
19 the Secretary of Health and Human Services.

1 **Subtitle G—Improving Access to**
2 **Health Care Services**

3 **SEC. 5601. SPENDING FOR FEDERALLY QUALIFIED HEALTH**
4 **CENTERS (FQHCS).**

5 (a) IN GENERAL.—Section 330(r) of the Public
6 Health Service Act (42 U.S.C. 254b(r)) is amended by
7 striking paragraph (1) and inserting the following:

8 “(1) GENERAL AMOUNTS FOR GRANTS.—For
9 the purpose of carrying out this section, in addition
10 to the amounts authorized to be appropriated under
11 subsection (d), there is authorized to be appro-
12 priated the following:

13 “(A) For fiscal year 2010,
14 \$2,988,821,592.

15 “(B) For fiscal year 2011,
16 \$3,862,107,440.

17 “(C) For fiscal year 2012, \$4,990,553,440.

18 “(D) For fiscal year 2013,
19 \$6,448,713,307.

20 “(E) For fiscal year 2014,
21 \$7,332,924,155.

22 “(F) For fiscal year 2015,
23 \$8,332,924,155.

24 “(G) For fiscal year 2016, and each subse-
25 quent fiscal year, the amount appropriated for

1 the preceding fiscal year adjusted by the prod-
2 uct of—

3 “(i) one plus the average percentage
4 increase in costs incurred per patient
5 served; and

6 “(ii) one plus the average percentage
7 increase in the total number of patients
8 served.”.

9 (b) RULE OF CONSTRUCTION.—Section 330(r) of the
10 Public Health Service Act (42 U.S.C. 254b(r)) is amended
11 by adding at the end the following:

12 “(4) RULE OF CONSTRUCTION WITH RESPECT
13 TO RURAL HEALTH CLINICS.—

14 “(A) IN GENERAL.—Nothing in this sec-
15 tion shall be construed to prevent a community
16 health center from contracting with a Federally
17 certified rural health clinic (as defined in sec-
18 tion 1861(aa)(2) of the Social Security Act), a
19 low-volume hospital (as defined for purposes of
20 section 1886 of such Act), a critical access hos-
21 pital, a sole community hospital (as defined for
22 purposes of section 1886(d)(5)(D)(iii) of such
23 Act), or a medicare-dependent share hospital
24 (as defined for purposes of section
25 1886(d)(5)(G)(iv) of such Act) for the delivery

1 of primary health care services that are avail-
 2 able at the clinic or hospital to individuals who
 3 would otherwise be eligible for free or reduced
 4 cost care if that individual were able to obtain
 5 that care at the community health center. Such
 6 services may be limited in scope to those pri-
 7 mary health care services available in that clinic
 8 or hospitals.

9 “(B) ASSURANCES.—In order for a clinic
 10 or hospital to receive funds under this section
 11 through a contract with a community health
 12 center under subparagraph (A), such clinic or
 13 hospital shall establish policies to ensure—

14 “(i) nondiscrimination based on the
 15 ability of a patient to pay; and

16 “(ii) the establishment of a sliding fee
 17 scale for low-income patients.”.

18 **SEC. 5602. NEGOTIATED RULEMAKING FOR DEVELOPMENT**
 19 **OF METHODOLOGY AND CRITERIA FOR DES-**
 20 **IGNATING MEDICALLY UNDERSERVED POPU-**
 21 **LATIONS AND HEALTH PROFESSIONS SHORT-**
 22 **AGE AREAS.**

23 (a) ESTABLISHMENT.—

24 (1) IN GENERAL.—The Secretary of Health and
 25 Human Services (in this section referred to as the

1 “Secretary”) shall establish, through a negotiated
2 rulemaking process under subchapter 3 of chapter 5
3 of title 5, United States Code, a comprehensive
4 methodology and criteria for designation of—

5 (A) medically underserved populations in
6 accordance with section 330(b)(3) of the Public
7 Health Service Act (42 U.S.C. 254b(b)(3));

8 (B) health professions shortage areas
9 under section 332 of the Public Health Service
10 Act (42 U.S.C. 254e).

11 (2) FACTORS TO CONSIDER.—In establishing
12 the methodology and criteria under paragraph (1),
13 the Secretary—

14 (A) shall consult with relevant stakeholders
15 who will be significantly affected by a rule
16 (such as national, State and regional organiza-
17 tions representing affected entities), State
18 health offices, community organizations, health
19 centers and other affected entities, and other
20 interested parties; and

21 (B) shall take into account—

22 (i) the timely availability and appro-
23 priateness of data used to determine a des-
24 ignation to potential applicants for such
25 designations;

1 (ii) the impact of the methodology and
2 criteria on communities of various types
3 and on health centers and other safety net
4 providers;

5 (iii) the degree of ease or difficulty
6 that will face potential applicants for such
7 designations in securing the necessary
8 data; and

9 (iv) the extent to which the method-
10 ology accurately measures various barriers
11 that confront individuals and population
12 groups in seeking health care services.

13 (b) PUBLICATION OF NOTICE.—In carrying out the
14 rulemaking process under this subsection, the Secretary
15 shall publish the notice provided for under section 564(a)
16 of title 5, United States Code, by not later than 45 days
17 after the date of the enactment of this Act.

18 (c) TARGET DATE FOR PUBLICATION OF RULE.—As
19 part of the notice under subsection (b), and for purposes
20 of this subsection, the “target date for publication”, as
21 referred to in section 564(a)(5) of title 5, United States
22 Code, shall be July 1, 2010.

23 (d) APPOINTMENT OF NEGOTIATED RULEMAKING
24 COMMITTEE AND FACILITATOR.—The Secretary shall pro-
25 vide for—

1 (1) the appointment of a negotiated rulemaking
2 committee under section 565(a) of title 5, United
3 States Code, by not later than 30 days after the end
4 of the comment period provided for under section
5 564(c) of such title; and

6 (2) the nomination of a facilitator under section
7 566(c) of such title 5 by not later than 10 days after
8 the date of appointment of the committee.

9 (e) PRELIMINARY COMMITTEE REPORT.—The nego-
10 tiated rulemaking committee appointed under subsection
11 (d) shall report to the Secretary, by not later than April
12 1, 2010, regarding the committee’s progress on achieving
13 a consensus with regard to the rulemaking proceeding and
14 whether such consensus is likely to occur before one month
15 before the target date for publication of the rule. If the
16 committee reports that the committee has failed to make
17 significant progress toward such consensus or is unlikely
18 to reach such consensus by the target date, the Secretary
19 may terminate such process and provide for the publica-
20 tion of a rule under this section through such other meth-
21 ods as the Secretary may provide.

22 (f) FINAL COMMITTEE REPORT.—If the committee
23 is not terminated under subsection (e), the rulemaking
24 committee shall submit a report containing a proposed

1 rule by not later than one month before the target publica-
2 tion date.

3 (g) INTERIM FINAL EFFECT.—The Secretary shall
4 publish a rule under this section in the Federal Register
5 by not later than the target publication date. Such rule
6 shall be effective and final immediately on an interim
7 basis, but is subject to change and revision after public
8 notice and opportunity for a period (of not less than 90
9 days) for public comment. In connection with such rule,
10 the Secretary shall specify the process for the timely re-
11 view and approval of applications for such designations
12 pursuant to such rules and consistent with this section.

13 (h) PUBLICATION OF RULE AFTER PUBLIC COM-
14 MENT.—The Secretary shall provide for consideration of
15 such comments and republication of such rule by not later
16 than 1 year after the target publication date.

17 **SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMER-**
18 **GENCY MEDICAL SERVICES FOR CHILDREN**
19 **PROGRAM.**

20 Section 1910 of the Public Health Service Act (42
21 U.S.C. 300w-9) is amended—

22 (1) in subsection (a), by striking “3-year period
23 (with an optional 4th year” and inserting “4-year
24 period (with an optional 5th year”;

25 (2) in subsection (d)—

1 (A) by striking “and such sums” and in-
 2 serting “such sums”; and

3 (B) by inserting before the period the fol-
 4 lowing: “, \$25,000,000 for fiscal year 2010,
 5 \$26,250,000 for fiscal year 2011, \$27,562,500
 6 for fiscal year 2012, \$28,940,625 for fiscal year
 7 2013, and \$30,387,656 for fiscal year 2014”.

8 **SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE**
 9 **IN COMMUNITY-BASED MENTAL HEALTH SET-**
 10 **TINGS.**

11 Subpart 3 of part B of title V of the Public Health
 12 Service Act (42 U.S.C. 290bb–31 et seq.) is amended by
 13 adding at the end the following:

14 **“SEC. 520K. AWARDS FOR CO-LOCATING PRIMARY AND SPE-**
 15 **CIALTY CARE IN COMMUNITY-BASED MENTAL**
 16 **HEALTH SETTINGS.**

17 “(a) DEFINITIONS.—In this section:

18 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
 19 tity’ means a qualified community mental health
 20 program defined under section 1913(b)(1).

21 “(2) SPECIAL POPULATIONS.—The term ‘spe-
 22 cial populations’ means adults with mental illnesses
 23 who have co-occurring primary care conditions and
 24 chronic diseases.

1 “(b) PROGRAM AUTHORIZED.—The Secretary, acting
2 through the Administrator shall award grants and cooper-
3 ative agreements to eligible entities to establish dem-
4 onstration projects for the provision of coordinated and
5 integrated services to special populations through the co-
6 location of primary and specialty care services in commu-
7 nity-based mental and behavioral health settings.

8 “(c) APPLICATION.—To be eligible to receive a grant
9 or cooperative agreement under this section, an eligible en-
10 tity shall submit an application to the Administrator at
11 such time, in such manner, and accompanied by such in-
12 formation as the Administrator may require, including a
13 description of partnerships, or other arrangements with
14 local primary care providers, including community health
15 centers, to provide services to special populations.

16 “(d) USE OF FUNDS.—

17 “(1) IN GENERAL.—For the benefit of special
18 populations, an eligible entity shall use funds award-
19 ed under this section for—

20 “(A) the provision, by qualified primary
21 care professionals, of on site primary care serv-
22 ices;

23 “(B) reasonable costs associated with
24 medically necessary referrals to qualified spe-
25 cialty care professionals, other coordinators of

1 care or, if permitted by the terms of the grant
2 or cooperative agreement, by qualified specialty
3 care professionals on a reasonable cost basis on
4 site at the eligible entity;

5 “(C) information technology required to
6 accommodate the clinical needs of primary and
7 specialty care professionals; or

8 “(D) facility modifications needed to bring
9 primary and specialty care professionals on site
10 at the eligible entity.

11 “(2) LIMITATION.—Not to exceed 15 percent of
12 grant or cooperative agreement funds may be used
13 for activities described in subparagraphs (C) and
14 (D) of paragraph (1).

15 “(e) EVALUATION.—Not later than 90 days after a
16 grant or cooperative agreement awarded under this section
17 expires, an eligible entity shall submit to the Secretary the
18 results of an evaluation to be conducted by the entity con-
19 cerning the effectiveness of the activities carried out under
20 the grant or agreement.

21 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
22 are authorized to be appropriated to carry out this section,
23 \$50,000,000 for fiscal year 2010 and such sums as may
24 be necessary for each of fiscal years 2011 through 2014.”.

1 **SEC. 5605. KEY NATIONAL INDICATORS.**

2 (a) DEFINITIONS.—In this section:

3 (1) ACADEMY.—The term “Academy” means
4 the National Academy of Sciences.

5 (2) COMMISSION.—The term “Commission”
6 means the Commission on Key National Indicators
7 established under subsection (b).

8 (3) INSTITUTE.—The term “Institute” means a
9 Key National Indicators Institute as designated
10 under subsection (c)(3).

11 (b) COMMISSION ON KEY NATIONAL INDICATORS.—

12 (1) ESTABLISHMENT.—There is established a
13 “Commission on Key National Indicators”.

14 (2) MEMBERSHIP.—

15 (A) NUMBER AND APPOINTMENT.—The
16 Commission shall be composed of 8 members, to
17 be appointed equally by the majority and mi-
18 nority leaders of the Senate and the Speaker
19 and minority leader of the House of Represent-
20 atives.

21 (B) PROHIBITED APPOINTMENTS.—Mem-
22 bers of the Commission shall not include Mem-
23 bers of Congress or other elected Federal,
24 State, or local government officials.

25 (C) QUALIFICATIONS.—In making appoint-
26 ments under subparagraph (A), the majority

1 and minority leaders of the Senate and the
2 Speaker and minority leader of the House of
3 Representatives shall appoint individuals who
4 have shown a dedication to improving civic dia-
5 logue and decision-making through the wide use
6 of scientific evidence and factual information.

7 (D) PERIOD OF APPOINTMENT.—Each
8 member of the Commission shall be appointed
9 for a 2-year term, except that 1 initial appoint-
10 ment shall be for 3 years. Any vacancies shall
11 not affect the power and duties of the Commis-
12 sion but shall be filled in the same manner as
13 the original appointment and shall last only for
14 the remainder of that term.

15 (E) DATE.—Members of the Commission
16 shall be appointed by not later than 30 days
17 after the date of enactment of this Act.

18 (F) INITIAL ORGANIZING PERIOD.—Not
19 later than 60 days after the date of enactment
20 of this Act, the Commission shall develop and
21 implement a schedule for completion of the re-
22 view and reports required under subsection (d).

23 (G) CO-CHAIRPERSONS.—The Commission
24 shall select 2 Co-Chairpersons from among its
25 members.

1 (c) DUTIES OF THE COMMISSION.—

2 (1) IN GENERAL.—The Commission shall—

3 (A) conduct comprehensive oversight of a
4 newly established key national indicators system
5 consistent with the purpose described in this
6 subsection;

7 (B) make recommendations on how to im-
8 prove the key national indicators system;

9 (C) coordinate with Federal Government
10 users and information providers to assure ac-
11 cess to relevant and quality data; and

12 (D) enter into contracts with the Academy.

13 (2) REPORTS.—

14 (A) ANNUAL REPORT TO CONGRESS.—Not
15 later than 1 year after the selection of the 2
16 Co-Chairpersons of the Commission, and each
17 subsequent year thereafter, the Commission
18 shall prepare and submit to the appropriate
19 Committees of Congress and the President a re-
20 port that contains a detailed statement of the
21 recommendations, findings, and conclusions of
22 the Commission on the activities of the Acad-
23 emy and a designated Institute related to the
24 establishment of a Key National Indicator Sys-
25 tem.

1 (B) ANNUAL REPORT TO THE ACADEMY.—

2 (i) IN GENERAL.—Not later than 6
3 months after the selection of the 2 Co-
4 Chairpersons of the Commission, and each
5 subsequent year thereafter, the Commis-
6 sion shall prepare and submit to the Acad-
7 emy and a designated Institute a report
8 making recommendations concerning po-
9 tential issue areas and key indicators to be
10 included in the Key National Indicators.

11 (ii) LIMITATION.—The Commission
12 shall not have the authority to direct the
13 Academy or, if established, the Institute,
14 to adopt, modify, or delete any key indica-
15 tors.

16 (3) CONTRACT WITH THE NATIONAL ACADEMY
17 OF SCIENCES.—

18 (A) IN GENERAL.—As soon as practicable
19 after the selection of the 2 Co-Chairpersons of
20 the Commission, the Co-Chairpersons shall
21 enter into an arrangement with the National
22 Academy of Sciences under which the Academy
23 shall—

1 (i) review available public and private
2 sector research on the selection of a set of
3 key national indicators;

4 (ii) determine how best to establish a
5 key national indicator system for the
6 United States, by either creating its own
7 institutional capability or designating an
8 independent private nonprofit organization
9 as an Institute to implement a key national
10 indicator system;

11 (iii) if the Academy designates an
12 independent Institute under clause (ii),
13 provide scientific and technical advice to
14 the Institute and create an appropriate
15 governance mechanism that balances Acad-
16 emy involvement and the independence of
17 the Institute; and

18 (iv) provide an annual report to the
19 Commission addressing scientific and tech-
20 nical issues related to the key national in-
21 dicator system and, if established, the In-
22 stitute, and governance of the Institute's
23 budget and operations.

24 (B) PARTICIPATION.—In executing the ar-
25 rangement under subparagraph (A), the Na-

1 tional Academy of Sciences shall convene a
2 multi-sector, multi-disciplinary process to define
3 major scientific and technical issues associated
4 with developing, maintaining, and evolving a
5 Key National Indicator System and, if an Insti-
6 tute is established, to provide it with scientific
7 and technical advice.

8 (C) ESTABLISHMENT OF A KEY NATIONAL
9 INDICATOR SYSTEM.—

10 (i) IN GENERAL.—In executing the ar-
11 rangement under subparagraph (A), the
12 National Academy of Sciences shall enable
13 the establishment of a key national indi-
14 cator system by—

15 (I) creating its own institutional
16 capability; or

17 (II) partnering with an inde-
18 pendent private nonprofit organization
19 as an Institute to implement a key na-
20 tional indicator system.

21 (ii) INSTITUTE.—If the Academy des-
22 ignates an Institute under clause (i)(II),
23 such Institute shall be a non-profit entity
24 (as defined for purposes of section
25 501(c)(3) of the Internal Revenue Code of

1 1986) with an educational mission, a gov-
2 ernance structure that emphasizes inde-
3 pendence, and characteristics that make
4 such entity appropriate for establishing a
5 key national indicator system.

6 (iii) RESPONSIBILITIES.—Either the
7 Academy or the Institute designated under
8 clause (i)(II) shall be responsible for the
9 following:

10 (I) Identifying and selecting issue
11 areas to be represented by the key na-
12 tional indicators.

13 (II) Identifying and selecting the
14 measures used for key national indica-
15 tors within the issue areas under sub-
16 clause (I).

17 (III) Identifying and selecting
18 data to populate the key national indi-
19 cators described under subclause (II).

20 (IV) Designing, publishing, and
21 maintaining a public website that con-
22 tains a freely accessible database al-
23 lowing public access to the key na-
24 tional indicators.

1 (V) Developing a quality assur-
2 ance framework to ensure rigorous
3 and independent processes and the se-
4 lection of quality data.

5 (VI) Developing a budget for the
6 construction and management of a
7 sustainable, adaptable, and evolving
8 key national indicator system that re-
9 flects all Commission funding of
10 Academy and, if an Institute is estab-
11 lished, Institute activities.

12 (VII) Reporting annually to the
13 Commission regarding its selection of
14 issue areas, key indicators, data, and
15 progress toward establishing a web-ac-
16 cessible database.

17 (VIII) Responding directly to the
18 Commission in response to any Com-
19 mission recommendations and to the
20 Academy regarding any inquiries by
21 the Academy.

22 (iv) GOVERNANCE.—Upon the estab-
23 lishment of a key national indicator sys-
24 tem, the Academy shall create an appro-
25 priate governance mechanism that incor-

1 porates advisory and control functions. If
2 an Institute is designated under clause
3 (i)(II), the governance mechanism shall
4 balance appropriate Academy involvement
5 and the independence of the Institute.

6 (v) MODIFICATION AND CHANGES.—

7 The Academy shall retain the sole discre-
8 tion, at any time, to alter its approach to
9 the establishment of a key national indi-
10 cator system or, if an Institute is des-
11 ignated under clause (i)(II), to alter any
12 aspect of its relationship with the Institute
13 or to designate a different non-profit entity
14 to serve as the Institute.

15 (vi) CONSTRUCTION.—Nothing in this

16 section shall be construed to limit the abil-
17 ity of the Academy or the Institute des-
18 ignated under clause (i)(II) to receive pri-
19 vate funding for activities related to the es-
20 tablishment of a key national indicator sys-
21 tem.

22 (D) ANNUAL REPORT.—As part of the ar-

23 rangement under subparagraph (A), the Na-
24 tional Academy of Sciences shall, not later than
25 270 days after the date of enactment of this

1 Act, and annually thereafter, submit to the Co-
2 Chairpersons of the Commission a report that
3 contains the findings and recommendations of
4 the Academy.

5 (d) GOVERNMENT ACCOUNTABILITY OFFICE STUDY
6 AND REPORT.—

7 (1) GAO STUDY.—The Comptroller General of
8 the United States shall conduct a study of previous
9 work conducted by all public agencies, private orga-
10 nizations, or foreign countries with respect to best
11 practices for a key national indicator system. The
12 study shall be submitted to the appropriate author-
13 izing committees of Congress.

14 (2) GAO FINANCIAL AUDIT.—If an Institute is
15 established under this section, the Comptroller Gen-
16 eral shall conduct an annual audit of the financial
17 statements of the Institute, in accordance with gen-
18 erally accepted government auditing standards and
19 submit a report on such audit to the Commission
20 and the appropriate authorizing committees of Con-
21 gress.

22 (3) GAO PROGRAMMATIC REVIEW.—The Comp-
23 troller General of the United States shall conduct
24 programmatic assessments of the Institute estab-
25 lished under this section as determined necessary by

1 the Comptroller General and report the findings to
2 the Commission and to the appropriate authorizing
3 committees of Congress.

4 (e) AUTHORIZATION OF APPROPRIATIONS.—

5 (1) IN GENERAL.—There are authorized to be
6 appropriated to carry out the purposes of this sec-
7 tion, \$10,000,000 for fiscal year 2010, and
8 \$7,500,000 for each of fiscal year 2011 through
9 2018.

10 (2) AVAILABILITY.—Amounts appropriated
11 under paragraph (1) shall remain available until ex-
12 pended.

13 **Subtitle H—General Provisions**

14 **SEC. 5701. REPORTS.**

15 (a) REPORTS BY SECRETARY OF HEALTH AND
16 HUMAN SERVICES.—On an annual basis, the Secretary of
17 Health and Human Services shall submit to the appro-
18 priate Committees of Congress a report on the activities
19 carried out under the amendments made by this title, and
20 the effectiveness of such activities.

21 (b) REPORTS BY RECIPIENTS OF FUNDS.—The Sec-
22 retary of Health and Human Services may require, as a
23 condition of receiving funds under the amendments made
24 by this title, that the entity receiving such award submit
25 to such Secretary such reports as the such Secretary may

1 require on activities carried out with such award, and the
2 effectiveness of such activities.

3 **TITLE VI—TRANSPARENCY AND**
4 **PROGRAM INTEGRITY**
5 **Subtitle A—Physician Ownership**
6 **and Other Transparency**

7 **SEC. 6001. LIMITATION ON MEDICARE EXCEPTION TO THE**
8 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
9 **FERRALS FOR HOSPITALS.**

10 (a) IN GENERAL.—Section 1877 of the Social Secu-
11 rity Act (42 U.S.C. 1395nn) is amended—

12 (1) in subsection (d)(2)—

13 (A) in subparagraph (A), by striking
14 “and” at the end;

15 (B) in subparagraph (B), by striking the
16 period at the end and inserting “; and”; and

17 (C) by adding at the end the following new
18 subparagraph:

19 “(C) in the case where the entity is a hos-
20 pital, the hospital meets the requirements of
21 paragraph (3)(D).”;

22 (2) in subsection (d)(3)—

23 (A) in subparagraph (B), by striking
24 “and” at the end;

1 (B) in subparagraph (C), by striking the
2 period at the end and inserting “; and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(D) the hospital meets the requirements
6 described in subsection (i)(1) not later than 18
7 months after the date of the enactment of this
8 subparagraph.”; and

9 (3) by adding at the end the following new sub-
10 section:

11 “(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY
12 FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO
13 OWNERSHIP OR INVESTMENT PROHIBITION.—

14 “(1) REQUIREMENTS DESCRIBED.—For pur-
15 poses of subsection (d)(3)(D), the requirements de-
16 scribed in this paragraph for a hospital are as fol-
17 lows:

18 “(A) PROVIDER AGREEMENT.—The hos-
19 pital had—

20 “(i) physician ownership or invest-
21 ment on February 1, 2010; and

22 “(ii) a provider agreement under sec-
23 tion 1866 in effect on such date.

24 “(B) LIMITATION ON EXPANSION OF FA-
25 CILITY CAPACITY.—Except as provided in para-

1 graph (3), the number of operating rooms, pro-
2 cedure rooms, and beds for which the hospital
3 is licensed at any time on or after the date of
4 the enactment of this subsection is no greater
5 than the number of operating rooms, procedure
6 rooms, and beds for which the hospital is li-
7 censed as of such date.

8 “(C) PREVENTING CONFLICTS OF INTER-
9 EST.—

10 “(i) The hospital submits to the Sec-
11 retary an annual report containing a de-
12 tailed description of—

13 “(I) the identity of each physi-
14 cian owner or investor and any other
15 owners or investors of the hospital;
16 and

17 “(II) the nature and extent of all
18 ownership and investment interests in
19 the hospital.

20 “(ii) The hospital has procedures in
21 place to require that any referring physi-
22 cian owner or investor discloses to the pa-
23 tient being referred, by a time that permits
24 the patient to make a meaningful decision

1 regarding the receipt of care, as deter-
2 mined by the Secretary—

3 “(I) the ownership or investment
4 interest, as applicable, of such refer-
5 ring physician in the hospital; and

6 “(II) if applicable, any such own-
7 ership or investment interest of the
8 treating physician.

9 “(iii) The hospital does not condition
10 any physician ownership or investment in-
11 terests either directly or indirectly on the
12 physician owner or investor making or in-
13 fluencing referrals to the hospital or other-
14 wise generating business for the hospital.

15 “(iv) The hospital discloses the fact
16 that the hospital is partially owned or in-
17 vested in by physicians—

18 “(I) on any public website for the
19 hospital; and

20 “(II) in any public advertising
21 for the hospital.

22 “(D) ENSURING BONA FIDE INVEST-
23 MENT.—

24 “(i) The percentage of the total value
25 of the ownership or investment interests

1 held in the hospital, or in an entity whose
2 assets include the hospital, by physician
3 owners or investors in the aggregate does
4 not exceed such percentage as of the date
5 of enactment of this subsection.

6 “(ii) Any ownership or investment in-
7 terests that the hospital offers to a physi-
8 cian owner or investor are not offered on
9 more favorable terms than the terms of-
10 fered to a person who is not a physician
11 owner or investor.

12 “(iii) The hospital (or any owner or
13 investor in the hospital) does not directly
14 or indirectly provide loans or financing for
15 any investment in the hospital by a physi-
16 cian owner or investor.

17 “(iv) The hospital (or any owner or
18 investor in the hospital) does not directly
19 or indirectly guarantee a loan, make a pay-
20 ment toward a loan, or otherwise subsidize
21 a loan, for any individual physician owner
22 or investor or group of physician owners or
23 investors that is related to acquiring any
24 ownership or investment interest in the
25 hospital.

1 “(v) Ownership or investment returns
2 are distributed to each owner or investor in
3 the hospital in an amount that is directly
4 proportional to the ownership or invest-
5 ment interest of such owner or investor in
6 the hospital.

7 “(vi) Physician owners and investors
8 do not receive, directly or indirectly, any
9 guaranteed receipt of or right to purchase
10 other business interests related to the hos-
11 pital, including the purchase or lease of
12 any property under the control of other
13 owners or investors in the hospital or lo-
14 cated near the premises of the hospital.

15 “(vii) The hospital does not offer a
16 physician owner or investor the oppor-
17 tunity to purchase or lease any property
18 under the control of the hospital or any
19 other owner or investor in the hospital on
20 more favorable terms than the terms of-
21 fered to an individual who is not a physi-
22 cian owner or investor.

23 “(E) PATIENT SAFETY.—

24 “(i) Insofar as the hospital admits a
25 patient and does not have any physician

1 available on the premises to provide serv-
2 ices during all hours in which the hospital
3 is providing services to such patient, before
4 admitting the patient—

5 “(I) the hospital discloses such
6 fact to a patient; and

7 “(II) following such disclosure,
8 the hospital receives from the patient
9 a signed acknowledgment that the pa-
10 tient understands such fact.

11 “(ii) The hospital has the capacity
12 to—

13 “(I) provide assessment and ini-
14 tial treatment for patients; and

15 “(II) refer and transfer patients
16 to hospitals with the capability to
17 treat the needs of the patient in-
18 volved.

19 “(F) LIMITATION ON APPLICATION TO
20 CERTAIN CONVERTED FACILITIES.—The hos-
21 pital was not converted from an ambulatory
22 surgical center to a hospital on or after the date
23 of enactment of this subsection.

24 “(2) PUBLICATION OF INFORMATION RE-
25 PORTED.—The Secretary shall publish, and update

1 on an annual basis, the information submitted by
2 hospitals under paragraph (1)(C)(i) on the public
3 Internet website of the Centers for Medicare & Med-
4 icaid Services.

5 “(3) EXCEPTION TO PROHIBITION ON EXPAN-
6 SION OF FACILITY CAPACITY.—

7 “(A) PROCESS.—

8 “(i) ESTABLISHMENT.—The Secretary
9 shall establish and implement a process
10 under which an applicable hospital (as de-
11 fined in subparagraph (E)) may apply for
12 an exception from the requirement under
13 paragraph (1)(B).

14 “(ii) OPPORTUNITY FOR COMMUNITY
15 INPUT.—The process under clause (i) shall
16 provide individuals and entities in the com-
17 munity in which the applicable hospital ap-
18 plying for an exception is located with the
19 opportunity to provide input with respect
20 to the application.

21 “(iii) TIMING FOR IMPLEMENTA-
22 TION.—The Secretary shall implement the
23 process under clause (i) on August 1,
24 2011.

1 “(iv) REGULATIONS.—Not later than
2 July 1, 2011, the Secretary shall promul-
3 gate regulations to carry out the process
4 under clause (i).

5 “(B) FREQUENCY.—The process described
6 in subparagraph (A) shall permit an applicable
7 hospital to apply for an exception up to once
8 every 2 years.

9 “(C) PERMITTED INCREASE.—

10 “(i) IN GENERAL.—Subject to clause
11 (ii) and subparagraph (D), an applicable
12 hospital granted an exception under the
13 process described in subparagraph (A) may
14 increase the number of operating rooms,
15 procedure rooms, and beds for which the
16 applicable hospital is licensed above the
17 baseline number of operating rooms, proce-
18 dure rooms, and beds of the applicable
19 hospital (or, if the applicable hospital has
20 been granted a previous exception under
21 this paragraph, above the number of oper-
22 ating rooms, procedure rooms, and beds
23 for which the hospital is licensed after the
24 application of the most recent increase
25 under such an exception).

1 “(ii) 100 PERCENT INCREASE LIMITA-
2 TION.—The Secretary shall not permit an
3 increase in the number of operating rooms,
4 procedure rooms, and beds for which an
5 applicable hospital is licensed under clause
6 (i) to the extent such increase would result
7 in the number of operating rooms, proce-
8 dure rooms, and beds for which the appli-
9 cable hospital is licensed exceeding 200
10 percent of the baseline number of oper-
11 ating rooms, procedure rooms, and beds of
12 the applicable hospital.

13 “(iii) BASELINE NUMBER OF OPER-
14 ATING ROOMS, PROCEDURE ROOMS, AND
15 BEDS.—In this paragraph, the term ‘base-
16 line number of operating rooms, procedure
17 rooms, and beds’ means the number of op-
18 erating rooms, procedure rooms, and beds
19 for which the applicable hospital is licensed
20 as of the date of enactment of this sub-
21 section.

22 “(D) INCREASE LIMITED TO FACILITIES
23 ON THE MAIN CAMPUS OF THE HOSPITAL.—
24 Any increase in the number of operating rooms,
25 procedure rooms, and beds for which an appli-

1 cable hospital is licensed pursuant to this para-
2 graph may only occur in facilities on the main
3 campus of the applicable hospital.

4 “(E) APPLICABLE HOSPITAL.—In this
5 paragraph, the term ‘applicable hospital’ means
6 a hospital—

7 “(i) that is located in a county in
8 which the percentage increase in the popu-
9 lation during the most recent 5-year period
10 (as of the date of the application under
11 subparagraph (A)) is at least 150 percent
12 of the percentage increase in the popu-
13 lation growth of the State in which the
14 hospital is located during that period, as
15 estimated by Bureau of the Census;

16 “(ii) whose annual percent of total in-
17 patient admissions that represent inpatient
18 admissions under the program under title
19 XIX is equal to or greater than the aver-
20 age percent with respect to such admis-
21 sions for all hospitals located in the county
22 in which the hospital is located;

23 “(iii) that does not discriminate
24 against beneficiaries of Federal health care
25 programs and does not permit physicians

1 practicing at the hospital to discriminate
2 against such beneficiaries;

3 “(iv) that is located in a State in
4 which the average bed capacity in the
5 State is less than the national average bed
6 capacity; and

7 “(v) that has an average bed occu-
8 pancy rate that is greater than the average
9 bed occupancy rate in the State in which
10 the hospital is located.

11 “(F) PROCEDURE ROOMS.—In this sub-
12 section, the term ‘procedure rooms’ includes
13 rooms in which catheterizations, angiographies,
14 angiograms, and endoscopies are performed, ex-
15 cept such term shall not include emergency
16 rooms or departments (exclusive of rooms in
17 which catheterizations, angiographies,
18 angiograms, and endoscopies are performed).

19 “(G) PUBLICATION OF FINAL DECI-
20 SIONS.—Not later than 60 days after receiving
21 a complete application under this paragraph,
22 the Secretary shall publish in the Federal Reg-
23 ister the final decision with respect to such ap-
24 plication.

1 “(H) LIMITATION ON REVIEW.—There
2 shall be no administrative or judicial review
3 under section 1869, section 1878, or otherwise
4 of the process under this paragraph (including
5 the establishment of such process).

6 “(4) COLLECTION OF OWNERSHIP AND INVEST-
7 MENT INFORMATION.—For purposes of subpara-
8 graphs (A)(i) and (D)(i) of paragraph (1), the Sec-
9 retary shall collect physician ownership and invest-
10 ment information for each hospital.

11 “(5) PHYSICIAN OWNER OR INVESTOR DE-
12 FINED.—For purposes of this subsection, the term
13 ‘physician owner or investor’ means a physician (or
14 an immediate family member of such physician) with
15 a direct or an indirect ownership or investment in-
16 terest in the hospital.

17 “(6) CLARIFICATION.—Nothing in this sub-
18 section shall be construed as preventing the Sec-
19 retary from revoking a hospital’s provider agreement
20 if not in compliance with regulations implementing
21 section 1866.”.

22 (b) ENFORCEMENT.—

23 (1) ENSURING COMPLIANCE.—The Secretary of
24 Health and Human Services shall establish policies
25 and procedures to ensure compliance with the re-

1 requirements described in subsection (i)(1) of section
 2 1877 of the Social Security Act, as added by sub-
 3 section (a)(3), beginning on the date such require-
 4 ments first apply. Such policies and procedures may
 5 include unannounced site reviews of hospitals.

6 (2) AUDITS.—Beginning not later than Novem-
 7 ber 1, 2011, the Secretary of Health and Human
 8 Services shall conduct audits to determine if hos-
 9 pitals violate the requirements referred to in para-
 10 graph (1).

11 **SEC. 6002. TRANSPARENCY REPORTS AND REPORTING OF**
 12 **PHYSICIAN OWNERSHIP OR INVESTMENT IN-**
 13 **TERESTS.**

14 Part A of title XI of the Social Security Act (42
 15 U.S.C. 1301 et seq.) is amended by inserting after section
 16 1128F the following new section:

17 **“SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING**
 18 **OF PHYSICIAN OWNERSHIP OR INVESTMENT**
 19 **INTERESTS.**

20 “(a) TRANSPARENCY REPORTS.—

21 “(1) PAYMENTS OR OTHER TRANSFERS OF
 22 VALUE.—

23 “(A) IN GENERAL.—On March 31, 2013,
 24 and on the 90th day of each calendar year be-
 25 ginning thereafter, any applicable manufacturer

1 that provides a payment or other transfer of
2 value to a covered recipient (or to an entity or
3 individual at the request of or designated on be-
4 half of a covered recipient), shall submit to the
5 Secretary, in such electronic form as the Sec-
6 retary shall require, the following information
7 with respect to the preceding calendar year:

8 “(i) The name of the covered recipi-
9 ent.

10 “(ii) The business address of the cov-
11 ered recipient and, in the case of a covered
12 recipient who is a physician, the specialty
13 and National Provider Identifier of the
14 covered recipient.

15 “(iii) The amount of the payment or
16 other transfer of value.

17 “(iv) The dates on which the payment
18 or other transfer of value was provided to
19 the covered recipient.

20 “(v) A description of the form of the
21 payment or other transfer of value, indi-
22 cated (as appropriate for all that apply)
23 as—

24 “(I) cash or a cash equivalent;

25 “(II) in-kind items or services;

1 “(III) stock, a stock option, or
2 any other ownership interest, divi-
3 dend, profit, or other return on invest-
4 ment; or

5 “(IV) any other form of payment
6 or other transfer of value (as defined
7 by the Secretary).

8 “(vi) A description of the nature of
9 the payment or other transfer of value, in-
10 dicated (as appropriate for all that apply)
11 as—

12 “(I) consulting fees;

13 “(II) compensation for services
14 other than consulting;

15 “(III) honoraria;

16 “(IV) gift;

17 “(V) entertainment;

18 “(VI) food;

19 “(VII) travel (including the speci-
20 fied destinations);

21 “(VIII) education;

22 “(IX) research;

23 “(X) charitable contribution;

24 “(XI) royalty or license;

1 “(XII) current or prospective
2 ownership or investment interest;

3 “(XIII) direct compensation for
4 serving as faculty or as a speaker for
5 a medical education program;

6 “(XIV) grant; or

7 “(XV) any other nature of the
8 payment or other transfer of value (as
9 defined by the Secretary).

10 “(vii) If the payment or other transfer
11 of value is related to marketing, education,
12 or research specific to a covered drug, de-
13 vice, biological, or medical supply, the
14 name of that covered drug, device, biologi-
15 cal, or medical supply.

16 “(viii) Any other categories of infor-
17 mation regarding the payment or other
18 transfer of value the Secretary determines
19 appropriate.

20 “(B) SPECIAL RULE FOR CERTAIN PAY-
21 MENTS OR OTHER TRANSFERS OF VALUE.—In
22 the case where an applicable manufacturer pro-
23 vides a payment or other transfer of value to an
24 entity or individual at the request of or des-
25 ignated on behalf of a covered recipient, the ap-

1 applicable manufacturer shall disclose that pay-
2 ment or other transfer of value under the name
3 of the covered recipient.

4 “(2) PHYSICIAN OWNERSHIP.—In addition to
5 the requirement under paragraph (1)(A), on March
6 31, 2013, and on the 90th day of each calendar year
7 beginning thereafter, any applicable manufacturer or
8 applicable group purchasing organization shall sub-
9 mit to the Secretary, in such electronic form as the
10 Secretary shall require, the following information re-
11 garding any ownership or investment interest (other
12 than an ownership or investment interest in a pub-
13 licly traded security and mutual fund, as described
14 in section 1877(e)) held by a physician (or an imme-
15 diate family member of such physician (as defined
16 for purposes of section 1877(a))) in the applicable
17 manufacturer or applicable group purchasing organi-
18 zation during the preceding year:

19 “(A) The dollar amount invested by each
20 physician holding such an ownership or invest-
21 ment interest.

22 “(B) The value and terms of each such
23 ownership or investment interest.

24 “(C) Any payment or other transfer of
25 value provided to a physician holding such an

1 ownership or investment interest (or to an enti-
2 ty or individual at the request of or designated
3 on behalf of a physician holding such an owner-
4 ship or investment interest), including the infor-
5 mation described in clauses (i) through (viii) of
6 paragraph (1)(A), except that in applying such
7 clauses, ‘physician’ shall be substituted for ‘cov-
8 ered recipient’ each place it appears.

9 “(D) Any other information regarding the
10 ownership or investment interest the Secretary
11 determines appropriate.

12 “(b) PENALTIES FOR NONCOMPLIANCE.—

13 “(1) FAILURE TO REPORT.—

14 “(A) IN GENERAL.—Subject to subpara-
15 graph (B) except as provided in paragraph (2),
16 any applicable manufacturer or applicable
17 group purchasing organization that fails to sub-
18 mit information required under subsection (a)
19 in a timely manner in accordance with rules or
20 regulations promulgated to carry out such sub-
21 section, shall be subject to a civil money penalty
22 of not less than \$1,000, but not more than
23 \$10,000, for each payment or other transfer of
24 value or ownership or investment interest not
25 reported as required under such subsection.

1 Such penalty shall be imposed and collected in
2 the same manner as civil money penalties under
3 subsection (a) of section 1128A are imposed
4 and collected under that section.

5 “(B) LIMITATION.—The total amount of
6 civil money penalties imposed under subpara-
7 graph (A) with respect to each annual submis-
8 sion of information under subsection (a) by an
9 applicable manufacturer or applicable group
10 purchasing organization shall not exceed
11 \$150,000.

12 “(2) KNOWING FAILURE TO REPORT.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), any applicable manufacturer or ap-
15 plicable group purchasing organization that
16 knowingly fails to submit information required
17 under subsection (a) in a timely manner in ac-
18 cordance with rules or regulations promulgated
19 to carry out such subsection, shall be subject to
20 a civil money penalty of not less than \$10,000,
21 but not more than \$100,000, for each payment
22 or other transfer of value or ownership or in-
23 vestment interest not reported as required
24 under such subsection. Such penalty shall be
25 imposed and collected in the same manner as

1 civil money penalties under subsection (a) of
2 section 1128A are imposed and collected under
3 that section.

4 “(B) LIMITATION.—The total amount of
5 civil money penalties imposed under subpara-
6 graph (A) with respect to each annual submis-
7 sion of information under subsection (a) by an
8 applicable manufacturer or applicable group
9 purchasing organization shall not exceed
10 \$1,000,000.

11 “(3) USE OF FUNDS.—Funds collected by the
12 Secretary as a result of the imposition of a civil
13 money penalty under this subsection shall be used to
14 carry out this section.

15 “(c) PROCEDURES FOR SUBMISSION OF INFORMA-
16 TION AND PUBLIC AVAILABILITY.—

17 “(1) IN GENERAL.—

18 “(A) ESTABLISHMENT.—Not later than
19 October 1, 2011, the Secretary shall establish
20 procedures—

21 “(i) for applicable manufacturers and
22 applicable group purchasing organizations
23 to submit information to the Secretary
24 under subsection (a); and

1 “(ii) for the Secretary to make such
2 information submitted available to the pub-
3 lic.

4 “(B) DEFINITION OF TERMS.—The proce-
5 dures established under subparagraph (A) shall
6 provide for the definition of terms (other than
7 those terms defined in subsection (e)), as ap-
8 propriate, for purposes of this section.

9 “(C) PUBLIC AVAILABILITY.—Except as
10 provided in subparagraph (E), the procedures
11 established under subparagraph (A)(ii) shall en-
12 sure that, not later than September 30, 2013,
13 and on June 30 of each calendar year beginning
14 thereafter, the information submitted under
15 subsection (a) with respect to the preceding cal-
16 endar year is made available through an Inter-
17 net website that—

18 “(i) is searchable and is in a format
19 that is clear and understandable;

20 “(ii) contains information that is pre-
21 sented by the name of the applicable man-
22 ufacturer or applicable group purchasing
23 organization, the name of the covered re-
24 cipient, the business address of the covered
25 recipient, the specialty of the covered re-

1 recipient, the value of the payment or other
2 transfer of value, the date on which the
3 payment or other transfer of value was
4 provided to the covered recipient, the form
5 of the payment or other transfer of value,
6 indicated (as appropriate) under subsection
7 (a)(1)(A)(v), the nature of the payment or
8 other transfer of value, indicated (as ap-
9 propriate) under subsection (a)(1)(A)(vi),
10 and the name of the covered drug, device,
11 biological, or medical supply, as applicable;

12 “(iii) contains information that is able
13 to be easily aggregated and downloaded;

14 “(iv) contains a description of any en-
15 forcement actions taken to carry out this
16 section, including any penalties imposed
17 under subsection (b), during the preceding
18 year;

19 “(v) contains background information
20 on industry-physician relationships;

21 “(vi) in the case of information sub-
22 mitted with respect to a payment or other
23 transfer of value described in subpara-
24 graph (E)(i), lists such information sepa-
25 rately from the other information sub-

1 mitted under subsection (a) and designates
2 such separately listed information as fund-
3 ing for clinical research;

4 “(vii) contains any other information
5 the Secretary determines would be helpful
6 to the average consumer;

7 “(viii) does not contain the National
8 Provider Identifier of the covered recipient,
9 and

10 “(ix) subject to subparagraph (D),
11 provides the applicable manufacturer, ap-
12 plicable group purchasing organization, or
13 covered recipient an opportunity to review
14 and submit corrections to the information
15 submitted with respect to the applicable
16 manufacturer, applicable group purchasing
17 organization, or covered recipient, respec-
18 tively, for a period of not less than 45 days
19 prior to such information being made
20 available to the public.

21 “(D) CLARIFICATION OF TIME PERIOD FOR
22 REVIEW AND CORRECTIONS.—In no case may
23 the 45-day period for review and submission of
24 corrections to information under subparagraph
25 (C)(ix) prevent such information from being

1 made available to the public in accordance with
2 the dates described in the matter preceding
3 clause (i) in subparagraph (C).

4 “(E) DELAYED PUBLICATION FOR PAY-
5 MENTS MADE PURSUANT TO PRODUCT RE-
6 SEARCH OR DEVELOPMENT AGREEMENTS AND
7 CLINICAL INVESTIGATIONS.—

8 “(i) IN GENERAL.—In the case of in-
9 formation submitted under subsection (a)
10 with respect to a payment or other transfer
11 of value made to a covered recipient by an
12 applicable manufacturer pursuant to a
13 product research or development agree-
14 ment for services furnished in connection
15 with research on a potential new medical
16 technology or a new application of an ex-
17 isting medical technology or the develop-
18 ment of a new drug, device, biological, or
19 medical supply, or by an applicable manu-
20 facturer in connection with a clinical inves-
21 tigation regarding a new drug, device, bio-
22 logical, or medical supply, the procedures
23 established under subparagraph (A)(ii)
24 shall provide that such information is
25 made available to the public on the first

1 date described in the matter preceding
2 clause (i) in subparagraph (C) after the
3 earlier of the following:

4 “(I) The date of the approval or
5 clearance of the covered drug, device,
6 biological, or medical supply by the
7 Food and Drug Administration.

8 “(II) Four calendar years after
9 the date such payment or other trans-
10 fer of value was made.

11 “(ii) CONFIDENTIALITY OF INFORMA-
12 TION PRIOR TO PUBLICATION.—Informa-
13 tion described in clause (i) shall be consid-
14 ered confidential and shall not be subject
15 to disclosure under section 552 of title 5,
16 United States Code, or any other similar
17 Federal, State, or local law, until on or
18 after the date on which the information is
19 made available to the public under such
20 clause.

21 “(2) CONSULTATION.—In establishing the pro-
22 cedures under paragraph (1), the Secretary shall
23 consult with the Inspector General of the Depart-
24 ment of Health and Human Services, affected indus-
25 try, consumers, consumer advocates, and other inter-

1 ested parties in order to ensure that the information
2 made available to the public under such paragraph
3 is presented in the appropriate overall context.

4 “(d) ANNUAL REPORTS AND RELATION TO STATE
5 LAWS.—

6 “(1) ANNUAL REPORT TO CONGRESS.—Not
7 later than April 1 of each year beginning with 2013,
8 the Secretary shall submit to Congress a report that
9 includes the following:

10 “(A) The information submitted under
11 subsection (a) during the preceding year, aggre-
12 gated for each applicable manufacturer and ap-
13 plicable group purchasing organization that
14 submitted such information during such year
15 (except, in the case of information submitted
16 with respect to a payment or other transfer of
17 value described in subsection (c)(1)(E)(i), such
18 information shall be included in the first report
19 submitted to Congress after the date on which
20 such information is made available to the public
21 under such subsection).

22 “(B) A description of any enforcement ac-
23 tions taken to carry out this section, including
24 any penalties imposed under subsection (b),
25 during the preceding year.

1 “(2) ANNUAL REPORTS TO STATES.—Not later
2 than September 30, 2013 and on June 30 of each
3 calendar year thereafter, the Secretary shall submit
4 to States a report that includes a summary of the
5 information submitted under subsection (a) during
6 the preceding year with respect to covered recipients
7 in the State (except, in the case of information sub-
8 mitted with respect to a payment or other transfer
9 of value described in subsection (c)(1)(E)(i), such in-
10 formation shall be included in the first report sub-
11 mitted to States after the date on which such infor-
12 mation is made available to the public under such
13 subsection).

14 “(3) RELATION TO STATE LAWS.—

15 “(A) IN GENERAL.—In the case of a pay-
16 ment or other transfer of value provided by an
17 applicable manufacturer that is received by a
18 covered recipient (as defined in subsection (e))
19 on or after January 1, 2012, subject to sub-
20 paragraph (B), the provisions of this section
21 shall preempt any statute or regulation of a
22 State or of a political subdivision of a State
23 that requires an applicable manufacturer (as so
24 defined) to disclose or report, in any format,
25 the type of information (as described in sub-

1 section (a)) regarding such payment or other
2 transfer of value.

3 “(B) NO PREEMPTION OF ADDITIONAL RE-
4 QUIREMENTS.—Subparagraph (A) shall not
5 preempt any statute or regulation of a State or
6 of a political subdivision of a State that re-
7 quires the disclosure or reporting of informa-
8 tion—

9 “(i) not of the type required to be dis-
10 closed or reported under this section;

11 “(ii) described in subsection
12 (e)(10)(B), except in the case of informa-
13 tion described in clause (i) of such sub-
14 section;

15 “(iii) by any person or entity other
16 than an applicable manufacturer (as so de-
17 fined) or a covered recipient (as defined in
18 subsection (e)); or

19 “(iv) to a Federal, State, or local gov-
20 ernmental agency for public health surveil-
21 lance, investigation, or other public health
22 purposes or health oversight purposes.

23 “(C) Nothing in subparagraph (A) shall be
24 construed to limit the discovery or admissibility
25 of information described in such subparagraph

1 in a criminal, civil, or administrative pro-
2 ceeding.

3 “(4) CONSULTATION.—The Secretary shall con-
4 sult with the Inspector General of the Department
5 of Health and Human Services on the implementa-
6 tion of this section.

7 “(e) DEFINITIONS.—In this section:

8 “(1) APPLICABLE GROUP PURCHASING ORGANI-
9 ZATION.—The term ‘applicable group purchasing or-
10 ganization’ means a group purchasing organization
11 (as defined by the Secretary) that purchases, ar-
12 ranges for, or negotiates the purchase of a covered
13 drug, device, biological, or medical supply which is
14 operating in the United States, or in a territory,
15 possession, or commonwealth of the United States.

16 “(2) APPLICABLE MANUFACTURER.—The term
17 ‘applicable manufacturer’ means a manufacturer of
18 a covered drug, device, biological, or medical supply
19 which is operating in the United States, or in a ter-
20 ritory, possession, or commonwealth of the United
21 States.

22 “(3) CLINICAL INVESTIGATION.—The term
23 ‘clinical investigation’ means any experiment involv-
24 ing 1 or more human subjects, or materials derived

1 from human subjects, in which a drug or device is
2 administered, dispensed, or used.

3 “(4) COVERED DEVICE.—The term ‘covered de-
4 vice’ means any device for which payment is avail-
5 able under title XVIII or a State plan under title
6 XIX or XXI (or a waiver of such a plan).

7 “(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR
8 MEDICAL SUPPLY.—The term ‘covered drug, device,
9 biological, or medical supply’ means any drug, bio-
10 logical product, device, or medical supply for which
11 payment is available under title XVIII or a State
12 plan under title XIX or XXI (or a waiver of such
13 a plan).

14 “(6) COVERED RECIPIENT.—

15 “(A) IN GENERAL.—Except as provided in
16 subparagraph (B), the term ‘covered recipient’
17 means the following:

18 “(i) A physician.

19 “(ii) A teaching hospital.

20 “(B) EXCLUSION.—Such term does not in-
21 clude a physician who is an employee of the ap-
22 plicable manufacturer that is required to submit
23 information under subsection (a).

24 “(7) EMPLOYEE.—The term ‘employee’ has the
25 meaning given such term in section 1877(h)(2).

1 “(8) KNOWINGLY.—The term ‘knowingly’ has
2 the meaning given such term in section 3729(b) of
3 title 31, United States Code.

4 “(9) MANUFACTURER OF A COVERED DRUG,
5 DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The
6 term ‘manufacturer of a covered drug, device, bio-
7 logical, or medical supply’ means any entity which is
8 engaged in the production, preparation, propagation,
9 compounding, or conversion of a covered drug, de-
10 vice, biological, or medical supply (or any entity
11 under common ownership with such entity which
12 provides assistance or support to such entity with re-
13 spect to the production, preparation, propagation,
14 compounding, conversion, marketing, promotion,
15 sale, or distribution of a covered drug, device, bio-
16 logical, or medical supply).

17 “(10) PAYMENT OR OTHER TRANSFER OF
18 VALUE.—

19 “(A) IN GENERAL.—The term ‘payment or
20 other transfer of value’ means a transfer of
21 anything of value. Such term does not include
22 a transfer of anything of value that is made in-
23 directly to a covered recipient through a third
24 party in connection with an activity or service
25 in the case where the applicable manufacturer

1 is unaware of the identity of the covered recipi-
2 ent.

3 “(B) EXCLUSIONS.—An applicable manu-
4 facturer shall not be required to submit infor-
5 mation under subsection (a) with respect to the
6 following:

7 “(i) A transfer of anything the value
8 of which is less than \$10, unless the aggre-
9 gate amount transferred to, requested by,
10 or designated on behalf of the covered re-
11 cipient by the applicable manufacturer dur-
12 ing the calendar year exceeds \$100. For
13 calendar years after 2012, the dollar
14 amounts specified in the preceding sen-
15 tence shall be increased by the same per-
16 centage as the percentage increase in the
17 consumer price index for all urban con-
18 sumers (all items; U.S. city average) for
19 the 12-month period ending with June of
20 the previous year.

21 “(ii) Product samples that are not in-
22 tended to be sold and are intended for pa-
23 tient use.

1 “(iii) Educational materials that di-
2 rectly benefit patients or are intended for
3 patient use.

4 “(iv) The loan of a covered device for
5 a short-term trial period, not to exceed 90
6 days, to permit evaluation of the covered
7 device by the covered recipient.

8 “(v) Items or services provided under
9 a contractual warranty, including the re-
10 placement of a covered device, where the
11 terms of the warranty are set forth in the
12 purchase or lease agreement for the cov-
13 ered device.

14 “(vi) A transfer of anything of value
15 to a covered recipient when the covered re-
16 cipient is a patient and not acting in the
17 professional capacity of a covered recipient.

18 “(vii) Discounts (including rebates).

19 “(viii) In-kind items used for the pro-
20 vision of charity care.

21 “(ix) A dividend or other profit dis-
22 tribution from, or ownership or investment
23 interest in, a publicly traded security and
24 mutual fund (as described in section
25 1877(c)).

1 “(x) In the case of an applicable man-
2 ufacturer who offers a self-insured plan,
3 payments for the provision of health care
4 to employees under the plan.

5 “(xi) In the case of a covered recipi-
6 ent who is a licensed non-medical profes-
7 sional, a transfer of anything of value to
8 the covered recipient if the transfer is pay-
9 ment solely for the non-medical profes-
10 sional services of such licensed non-medical
11 professional.

12 “(xii) In the case of a covered recipi-
13 ent who is a physician, a transfer of any-
14 thing of value to the covered recipient if
15 the transfer is payment solely for the serv-
16 ices of the covered recipient with respect to
17 a civil or criminal action or an administra-
18 tive proceeding.

19 “(11) PHYSICIAN.—The term ‘physician’ has
20 the meaning given that term in section 1861(r).”.

1 **SEC. 6003. DISCLOSURE REQUIREMENTS FOR IN-OFFICE**
2 **ANCILLARY SERVICES EXCEPTION TO THE**
3 **PROHIBITION ON PHYSICIAN SELF-REFER-**
4 **RAL FOR CERTAIN IMAGING SERVICES.**

5 (a) IN GENERAL.—Section 1877(b)(2) of the Social
6 Security Act (42 U.S.C. 1395nn(b)(2)) is amended by
7 adding at the end the following new sentence: “Such re-
8 quirements shall, with respect to magnetic resonance im-
9 aging, computed tomography, positron emission tomog-
10 raphy, and any other designated health services specified
11 under subsection (h)(6)(D) that the Secretary determines
12 appropriate, include a requirement that the referring phy-
13 sician inform the individual in writing at the time of the
14 referral that the individual may obtain the services for
15 which the individual is being referred from a person other
16 than a person described in subparagraph (A)(i) and pro-
17 vide such individual with a written list of suppliers (as
18 defined in section 1861(d)) who furnish such services in
19 the area in which such individual resides.”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 this section shall apply to services furnished on or after
22 January 1, 2010.

23 **SEC. 6004. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.**

24 Part A of title XI of the Social Security Act (42
25 U.S.C. 1301 et seq.), as amended by section 6002, is

1 amended by inserting after section 1128G the following
2 new section:

3 **“SEC. 1128H. REPORTING OF INFORMATION RELATING TO**
4 **DRUG SAMPLES.**

5 “(a) IN GENERAL.—Not later than April 1 of each
6 year (beginning with 2012), each manufacturer and au-
7 thorized distributor of record of an applicable drug shall
8 submit to the Secretary (in a form and manner specified
9 by the Secretary) the following information with respect
10 to the preceding year:

11 “(1) In the case of a manufacturer or author-
12 ized distributor of record which makes distributions
13 by mail or common carrier under subsection (d)(2)
14 of section 503 of the Federal Food, Drug, and Cos-
15 metic Act (21 U.S.C. 353), the identity and quantity
16 of drug samples requested and the identity and
17 quantity of drug samples distributed under such
18 subsection during that year, aggregated by—

19 “(A) the name, address, professional des-
20 ignation, and signature of the practitioner mak-
21 ing the request under subparagraph (A)(i) of
22 such subsection, or of any individual who makes
23 or signs for the request on behalf of the practi-
24 tioner; and

1 “(B) any other category of information de-
2 termined appropriate by the Secretary.

3 “(2) In the case of a manufacturer or author-
4 ized distributor of record which makes distributions
5 by means other than mail or common carrier under
6 subsection (d)(3) of such section 503, the identity
7 and quantity of drug samples requested and the
8 identity and quantity of drug samples distributed
9 under such subsection during that year, aggregated
10 by—

11 “(A) the name, address, professional des-
12 ignation, and signature of the practitioner mak-
13 ing the request under subparagraph (A)(i) of
14 such subsection, or of any individual who makes
15 or signs for the request on behalf of the practi-
16 tioner; and

17 “(B) any other category of information de-
18 termined appropriate by the Secretary.

19 “(b) DEFINITIONS.—In this section:

20 “(1) APPLICABLE DRUG.—The term ‘applicable
21 drug’ means a drug—

22 “(A) which is subject to subsection (b) of
23 such section 503; and

1 “(B) for which payment is available under
2 title XVIII or a State plan under title XIX or
3 XXI (or a waiver of such a plan).

4 “(2) AUTHORIZED DISTRIBUTOR OF RECORD.—
5 The term ‘authorized distributor of record’ has the
6 meaning given that term in subsection (e)(3)(A) of
7 such section.

8 “(3) MANUFACTURER.—The term ‘manufac-
9 turer’ has the meaning given that term for purposes
10 of subsection (d) of such section.”.

11 **SEC. 6005. PHARMACY BENEFIT MANAGERS TRANS-**
12 **PARENCY REQUIREMENTS.**

13 Part A of title XI of the Social Security Act (42
14 U.S.C. 1301 et seq.) is amended by inserting after section
15 1150 the following new section:

16 **“SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANS-**
17 **PARENCY REQUIREMENTS.**

18 “(a) PROVISION OF INFORMATION.—A health bene-
19 fits plan or any entity that provides pharmacy benefits
20 management services on behalf of a health benefits plan
21 (in this section referred to as a ‘PBM’) that manages pre-
22 scription drug coverage under a contract with—

23 “(1) a PDP sponsor of a prescription drug plan
24 or an MA organization offering an MA–PD plan
25 under part D of title XVIII; or

1 “(2) a qualified health benefits plan offered
2 through an exchange established by a State under
3 section 1311 of the Patient Protection and Afford-
4 able Care Act,
5 shall provide the information described in subsection (b)
6 to the Secretary and, in the case of a PBM, to the plan
7 with which the PBM is under contract with, at such times,
8 and in such form and manner, as the Secretary shall speci-
9 fy.

10 “(b) INFORMATION DESCRIBED.—The information
11 described in this subsection is the following with respect
12 to services provided by a health benefits plan or PBM for
13 a contract year:

14 “(1) The percentage of all prescriptions that
15 were provided through retail pharmacies compared
16 to mail order pharmacies, and the percentage of pre-
17 scriptions for which a generic drug was available and
18 dispensed (generic dispensing rate), by pharmacy
19 type (which includes an independent pharmacy,
20 chain pharmacy, supermarket pharmacy, or mass
21 merchandiser pharmacy that is licensed as a phar-
22 macy by the State and that dispenses medication to
23 the general public), that is paid by the health bene-
24 fits plan or PBM under the contract.

1 “(2) The aggregate amount, and the type of re-
2 bates, discounts, or price concessions (excluding
3 bona fide service fees, which include but are not lim-
4 ited to distribution service fees, inventory manage-
5 ment fees, product stocking allowances, and fees as-
6 sociated with administrative services agreements and
7 patient care programs (such as medication compli-
8 ance programs and patient education programs))that
9 the PBM negotiates that are attributable to patient
10 utilization under the plan, and the aggregate amount
11 of the rebates, discounts, or price concessions that
12 are passed through to the plan sponsor, and the
13 total number of prescriptions that were dispensed.

14 “(3) The aggregate amount of the difference
15 between the amount the health benefits plan pays
16 the PBM and the amount that the PBM pays retail
17 pharmacies, and mail order pharmacies, and the
18 total number of prescriptions that were dispensed.

19 “(c) CONFIDENTIALITY.—Information disclosed by a
20 health benefits plan or PBM under this section is con-
21 fidential and shall not be disclosed by the Secretary or
22 by a plan receiving the information, except that the Sec-
23 retary may disclose the information in a form which does
24 not disclose the identity of a specific PBM, plan, or prices
25 charged for drugs, for the following purposes:

1 “(1) As the Secretary determines to be nec-
2 essary to carry out this section or part D of title
3 XVIII.

4 “(2) To permit the Comptroller General to re-
5 view the information provided.

6 “(3) To permit the Director of the Congres-
7 sional Budget Office to review the information pro-
8 vided.

9 “(4) To States to carry out section 1311 of the
10 Patient Protection and Affordable Care Act.

11 “(d) PENALTIES.—The provisions of subsection
12 (b)(3)(C) of section 1927 shall apply to a health benefits
13 plan or PBM that fails to provide information required
14 under subsection (a) on a timely basis or that knowingly
15 provides false information in the same manner as such
16 provisions apply to a manufacturer with an agreement
17 under that section.”.

1 **Subtitle B—Nursing Home**
2 **Transparency and Improvement**

3 **PART I—IMPROVING TRANSPARENCY OF**
4 **INFORMATION**

5 **SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND**
6 **ADDITIONAL DISCLOSABLE PARTIES INFOR-**
7 **MATION.**

8 (a) IN GENERAL.—Section 1124 of the Social Secu-
9 rity Act (42 U.S.C. 1320a–3) is amended by adding at
10 the end the following new subsection:

11 “(c) REQUIRED DISCLOSURE OF OWNERSHIP AND
12 ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

13 “(1) DISCLOSURE.—A facility shall have the in-
14 formation described in paragraph (2) available—

15 “(A) during the period beginning on the
16 date of the enactment of this subsection and
17 ending on the date such information is made
18 available to the public under section 6101(b) of
19 the Patient Protection and Affordable Care Act
20 for submission to the Secretary, the Inspector
21 General of the Department of Health and
22 Human Services, the State in which the facility
23 is located, and the State long-term care om-
24 budsman in the case where the Secretary, the
25 Inspector General, the State, or the State long-

1 term care ombudsman requests such informa-
2 tion; and

3 “(B) beginning on the effective date of the
4 final regulations promulgated under paragraph
5 (3)(A), for reporting such information in ac-
6 cordance with such final regulations.

7 Nothing in subparagraph (A) shall be construed as
8 authorizing a facility to dispose of or delete informa-
9 tion described in such subparagraph after the effec-
10 tive date of the final regulations promulgated under
11 paragraph (3)(A).

12 “(2) INFORMATION DESCRIBED.—

13 “(A) IN GENERAL.—The following infor-
14 mation is described in this paragraph:

15 “(i) The information described in sub-
16 sections (a) and (b), subject to subpara-
17 graph (C).

18 “(ii) The identity of and information
19 on—

20 “(I) each member of the gov-
21 erning body of the facility, including
22 the name, title, and period of service
23 of each such member;

24 “(II) each person or entity who is
25 an officer, director, member, partner,

1 trustee, or managing employee of the
2 facility, including the name, title, and
3 period of service of each such person
4 or entity; and

5 “(III) each person or entity who
6 is an additional disclosable party of
7 the facility.

8 “(iii) The organizational structure of
9 each additional disclosable party of the fa-
10 cility and a description of the relationship
11 of each such additional disclosable party to
12 the facility and to one another.

13 “(B) SPECIAL RULE WHERE INFORMATION
14 IS ALREADY REPORTED OR SUBMITTED.—To
15 the extent that information reported by a facil-
16 ity to the Internal Revenue Service on Form
17 990, information submitted by a facility to the
18 Securities and Exchange Commission, or infor-
19 mation otherwise submitted to the Secretary or
20 any other Federal agency contains the informa-
21 tion described in clauses (i), (ii), or (iii) of sub-
22 paragraph (A), the facility may provide such
23 Form or such information submitted to meet
24 the requirements of paragraph (1).

1 “(C) SPECIAL RULE.—In applying sub-
2 paragraph (A)(i)—

3 “(i) with respect to subsections (a)
4 and (b), ‘ownership or control interest’
5 shall include direct or indirect interests, in-
6 cluding such interests in intermediate enti-
7 ties; and

8 “(ii) subsection (a)(3)(A)(ii) shall in-
9 clude the owner of a whole or part interest
10 in any mortgage, deed of trust, note, or
11 other obligation secured, in whole or in
12 part, by the entity or any of the property
13 or assets thereof, if the interest is equal to
14 or exceeds 5 percent of the total property
15 or assets of the entirety.

16 “(3) REPORTING.—

17 “(A) IN GENERAL.—Not later than the
18 date that is 2 years after the date of the enact-
19 ment of this subsection, the Secretary shall pro-
20 mulgate final regulations requiring, effective on
21 the date that is 90 days after the date on which
22 such final regulations are published in the Fed-
23 eral Register, a facility to report the informa-
24 tion described in paragraph (2) to the Secretary
25 in a standardized format, and such other regu-

1 lations as are necessary to carry out this sub-
2 section. Such final regulations shall ensure that
3 the facility certifies, as a condition of participa-
4 tion and payment under the program under
5 title XVIII or XIX, that the information re-
6 ported by the facility in accordance with such
7 final regulations is, to the best of the facility’s
8 knowledge, accurate and current.

9 “(B) GUIDANCE.—The Secretary shall pro-
10 vide guidance and technical assistance to States
11 on how to adopt the standardized format under
12 subparagraph (A).

13 “(4) NO EFFECT ON EXISTING REPORTING RE-
14 QUIREMENTS.—Nothing in this subsection shall re-
15 duce, diminish, or alter any reporting requirement
16 for a facility that is in effect as of the date of the
17 enactment of this subsection.

18 “(5) DEFINITIONS.—In this subsection:

19 “(A) ADDITIONAL DISCLOSABLE PARTY.—
20 The term ‘additional disclosable party’ means,
21 with respect to a facility, any person or entity
22 who—

23 “(i) exercises operational, financial, or
24 managerial control over the facility or a
25 part thereof, or provides policies or proce-

1 dures for any of the operations of the facil-
2 ity, or provides financial or cash manage-
3 ment services to the facility;

4 “(ii) leases or subleases real property
5 to the facility, or owns a whole or part in-
6 terest equal to or exceeding 5 percent of
7 the total value of such real property; or

8 “(iii) provides management or admin-
9 istrative services, management or clinical
10 consulting services, or accounting or finan-
11 cial services to the facility.

12 “(B) FACILITY.—The term ‘facility’ means
13 a disclosing entity which is—

14 “(i) a skilled nursing facility (as de-
15 fined in section 1819(a)); or

16 “(ii) a nursing facility (as defined in
17 section 1919(a)).

18 “(C) MANAGING EMPLOYEE.—The term
19 ‘managing employee’ means, with respect to a
20 facility, an individual (including a general man-
21 ager, business manager, administrator, director,
22 or consultant) who directly or indirectly man-
23 ages, advises, or supervises any element of the
24 practices, finances, or operations of the facility.

1 “(D) ORGANIZATIONAL STRUCTURE.—The
2 term ‘organizational structure’ means, in the
3 case of—

4 “(i) a corporation, the officers, direc-
5 tors, and shareholders of the corporation
6 who have an ownership interest in the cor-
7 poration which is equal to or exceeds 5
8 percent;

9 “(ii) a limited liability company, the
10 members and managers of the limited li-
11 ability company (including, as applicable,
12 what percentage each member and man-
13 ager has of the ownership interest in the
14 limited liability company);

15 “(iii) a general partnership, the part-
16 ners of the general partnership;

17 “(iv) a limited partnership, the gen-
18 eral partners and any limited partners of
19 the limited partnership who have an own-
20 ership interest in the limited partnership
21 which is equal to or exceeds 10 percent;

22 “(v) a trust, the trustees of the trust;

23 “(vi) an individual, contact informa-
24 tion for the individual; and

1 “(vii) any other person or entity, such
2 information as the Secretary determines
3 appropriate.”.

4 (b) PUBLIC AVAILABILITY OF INFORMATION.—Not
5 later than the date that is 1 year after the date on which
6 the final regulations promulgated under section
7 1124(c)(3)(A) of the Social Security Act, as added by sub-
8 section (a), are published in the Federal Register, the Sec-
9 retary of Health and Human Services shall make the in-
10 formation reported in accordance with such final regula-
11 tions available to the public in accordance with procedures
12 established by the Secretary.

13 (c) CONFORMING AMENDMENTS.—

14 (1) IN GENERAL.—

15 (A) SKILLED NURSING FACILITIES.—Sec-
16 tion 1819(d)(1) of the Social Security Act (42
17 U.S.C. 1395i–3(d)(1)) is amended by striking
18 subparagraph (B) and redesignating subpara-
19 graph (C) as subparagraph (B).

20 (B) NURSING FACILITIES.—Section
21 1919(d)(1) of the Social Security Act (42
22 U.S.C. 1396r(d)(1)) is amended by striking
23 subparagraph (B) and redesignating subpara-
24 graph (C) as subparagraph (B).

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall take effect on the date on
3 which the Secretary makes the information described
4 in subsection (b)(1) available to the public under
5 such subsection.

6 **SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED**
7 **NURSING FACILITIES AND NURSING FACILI-**
8 **TIES.**

9 Part A of title XI of the Social Security Act (42
10 U.S.C. 1301 et seq.), as amended by sections 6002 and
11 6004, is amended by inserting after section 1128H the
12 following new section:

13 **“SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILI-**
14 **TIES.**

15 “(a) DEFINITION OF FACILITY.—In this section, the
16 term ‘facility’ means—

17 “(1) a skilled nursing facility (as defined in sec-
18 tion 1819(a)); or

19 “(2) a nursing facility (as defined in section
20 1919(a)).

21 “(b) EFFECTIVE COMPLIANCE AND ETHICS PRO-
22 GRAMS.—

23 “(1) REQUIREMENT.—On or after the date that
24 is 36 months after the date of the enactment of this
25 section, a facility shall, with respect to the entity

1 that operates the facility (in this subparagraph re-
2 ferred to as the ‘operating organization’ or ‘organi-
3 zation’), have in operation a compliance and ethics
4 program that is effective in preventing and detecting
5 criminal, civil, and administrative violations under
6 this Act and in promoting quality of care consistent
7 with regulations developed under paragraph (2).

8 “(2) DEVELOPMENT OF REGULATIONS.—

9 “(A) IN GENERAL.—Not later than the
10 date that is 2 years after such date of the en-
11 actment, the Secretary, working jointly with the
12 Inspector General of the Department of Health
13 and Human Services, shall promulgate regula-
14 tions for an effective compliance and ethics pro-
15 gram for operating organizations, which may
16 include a model compliance program.

17 “(B) DESIGN OF REGULATIONS.—Such
18 regulations with respect to specific elements or
19 formality of a program shall, in the case of an
20 organization that operates 5 or more facilities,
21 vary with the size of the organization, such that
22 larger organizations should have a more formal
23 program and include established written policies
24 defining the standards and procedures to be fol-
25 lowed by its employees. Such requirements may

1 specifically apply to the corporate level manage-
2 ment of multi unit nursing home chains.

3 “(C) EVALUATION.—Not later than 3
4 years after the date of the promulgation of reg-
5 ulations under this paragraph, the Secretary
6 shall complete an evaluation of the compliance
7 and ethics programs required to be established
8 under this subsection. Such evaluation shall de-
9 termine if such programs led to changes in defi-
10 ciency citations, changes in quality perform-
11 ance, or changes in other metrics of patient
12 quality of care. The Secretary shall submit to
13 Congress a report on such evaluation and shall
14 include in such report such recommendations
15 regarding changes in the requirements for such
16 programs as the Secretary determines appro-
17 priate.

18 “(3) REQUIREMENTS FOR COMPLIANCE AND
19 ETHICS PROGRAMS.—In this subsection, the term
20 ‘compliance and ethics program’ means, with respect
21 to a facility, a program of the operating organization
22 that—

23 “(A) has been reasonably designed, imple-
24 mented, and enforced so that it generally will be
25 effective in preventing and detecting criminal,

1 civil, and administrative violations under this
2 Act and in promoting quality of care; and

3 “(B) includes at least the required compo-
4 nents specified in paragraph (4).

5 “(4) REQUIRED COMPONENTS OF PROGRAM.—

6 The required components of a compliance and ethics
7 program of an operating organization are the fol-
8 lowing:

9 “(A) The organization must have estab-
10 lished compliance standards and procedures to
11 be followed by its employees and other agents
12 that are reasonably capable of reducing the
13 prospect of criminal, civil, and administrative
14 violations under this Act.

15 “(B) Specific individuals within high-level
16 personnel of the organization must have been
17 assigned overall responsibility to oversee compli-
18 ance with such standards and procedures and
19 have sufficient resources and authority to as-
20 sure such compliance.

21 “(C) The organization must have used due
22 care not to delegate substantial discretionary
23 authority to individuals whom the organization
24 knew, or should have known through the exer-
25 cise of due diligence, had a propensity to en-

1 gage in criminal, civil, and administrative viola-
2 tions under this Act.

3 “(D) The organization must have taken
4 steps to communicate effectively its standards
5 and procedures to all employees and other
6 agents, such as by requiring participation in
7 training programs or by disseminating publica-
8 tions that explain in a practical manner what is
9 required.

10 “(E) The organization must have taken
11 reasonable steps to achieve compliance with its
12 standards, such as by utilizing monitoring and
13 auditing systems reasonably designed to detect
14 criminal, civil, and administrative violations
15 under this Act by its employees and other
16 agents and by having in place and publicizing
17 a reporting system whereby employees and
18 other agents could report violations by others
19 within the organization without fear of retribu-
20 tion.

21 “(F) The standards must have been con-
22 sistently enforced through appropriate discipli-
23 nary mechanisms, including, as appropriate,
24 discipline of individuals responsible for the fail-
25 ure to detect an offense.

1 “(G) After an offense has been detected,
2 the organization must have taken all reasonable
3 steps to respond appropriately to the offense
4 and to prevent further similar offenses, includ-
5 ing any necessary modification to its program
6 to prevent and detect criminal, civil, and admin-
7 istrative violations under this Act.

8 “(H) The organization must periodically
9 undertake reassessment of its compliance pro-
10 gram to identify changes necessary to reflect
11 changes within the organization and its facili-
12 ties.

13 “(c) QUALITY ASSURANCE AND PERFORMANCE IM-
14 PROVEMENT PROGRAM.—

15 “(1) IN GENERAL.—Not later than December
16 31, 2011, the Secretary shall establish and imple-
17 ment a quality assurance and performance improve-
18 ment program (in this subparagraph referred to as
19 the ‘QAPI program’) for facilities, including multi
20 unit chains of facilities. Under the QAPI program,
21 the Secretary shall establish standards relating to
22 quality assurance and performance improvement
23 with respect to facilities and provide technical assist-
24 ance to facilities on the development of best prac-
25 tices in order to meet such standards. Not later than

1 1 year after the date on which the regulations are
 2 promulgated under paragraph (2), a facility must
 3 submit to the Secretary a plan for the facility to
 4 meet such standards and implement such best prac-
 5 tices, including how to coordinate the implementa-
 6 tion of such plan with quality assessment and assur-
 7 ance activities conducted under sections
 8 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

9 “(2) REGULATIONS.—The Secretary shall pro-
 10 mulgate regulations to carry out this subsection.”.

11 **SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.**

12 (a) SKILLED NURSING FACILITIES.—

13 (1) IN GENERAL.—Section 1819 of the Social
 14 Security Act (42 U.S.C. 1395i-3) is amended—

15 (A) by redesignating subsection (i) as sub-
 16 section (j); and

17 (B) by inserting after subsection (h) the
 18 following new subsection:

19 “(i) NURSING HOME COMPARE WEBSITE.—

20 “(1) INCLUSION OF ADDITIONAL INFORMA-
 21 TION.—

22 “(A) IN GENERAL.—The Secretary shall
 23 ensure that the Department of Health and
 24 Human Services includes, as part of the infor-
 25 mation provided for comparison of nursing

1 homes on the official Internet website of the
2 Federal Government for Medicare beneficiaries
3 (commonly referred to as the ‘Nursing Home
4 Compare’ Medicare website) (or a successor
5 website), the following information in a manner
6 that is prominent, updated on a timely basis,
7 easily accessible, readily understandable to con-
8 sumers of long-term care services, and search-
9 able:

10 “(i) Staffing data for each facility (in-
11 cluding resident census data and data on
12 the hours of care provided per resident per
13 day) based on data submitted under sec-
14 tion 1128I(g), including information on
15 staffing turnover and tenure, in a format
16 that is clearly understandable to con-
17 sumers of long-term care services and al-
18 lows such consumers to compare dif-
19 ferences in staffing between facilities and
20 State and national averages for the facili-
21 ties. Such format shall include—

22 “(I) concise explanations of how
23 to interpret the data (such as a plain
24 English explanation of data reflecting

1 ‘nursing home staff hours per resident
2 day’);

3 “(II) differences in types of staff
4 (such as training associated with dif-
5 ferent categories of staff);

6 “(III) the relationship between
7 nurse staffing levels and quality of
8 care; and

9 “(IV) an explanation that appro-
10 prium staffing levels vary based on
11 patient case mix.

12 “(ii) Links to State Internet websites
13 with information regarding State survey
14 and certification programs, links to Form
15 2567 State inspection reports (or a suc-
16 cessor form) on such websites, information
17 to guide consumers in how to interpret and
18 understand such reports, and the facility
19 plan of correction or other response to
20 such report. Any such links shall be posted
21 on a timely basis.

22 “(iii) The standardized complaint
23 form developed under section 1128I(f), in-
24 cluding explanatory material on what com-
25 plaint forms are, how they are used, and

1 how to file a complaint with the State sur-
2 vey and certification program and the
3 State long-term care ombudsman program.

4 “(iv) Summary information on the
5 number, type, severity, and outcome of
6 substantiated complaints.

7 “(v) The number of adjudicated in-
8 stances of criminal violations by a facility
9 or the employees of a facility—

10 “(I) that were committed inside
11 the facility;

12 “(II) with respect to such in-
13 stances of violations or crimes com-
14 mitted inside of the facility that were
15 the violations or crimes of abuse, ne-
16 glect, and exploitation, criminal sexual
17 abuse, or other violations or crimes
18 that resulted in serious bodily injury;
19 and

20 “(III) the number of civil mone-
21 tary penalties levied against the facil-
22 ity, employees, contractors, and other
23 agents.

24 “(B) DEADLINE FOR PROVISION OF INFOR-
25 MATION.—

1 “(i) IN GENERAL.—Except as pro-
2 vided in clause (ii), the Secretary shall en-
3 sure that the information described in sub-
4 paragraph (A) is included on such website
5 (or a successor website) not later than 1
6 year after the date of the enactment of this
7 subsection.

8 “(ii) EXCEPTION.—The Secretary
9 shall ensure that the information described
10 in subparagraph (A)(i) is included on such
11 website (or a successor website) not later
12 than the date on which the requirements
13 under section 1128I(g) are implemented.

14 “(2) REVIEW AND MODIFICATION OF
15 WEBSITE.—

16 “(A) IN GENERAL.—The Secretary shall
17 establish a process—

18 “(i) to review the accuracy, clarity of
19 presentation, timeliness, and comprehen-
20 siveness of information reported on such
21 website as of the day before the date of the
22 enactment of this subsection; and

23 “(ii) not later than 1 year after the
24 date of the enactment of this subsection, to
25 modify or revamp such website in accord-

1 ance with the review conducted under
2 clause (i).

3 “(B) CONSULTATION.—In conducting the
4 review under subparagraph (A)(i), the Sec-
5 retary shall consult with—

6 “(i) State long-term care ombudsman
7 programs;

8 “(ii) consumer advocacy groups;

9 “(iii) provider stakeholder groups; and

10 “(iv) any other representatives of pro-
11 grams or groups the Secretary determines
12 appropriate.”.

13 (2) TIMELINESS OF SUBMISSION OF SURVEY
14 AND CERTIFICATION INFORMATION.—

15 (A) IN GENERAL.—Section 1819(g)(5) of
16 the Social Security Act (42 U.S.C. 1395i-
17 3(g)(5)) is amended by adding at the end the
18 following new subparagraph:

19 “(E) SUBMISSION OF SURVEY AND CER-
20 TIFICATION INFORMATION TO THE SEC-
21 RETARY.—In order to improve the timeliness of
22 information made available to the public under
23 subparagraph (A) and provided on the Nursing
24 Home Compare Medicare website under sub-
25 section (i), each State shall submit information

1 respecting any survey or certification made re-
2 specting a skilled nursing facility (including any
3 enforcement actions taken by the State) to the
4 Secretary not later than the date on which the
5 State sends such information to the facility.
6 The Secretary shall use the information sub-
7 mitted under the preceding sentence to update
8 the information provided on the Nursing Home
9 Compare Medicare website as expeditiously as
10 practicable but not less frequently than quar-
11 terly.”.

12 (B) EFFECTIVE DATE.—The amendment
13 made by this paragraph shall take effect 1 year
14 after the date of the enactment of this Act.

15 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
16 tion 1819(f) of the Social Security Act (42 U.S.C.
17 1395i–3(f)) is amended by adding at the end the fol-
18 lowing new paragraph:

19 “(8) SPECIAL FOCUS FACILITY PROGRAM.—

20 “(A) IN GENERAL.—The Secretary shall
21 conduct a special focus facility program for en-
22 forcement of requirements for skilled nursing
23 facilities that the Secretary has identified as
24 having substantially failed to meet applicable
25 requirement of this Act.

1 “(B) PERIODIC SURVEYS.—Under such
2 program the Secretary shall conduct surveys of
3 each facility in the program not less than once
4 every 6 months.”.

5 (b) NURSING FACILITIES.—

6 (1) IN GENERAL.—Section 1919 of the Social
7 Security Act (42 U.S.C. 1396r) is amended—

8 (A) by redesignating subsection (i) as sub-
9 section (j); and

10 (B) by inserting after subsection (h) the
11 following new subsection:

12 “(i) NURSING HOME COMPARE WEBSITE.—

13 “(1) INCLUSION OF ADDITIONAL INFORMA-
14 TION.—

15 “(A) IN GENERAL.—The Secretary shall
16 ensure that the Department of Health and
17 Human Services includes, as part of the infor-
18 mation provided for comparison of nursing
19 homes on the official Internet website of the
20 Federal Government for Medicare beneficiaries
21 (commonly referred to as the ‘Nursing Home
22 Compare’ Medicare website) (or a successor
23 website), the following information in a manner
24 that is prominent, updated on a timely basis,
25 easily accessible, readily understandable to con-

1 consumers of long-term care services, and search-
2 able:

3 “(i) Staffing data for each facility (in-
4 cluding resident census data and data on
5 the hours of care provided per resident per
6 day) based on data submitted under sec-
7 tion 1128I(g), including information on
8 staffing turnover and tenure, in a format
9 that is clearly understandable to con-
10 sumers of long-term care services and al-
11 lows such consumers to compare dif-
12 ferences in staffing between facilities and
13 State and national averages for the facili-
14 ties. Such format shall include—

15 “(I) concise explanations of how
16 to interpret the data (such as plain
17 English explanation of data reflecting
18 ‘nursing home staff hours per resident
19 day’);

20 “(II) differences in types of staff
21 (such as training associated with dif-
22 ferent categories of staff);

23 “(III) the relationship between
24 nurse staffing levels and quality of
25 care; and

1 “(IV) an explanation that appro-
2 priate staffing levels vary based on
3 patient case mix.

4 “(ii) Links to State Internet websites
5 with information regarding State survey
6 and certification programs, links to Form
7 2567 State inspection reports (or a suc-
8 cessor form) on such websites, information
9 to guide consumers in how to interpret and
10 understand such reports, and the facility
11 plan of correction or other response to
12 such report. Any such links shall be posted
13 on a timely basis.

14 “(iii) The standardized complaint
15 form developed under section 1128I(f), in-
16 cluding explanatory material on what com-
17 plaint forms are, how they are used, and
18 how to file a complaint with the State sur-
19 vey and certification program and the
20 State long-term care ombudsman program.

21 “(iv) Summary information on the
22 number, type, severity, and outcome of
23 substantiated complaints.

1 “(v) The number of adjudicated in-
2 stances of criminal violations by a facility
3 or the employees of a facility—

4 “(I) that were committed inside
5 of the facility; and

6 “(II) with respect to such in-
7 stances of violations or crimes com-
8 mitted outside of the facility, that
9 were violations or crimes that resulted
10 in the serious bodily injury of an
11 elder.

12 “(B) DEADLINE FOR PROVISION OF INFOR-
13 MATION.—

14 “(i) IN GENERAL.—Except as pro-
15 vided in clause (ii), the Secretary shall en-
16 sure that the information described in sub-
17 paragraph (A) is included on such website
18 (or a successor website) not later than 1
19 year after the date of the enactment of this
20 subsection.

21 “(ii) EXCEPTION.—The Secretary
22 shall ensure that the information described
23 in subparagraph (A)(i) is included on such
24 website (or a successor website) not later

1 than the date on which the requirements
2 under section 1128I(g) are implemented.

3 “(2) REVIEW AND MODIFICATION OF
4 WEBSITE.—

5 “(A) IN GENERAL.—The Secretary shall
6 establish a process—

7 “(i) to review the accuracy, clarity of
8 presentation, timeliness, and comprehen-
9 siveness of information reported on such
10 website as of the day before the date of the
11 enactment of this subsection; and

12 “(ii) not later than 1 year after the
13 date of the enactment of this subsection, to
14 modify or revamp such website in accord-
15 ance with the review conducted under
16 clause (i).

17 “(B) CONSULTATION.—In conducting the
18 review under subparagraph (A)(i), the Sec-
19 retary shall consult with—

20 “(i) State long-term care ombudsman
21 programs;

22 “(ii) consumer advocacy groups;

23 “(iii) provider stakeholder groups;

24 “(iv) skilled nursing facility employees
25 and their representatives; and

1 “(v) any other representatives of pro-
2 grams or groups the Secretary determines
3 appropriate.”.

4 (2) TIMELINESS OF SUBMISSION OF SURVEY
5 AND CERTIFICATION INFORMATION.—

6 (A) IN GENERAL.—Section 1919(g)(5) of
7 the Social Security Act (42 U.S.C. 1396r(g)(5))
8 is amended by adding at the end the following
9 new subparagraph:

10 “(E) SUBMISSION OF SURVEY AND CER-
11 TIFICATION INFORMATION TO THE SEC-
12 RETARY.—In order to improve the timeliness of
13 information made available to the public under
14 subparagraph (A) and provided on the Nursing
15 Home Compare Medicare website under sub-
16 section (i), each State shall submit information
17 respecting any survey or certification made re-
18 specting a nursing facility (including any en-
19 forcement actions taken by the State) to the
20 Secretary not later than the date on which the
21 State sends such information to the facility.
22 The Secretary shall use the information sub-
23 mitted under the preceding sentence to update
24 the information provided on the Nursing Home
25 Compare Medicare website as expeditiously as

1 practicable but not less frequently than quar-
2 terly.”.

3 (B) EFFECTIVE DATE.—The amendment
4 made by this paragraph shall take effect 1 year
5 after the date of the enactment of this Act.

6 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
7 tion 1919(f) of the Social Security Act (42 U.S.C.
8 1396r(f)) is amended by adding at the end of the
9 following new paragraph:

10 “(10) SPECIAL FOCUS FACILITY PROGRAM.—

11 “(A) IN GENERAL.—The Secretary shall
12 conduct a special focus facility program for en-
13 forcement of requirements for nursing facilities
14 that the Secretary has identified as having sub-
15 stantially failed to meet applicable requirements
16 of this Act.

17 “(B) PERIODIC SURVEYS.—Under such
18 program the Secretary shall conduct surveys of
19 each facility in the program not less often than
20 once every 6 months.”.

21 (c) AVAILABILITY OF REPORTS ON SURVEYS, CER-
22 TIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

23 (1) SKILLED NURSING FACILITIES.—Section
24 1819(d)(1) of the Social Security Act (42 U.S.C.
25 1395i–3(d)(1)), as amended by section 6101, is

1 amended by adding at the end the following new
2 subparagraph:

3 “(C) AVAILABILITY OF SURVEY, CERTIFI-
4 CATION, AND COMPLAINT INVESTIGATION RE-
5 PORTS.—A skilled nursing facility must—

6 “(i) have reports with respect to any
7 surveys, certifications, and complaint in-
8 vestigations made respecting the facility
9 during the 3 preceding years available for
10 any individual to review upon request; and

11 “(ii) post notice of the availability of
12 such reports in areas of the facility that
13 are prominent and accessible to the public.

14 The facility shall not make available under
15 clause (i) identifying information about com-
16 plainants or residents.”.

17 (2) NURSING FACILITIES.—Section 1919(d)(1)
18 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
19 as amended by section 6101, is amended by adding
20 at the end the following new subparagraph:

21 “(V) AVAILABILITY OF SURVEY, CERTIFI-
22 CATION, AND COMPLAINT INVESTIGATION RE-
23 PORTS.—A nursing facility must—

24 “(i) have reports with respect to any
25 surveys, certifications, and complaint in-

1 vestigations made respecting the facility
2 during the 3 preceding years available for
3 any individual to review upon request; and

4 “(ii) post notice of the availability of
5 such reports in areas of the facility that
6 are prominent and accessible to the public.

7 The facility shall not make available under
8 clause (i) identifying information about com-
9 plainants or residents.”.

10 (3) EFFECTIVE DATE.—The amendments made
11 by this subsection shall take effect 1 year after the
12 date of the enactment of this Act.

13 (d) GUIDANCE TO STATES ON FORM 2567 STATE IN-
14 SPECTION REPORTS AND COMPLAINT INVESTIGATION RE-
15 PORTS.—

16 (1) GUIDANCE.—The Secretary of Health and
17 Human Services (in this subtitle referred to as the
18 “Secretary”) shall provide guidance to States on
19 how States can establish electronic links to Form
20 2567 State inspection reports (or a successor form),
21 complaint investigation reports, and a facility’s plan
22 of correction or other response to such Form 2567
23 State inspection reports (or a successor form) on the
24 Internet website of the State that provides informa-
25 tion on skilled nursing facilities and nursing facili-

1 ties and the Secretary shall, if possible, include such
2 information on Nursing Home Compare.

3 (2) REQUIREMENT.—Section 1902(a)(9) of the
4 Social Security Act (42 U.S.C. 1396a(a)(9)) is
5 amended—

6 (A) by striking “and” at the end of sub-
7 paragraph (B);

8 (B) by striking the semicolon at the end of
9 subparagraph (C) and inserting “, and”; and

10 (C) by adding at the end the following new
11 subparagraph:

12 “(D) that the State maintain a consumer-
13 oriented website providing useful information to
14 consumers regarding all skilled nursing facili-
15 ties and all nursing facilities in the State, in-
16 cluding for each facility, Form 2567 State in-
17 spection reports (or a successor form), com-
18 plaint investigation reports, the facility’s plan of
19 correction, and such other information that the
20 State or the Secretary considers useful in as-
21 sisting the public to assess the quality of long
22 term care options and the quality of care pro-
23 vided by individual facilities;”.

24 (3) DEFINITIONS.—In this subsection:

1 (A) NURSING FACILITY.—The term “nurs-
2 ing facility” has the meaning given such term
3 in section 1919(a) of the Social Security Act
4 (42 U.S.C. 1396r(a)).

5 (B) SECRETARY.—The term “Secretary”
6 means the Secretary of Health and Human
7 Services.

8 (C) SKILLED NURSING FACILITY.—The
9 term “skilled nursing facility” has the meaning
10 given such term in section 1819(a) of the Social
11 Security Act (42 U.S.C. 1395i–3(a)).

12 (e) DEVELOPMENT OF CONSUMER RIGHTS INFORMA-
13 TION PAGE ON NURSING HOME COMPARE WEBSITE.—
14 Not later than 1 year after the date of enactment of this
15 Act, the Secretary shall ensure that the Department of
16 Health and Human Services, as part of the information
17 provided for comparison of nursing facilities on the Nurs-
18 ing Home Compare Medicare website develops and in-
19 cludes a consumer rights information page that contains
20 links to descriptions of, and information with respect to,
21 the following:

22 (1) The documentation on nursing facilities
23 that is available to the public.

1 (2) General information and tips on choosing a
2 nursing facility that meets the needs of the indi-
3 vidual.

4 (3) General information on consumer rights
5 with respect to nursing facilities.

6 (4) The nursing facility survey process (on a
7 national and State-specific basis).

8 (5) On a State-specific basis, the services avail-
9 able through the State long-term care ombudsman
10 for such State.

11 **SEC. 6104. REPORTING OF EXPENDITURES.**

12 Section 1888 of the Social Security Act (42 U.S.C.
13 1395yy) is amended by adding at the end the following
14 new subsection:

15 “(f) REPORTING OF DIRECT CARE EXPENDI-
16 TURES.—

17 “(1) IN GENERAL.—For cost reports submitted
18 under this title for cost reporting periods beginning
19 on or after the date that is 2 years after the date
20 of the enactment of this subsection, skilled nursing
21 facilities shall separately report expenditures for
22 wages and benefits for direct care staff (breaking
23 out (at a minimum) registered nurses, licensed pro-
24 fessional nurses, certified nurse assistants, and other
25 medical and therapy staff).

1 “(2) MODIFICATION OF FORM.—The Secretary,
2 in consultation with private sector accountants expe-
3 rienced with Medicare and Medicaid nursing facility
4 home cost reports, shall redesign such reports to
5 meet the requirement of paragraph (1) not later
6 than 1 year after the date of the enactment of this
7 subsection.

8 “(3) CATEGORIZATION BY FUNCTIONAL AC-
9 COUNTS.—Not later than 30 months after the date
10 of the enactment of this subsection, the Secretary,
11 working in consultation with the Medicare Payment
12 Advisory Commission, the Medicaid and CHIP Pay-
13 ment and Access Commission, the Inspector General
14 of the Department of Health and Human Services,
15 and other expert parties the Secretary determines
16 appropriate, shall take the expenditures listed on
17 cost reports, as modified under paragraph (1), sub-
18 mitted by skilled nursing facilities and categorize
19 such expenditures, regardless of any source of pay-
20 ment for such expenditures, for each skilled nursing
21 facility into the following functional accounts on an
22 annual basis:

23 “(A) Spending on direct care services (in-
24 cluding nursing, therapy, and medical services).

1 “(B) Spending on indirect care (including
2 housekeeping and dietary services).

3 “(C) Capital assets (including building and
4 land costs).

5 “(D) Administrative services costs.

6 “(4) AVAILABILITY OF INFORMATION SUB-
7 MITTED.—The Secretary shall establish procedures
8 to make information on expenditures submitted
9 under this subsection readily available to interested
10 parties upon request, subject to such requirements
11 as the Secretary may specify under the procedures
12 established under this paragraph.”.

13 **SEC. 6105. STANDARDIZED COMPLAINT FORM.**

14 (a) IN GENERAL.—Section 1128I of the Social Secu-
15 rity Act, as added and amended by this Act, is amended
16 by adding at the end the following new subsection:

17 “(f) STANDARDIZED COMPLAINT FORM.—

18 “(1) DEVELOPMENT BY THE SECRETARY.—The
19 Secretary shall develop a standardized complaint
20 form for use by a resident (or a person acting on the
21 resident’s behalf) in filing a complaint with a State
22 survey and certification agency and a State long-
23 term care ombudsman program with respect to a fa-
24 cility.

1 “(2) COMPLAINT FORMS AND RESOLUTION
2 PROCESSES.—

3 “(A) COMPLAINT FORMS.—The State must
4 make the standardized complaint form devel-
5 oped under paragraph (1) available upon re-
6 quest to—

7 “(i) a resident of a facility; and

8 “(ii) any person acting on the resi-
9 dent’s behalf.

10 “(B) COMPLAINT RESOLUTION PROCESS.—

11 The State must establish a complaint resolution
12 process in order to ensure that the legal rep-
13 resentative of a resident of a facility or other
14 responsible party is not denied access to such
15 resident or otherwise retaliated against if they
16 have complained about the quality of care pro-
17 vided by the facility or other issues relating to
18 the facility. Such complaint resolution process
19 shall include—

20 “(i) procedures to assure accurate
21 tracking of complaints received, including
22 notification to the complainant that a com-
23 plaint has been received;

1 “(ii) procedures to determine the like-
2 ly severity of a complaint and for the in-
3 vestigation of the complaint; and

4 “(iii) deadlines for responding to a
5 complaint and for notifying the complain-
6 ant of the outcome of the investigation.

7 “(3) **RULE OF CONSTRUCTION.**—Nothing in
8 this subsection shall be construed as preventing a
9 resident of a facility (or a person acting on the resi-
10 dent’s behalf) from submitting a complaint in a
11 manner or format other than by using the standard-
12 ized complaint form developed under paragraph (1)
13 (including submitting a complaint orally).”.

14 “(b) **EFFECTIVE DATE.**—The amendment made by
15 this section shall take effect 1 year after the date of the
16 enactment of this Act.

17 **SEC. 6106. ENSURING STAFFING ACCOUNTABILITY.**

18 Section 1128I of the Social Security Act, as added
19 and amended by this Act, is amended by adding at the
20 end the following new subsection:

21 “(g) **SUBMISSION OF STAFFING INFORMATION**
22 **BASED ON PAYROLL DATA IN A UNIFORM FORMAT.**—Be-
23 ginning not later than 2 years after the date of the enact-
24 ment of this subsection, and after consulting with State
25 long-term care ombudsman programs, consumer advocacy

1 groups, provider stakeholder groups, employees and their
2 representatives, and other parties the Secretary deems ap-
3 propriate, the Secretary shall require a facility to elec-
4 tronically submit to the Secretary direct care staffing in-
5 formation (including information with respect to agency
6 and contract staff) based on payroll and other verifiable
7 and auditable data in a uniform format (according to spec-
8 ifications established by the Secretary in consultation with
9 such programs, groups, and parties). Such specifications
10 shall require that the information submitted under the
11 preceding sentence—

12 “(1) specify the category of work a certified em-
13 ployee performs (such as whether the employee is a
14 registered nurse, licensed practical nurse, licensed
15 vocational nurse, certified nursing assistant, thera-
16 pist, or other medical personnel);

17 “(2) include resident census data and informa-
18 tion on resident case mix;

19 “(3) include a regular reporting schedule; and

20 “(4) include information on employee turnover
21 and tenure and on the hours of care provided by
22 each category of certified employees referenced in
23 paragraph (1) per resident per day.

24 Nothing in this subsection shall be construed as pre-
25 venting the Secretary from requiring submission of such

1 information with respect to specific categories, such as
2 nursing staff, before other categories of certified employ-
3 ees. Information under this subsection with respect to
4 agency and contract staff shall be kept separate from in-
5 formation on employee staffing.”.

6 **SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUAL-**
7 **ITY RATING SYSTEM.**

8 (a) STUDY.—The Comptroller General of the United
9 States (in this section referred to as the “Comptroller
10 General”) shall conduct a study on the Five-Star Quality
11 Rating System for nursing homes of the Centers for Medi-
12 care & Medicaid Services. Such study shall include an
13 analysis of—

- 14 (1) how such system is being implemented;
15 (2) any problems associated with such system
16 or its implementation; and
17 (3) how such system could be improved.

18 (b) REPORT.—Not later than 2 years after the date
19 of enactment of this Act, the Comptroller General shall
20 submit to Congress a report containing the results of the
21 study conducted under subsection (a), together with rec-
22 ommendations for such legislation and administrative ac-
23 tion as the Comptroller General determines appropriate.

1 **PART II—TARGETING ENFORCEMENT**

2 **SEC. 6111. CIVIL MONEY PENALTIES.**

3 (a) SKILLED NURSING FACILITIES.—

4 (1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of
5 the Social Security Act (42 U.S.C. 1395i-
6 3(h)(2)(B)(ii)) is amended—

7 (A) by striking “PENALTIES.—The Sec-
8 retary” and inserting “PENALTIES.—

9 “(I) IN GENERAL.—Subject to
10 subclause (II), the Secretary”; and

11 (B) by adding at the end the following new
12 subclauses:

13 “(II) REDUCTION OF CIVIL
14 MONEY PENALTIES IN CERTAIN CIR-
15 CUMSTANCES.—Subject to subclause
16 (III), in the case where a facility self-
17 reports and promptly corrects a defi-
18 ciency for which a penalty was im-
19 posed under this clause not later than
20 10 calendar days after the date of
21 such imposition, the Secretary may
22 reduce the amount of the penalty im-
23 posed by not more than 50 percent.

24 “(III) PROHIBITIONS ON REDUC-
25 TION FOR CERTAIN DEFICIENCIES.—

1 “(aa) REPEAT DEFICI-
2 CIENCIES.—The Secretary may
3 not reduce the amount of a pen-
4 alty under subclause (II) if the
5 Secretary had reduced a penalty
6 imposed on the facility in the
7 preceding year under such sub-
8 clause with respect to a repeat
9 deficiency.

10 “(bb) CERTAIN OTHER DE-
11 FICIENCIES.—The Secretary may
12 not reduce the amount of a pen-
13 alty under subclause (II) if the
14 penalty is imposed on the facility
15 for a deficiency that is found to
16 result in a pattern of harm or
17 widespread harm, immediately
18 jeopardizes the health or safety
19 of a resident or residents of the
20 facility, or results in the death of
21 a resident of the facility.

22 “(IV) COLLECTION OF CIVIL
23 MONEY PENALTIES.—In the case of a
24 civil money penalty imposed under

1 this clause, the Secretary shall issue
2 regulations that—

3 “(aa) subject to item (cc),
4 not later than 30 days after the
5 imposition of the penalty, provide
6 for the facility to have the oppor-
7 tunity to participate in an inde-
8 pendent informal dispute resolu-
9 tion process which generates a
10 written record prior to the collec-
11 tion of such penalty;

12 “(bb) in the case where the
13 penalty is imposed for each day
14 of noncompliance, provide that a
15 penalty may not be imposed for
16 any day during the period begin-
17 ning on the initial day of the im-
18 position of the penalty and end-
19 ing on the day on which the in-
20 formal dispute resolution process
21 under item (aa) is completed;

22 “(cc) may provide for the
23 collection of such civil money
24 penalty and the placement of
25 such amounts collected in an es-

1 crow account under the direction
2 of the Secretary on the earlier of
3 the date on which the informal
4 dispute resolution process under
5 item (aa) is completed or the
6 date that is 90 days after the
7 date of the imposition of the pen-
8 alty;

9 “(dd) may provide that such
10 amounts collected are kept in
11 such account pending the resolu-
12 tion of any subsequent appeals;

13 “(ee) in the case where the
14 facility successfully appeals the
15 penalty, may provide for the re-
16 turn of such amounts collected
17 (plus interest) to the facility; and

18 “(ff) in the case where all
19 such appeals are unsuccessful,
20 may provide that some portion of
21 such amounts collected may be
22 used to support activities that
23 benefit residents, including as-
24 sistance to support and protect
25 residents of a facility that closes

1 (voluntarily or involuntarily) or is
2 decertified (including offsetting
3 costs of relocating residents to
4 home and community-based set-
5 tings or another facility), projects
6 that support resident and family
7 councils and other consumer in-
8 volvement in assuring quality
9 care in facilities, and facility im-
10 provement initiatives approved by
11 the Secretary (including joint
12 training of facility staff and sur-
13 veyors, technical assistance for
14 facilities implementing quality as-
15 surance programs, the appoint-
16 ment of temporary management
17 firms, and other activities ap-
18 proved by the Secretary).”.

19 (2) CONFORMING AMENDMENT.—The second
20 sentence of section 1819(h)(5) of the Social Security
21 Act (42 U.S.C. 1395i–3(h)(5)) is amended by insert-
22 ing “(ii)(IV),” after “(i),”.

23 (b) NURSING FACILITIES.—

1 (1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of
2 the Social Security Act (42 U.S.C. 1396r(h)(3)(C))
3 is amended—

4 (A) by striking “PENALTIES.—The Sec-
5 retary” and inserting “PENALTIES.—

6 “(I) IN GENERAL.—Subject to
7 subclause (II), the Secretary”; and

8 (B) by adding at the end the following new
9 subclauses:

10 “(II) REDUCTION OF CIVIL
11 MONEY PENALTIES IN CERTAIN CIR-
12 CUMSTANCES.—Subject to subclause
13 (III), in the case where a facility self-
14 reports and promptly corrects a defi-
15 ciency for which a penalty was im-
16 posed under this clause not later than
17 10 calendar days after the date of
18 such imposition, the Secretary may
19 reduce the amount of the penalty im-
20 posed by not more than 50 percent.

21 “(III) PROHIBITIONS ON REDUC-
22 TION FOR CERTAIN DEFICIENCIES.—

23 “(aa) REPEAT DEFICI-
24 CIENCIES.—The Secretary may
25 not reduce the amount of a pen-

1 alty under subclause (II) if the
2 Secretary had reduced a penalty
3 imposed on the facility in the
4 preceding year under such sub-
5 clause with respect to a repeat
6 deficiency.

7 “(bb) CERTAIN OTHER DE-
8 FICIENCIES.—The Secretary may
9 not reduce the amount of a pen-
10 alty under subclause (II) if the
11 penalty is imposed on the facility
12 for a deficiency that is found to
13 result in a pattern of harm or
14 widespread harm, immediately
15 jeopardizes the health or safety
16 of a resident or residents of the
17 facility, or results in the death of
18 a resident of the facility.

19 “(IV) COLLECTION OF CIVIL
20 MONEY PENALTIES.—In the case of a
21 civil money penalty imposed under
22 this clause, the Secretary shall issue
23 regulations that—

24 “(aa) subject to item (cc),
25 not later than 30 days after the

1 imposition of the penalty, provide
2 for the facility to have the oppor-
3 tunity to participate in an inde-
4 pendent informal dispute resolu-
5 tion process which generates a
6 written record prior to the collec-
7 tion of such penalty;

8 “(bb) in the case where the
9 penalty is imposed for each day
10 of noncompliance, provide that a
11 penalty may not be imposed for
12 any day during the period begin-
13 ning on the initial day of the im-
14 position of the penalty and end-
15 ing on the day on which the in-
16 formal dispute resolution process
17 under item (aa) is completed;

18 “(cc) may provide for the
19 collection of such civil money
20 penalty and the placement of
21 such amounts collected in an es-
22 crow account under the direction
23 of the Secretary on the earlier of
24 the date on which the informal
25 dispute resolution process under

1 item (aa) is completed or the
2 date that is 90 days after the
3 date of the imposition of the pen-
4 alty;

5 “(dd) may provide that such
6 amounts collected are kept in
7 such account pending the resolu-
8 tion of any subsequent appeals;

9 “(ee) in the case where the
10 facility successfully appeals the
11 penalty, may provide for the re-
12 turn of such amounts collected
13 (plus interest) to the facility; and

14 “(ff) in the case where all
15 such appeals are unsuccessful,
16 may provide that some portion of
17 such amounts collected may be
18 used to support activities that
19 benefit residents, including as-
20 sistance to support and protect
21 residents of a facility that closes
22 (voluntarily or involuntarily) or is
23 decertified (including offsetting
24 costs of relocating residents to
25 home and community-based set-

1 tings or another facility), projects
2 that support resident and family
3 councils and other consumer in-
4 volvement in assuring quality
5 care in facilities, and facility im-
6 provement initiatives approved by
7 the Secretary (including joint
8 training of facility staff and sur-
9 veyors, technical assistance for
10 facilities implementing quality as-
11 surance programs, the appoint-
12 ment of temporary management
13 firms, and other activities ap-
14 proved by the Secretary).”.

15 (2) CONFORMING AMENDMENT.—Section
16 1919(h)(5)(8) of the Social Security Act (42 U.S.C.
17 1396r(h)(5)(8)) is amended by inserting “(ii)(IV),”
18 after “(i),”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall take effect 1 year after the date of the
21 enactment of this Act.

22 **SEC. 6112. NATIONAL INDEPENDENT MONITOR DEM-**
23 **ONSTRATION PROJECT.**

24 (a) ESTABLISHMENT.—

1 (1) IN GENERAL.—The Secretary, in consulta-
2 tion with the Inspector General of the Department
3 of Health and Human Services, shall conduct a dem-
4 onstration project to develop, test, and implement an
5 independent monitor program to oversee interstate
6 and large intrastate chains of skilled nursing facili-
7 ties and nursing facilities.

8 (2) SELECTION.—The Secretary shall select
9 chains of skilled nursing facilities and nursing facili-
10 ties described in paragraph (1) to participate in the
11 demonstration project under this section from
12 among those chains that submit an application to
13 the Secretary at such time, in such manner, and
14 containing such information as the Secretary may
15 require.

16 (3) DURATION.—The Secretary shall conduct
17 the demonstration project under this section for a 2-
18 year period.

19 (4) IMPLEMENTATION.—The Secretary shall
20 implement the demonstration project under this sec-
21 tion not later than 1 year after the date of the en-
22 actment of this Act.

23 (b) REQUIREMENTS.—The Secretary shall evaluate
24 chains selected to participate in the demonstration project
25 under this section based on criteria selected by the Sec-

1 retary, including where evidence suggests that a number
2 of the facilities of the chain are experiencing serious safety
3 and quality of care problems. Such criteria may include
4 the evaluation of a chain that includes a number of facili-
5 ties participating in the “Special Focus Facility” program
6 (or a successor program) or multiple facilities with a
7 record of repeated serious safety and quality of care defi-
8 ciencies.

9 (c) RESPONSIBILITIES.—An independent monitor
10 that enters into a contract with the Secretary to partici-
11 pate in the conduct of the demonstration project under
12 this section shall—

13 (1) conduct periodic reviews and prepare root-
14 cause quality and deficiency analyses of a chain to
15 assess if facilities of the chain are in compliance
16 with State and Federal laws and regulations applica-
17 ble to the facilities;

18 (2) conduct sustained oversight of the efforts of
19 the chain, whether publicly or privately held, to
20 achieve compliance by facilities of the chain with
21 State and Federal laws and regulations applicable to
22 the facilities;

23 (3) analyze the management structure, distribu-
24 tion of expenditures, and nurse staffing levels of fa-

1 cilities of the chain in relation to resident census,
2 staff turnover rates, and tenure;

3 (4) report findings and recommendations with
4 respect to such reviews, analyses, and oversight to
5 the chain and facilities of the chain, to the Sec-
6 retary, and to relevant States; and

7 (5) publish the results of such reviews, anal-
8 yses, and oversight.

9 (d) IMPLEMENTATION OF RECOMMENDATIONS.—

10 (1) RECEIPT OF FINDING BY CHAIN.—Not later
11 than 10 days after receipt of a finding of an inde-
12 pendent monitor under subsection (c)(4), a chain
13 participating in the demonstration project shall sub-
14 mit to the independent monitor a report—

15 (A) outlining corrective actions the chain
16 will take to implement the recommendations in
17 such report; or

18 (B) indicating that the chain will not im-
19 plement such recommendations, and why it will
20 not do so.

21 (2) RECEIPT OF REPORT BY INDEPENDENT
22 MONITOR.—Not later than 10 days after receipt of
23 a report submitted by a chain under paragraph (1),
24 an independent monitor shall finalize its rec-
25 ommendations and submit a report to the chain and

1 facilities of the chain, the Secretary, and the State
2 or States, as appropriate, containing such final rec-
3 ommendations.

4 (e) COST OF APPOINTMENT.—A chain shall be re-
5 sponsible for a portion of the costs associated with the
6 appointment of independent monitors under the dem-
7 onstration project under this section. The chain shall pay
8 such portion to the Secretary (in an amount and in ac-
9 cordance with procedures established by the Secretary).

10 (f) WAIVER AUTHORITY.—The Secretary may waive
11 such requirements of titles XVIII and XIX of the Social
12 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as
13 may be necessary for the purpose of carrying out the dem-
14 onstration project under this section.

15 (g) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated such sums as may be
17 necessary to carry out this section.

18 (h) DEFINITIONS.—In this section:

19 (1) ADDITIONAL DISCLOSABLE PARTY.—The
20 term “additional disclosable party” has the meaning
21 given such term in section 1124(c)(5)(A) of the So-
22 cial Security Act, as added by section 4201(a).

23 (2) FACILITY.—The term “facility” means a
24 skilled nursing facility or a nursing facility.

1 (3) NURSING FACILITY.—The term “nursing
2 facility” has the meaning given such term in section
3 1919(a) of the Social Security Act (42 U.S.C.
4 1396r(a)).

5 (4) SECRETARY.—The term “Secretary” means
6 the Secretary of Health and Human Services, acting
7 through the Assistant Secretary for Planning and
8 Evaluation.

9 (5) SKILLED NURSING FACILITY.—The term
10 “skilled nursing facility” has the meaning given such
11 term in section 1819(a) of the Social Security Act
12 (42 U.S.C. 1395(a)).

13 (i) EVALUATION AND REPORT.—

14 (1) EVALUATION.—The Secretary, in consulta-
15 tion with the Inspector General of the Department
16 of Health and Human Services, shall evaluate the
17 demonstration project conducted under this section.

18 (2) REPORT.—Not later than 180 days after
19 the completion of the demonstration project under
20 this section, the Secretary shall submit to Congress
21 a report containing the results of the evaluation con-
22 ducted under paragraph (1), together with rec-
23 ommendations—

1 (A) as to whether the independent monitor
2 program should be established on a permanent
3 basis;

4 (B) if the Secretary recommends that such
5 program be so established, on appropriate pro-
6 cedures and mechanisms for such establish-
7 ment; and

8 (C) for such legislation and administrative
9 action as the Secretary determines appropriate.

10 **SEC. 6113. NOTIFICATION OF FACILITY CLOSURE.**

11 (a) IN GENERAL.—Section 1128I of the Social Secu-
12 rity Act, as added and amended by this Act, is amended
13 by adding at the end the following new subsection:

14 “(h) NOTIFICATION OF FACILITY CLOSURE.—

15 “(1) IN GENERAL.—Any individual who is the
16 administrator of a facility must—

17 “(A) submit to the Secretary, the State
18 long-term care ombudsman, residents of the fa-
19 cility, and the legal representatives of such resi-
20 dents or other responsible parties, written noti-
21 fication of an impending closure—

22 “(i) subject to clause (ii), not later
23 than the date that is 60 days prior to the
24 date of such closure; and

1 “(ii) in the case of a facility where the
2 Secretary terminates the facility’s partici-
3 pation under this title, not later than the
4 date that the Secretary determines appro-
5 priate;

6 “(B) ensure that the facility does not
7 admit any new residents on or after the date on
8 which such written notification is submitted;
9 and

10 “(C) include in the notice a plan for the
11 transfer and adequate relocation of the resi-
12 dents of the facility by a specified date prior to
13 closure that has been approved by the State, in-
14 cluding assurances that the residents will be
15 transferred to the most appropriate facility or
16 other setting in terms of quality, services, and
17 location, taking into consideration the needs,
18 choice, and best interests of each resident.

19 “(2) RELOCATION.—

20 “(A) IN GENERAL.—The State shall ensure
21 that, before a facility closes, all residents of the
22 facility have been successfully relocated to an-
23 other facility or an alternative home and com-
24 munity-based setting.

1 “(B) CONTINUATION OF PAYMENTS UNTIL
2 RESIDENTS RELOCATED.—The Secretary may,
3 as the Secretary determines appropriate, con-
4 tinue to make payments under this title with re-
5 spect to residents of a facility that has sub-
6 mitted a notification under paragraph (1) dur-
7 ing the period beginning on the date such noti-
8 fication is submitted and ending on the date on
9 which the resident is successfully relocated.

10 “(3) SANCTIONS.—Any individual who is the
11 administrator of a facility that fails to comply with
12 the requirements of paragraph (1)—

13 “(A) shall be subject to a civil monetary
14 penalty of up to \$100,000;

15 “(B) may be subject to exclusion from par-
16 ticipation in any Federal health care program
17 (as defined in section 1128B(f)); and

18 “(C) shall be subject to any other penalties
19 that may be prescribed by law.

20 “(4) PROCEDURE.—The provisions of section
21 1128A (other than subsections (a) and (b) and the
22 second sentence of subsection (f)) shall apply to a
23 civil money penalty or exclusion under paragraph (3)
24 in the same manner as such provisions apply to a
25 penalty or proceeding under section 1128A(a).”.

1 (b) CONFORMING AMENDMENTS.—Section
 2 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–
 3 3(h)(4)) is amended—

4 (1) in the first sentence, by striking “the Sec-
 5 retary shall terminate” and inserting “the Secretary,
 6 subject to section 1128I(h), shall terminate”; and

7 (2) in the second sentence, by striking “sub-
 8 section (c)(2)” and inserting “subsection (c)(2) and
 9 section 1128I(h)”.

10 (c) EFFECTIVE DATE.—The amendments made by
 11 this section shall take effect 1 year after the date of the
 12 enactment of this Act.

13 **SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CUL-**
 14 **TURE CHANGE AND USE OF INFORMATION**
 15 **TECHNOLOGY IN NURSING HOMES.**

16 (a) IN GENERAL.—The Secretary shall conduct 2
 17 demonstration projects, 1 for the development of best
 18 practices in skilled nursing facilities and nursing facilities
 19 that are involved in the culture change movement (includ-
 20 ing the development of resources for facilities to find and
 21 access funding in order to undertake culture change) and
 22 1 for the development of best practices in skilled nursing
 23 facilities and nursing facilities for the use of information
 24 technology to improve resident care.

25 (b) CONDUCT OF DEMONSTRATION PROJECTS.—

1 (1) GRANT AWARD.—Under each demonstration
2 project conducted under this section, the Secretary
3 shall award 1 or more grants to facility-based set-
4 tings for the development of best practices described
5 in subsection (a) with respect to the demonstration
6 project involved. Such award shall be made on a
7 competitive basis and may be allocated in 1 lump-
8 sum payment.

9 (2) CONSIDERATION OF SPECIAL NEEDS OF
10 RESIDENTS.—Each demonstration project conducted
11 under this section shall take into consideration the
12 special needs of residents of skilled nursing facilities
13 and nursing facilities who have cognitive impair-
14 ment, including dementia.

15 (c) DURATION AND IMPLEMENTATION.—

16 (1) DURATION.—The demonstration projects
17 shall each be conducted for a period not to exceed
18 3 years.

19 (2) IMPLEMENTATION.—The demonstration
20 projects shall each be implemented not later than 1
21 year after the date of the enactment of this Act.

22 (d) DEFINITIONS.—In this section:

23 (1) NURSING FACILITY.—The term “nursing
24 facility” has the meaning given such term in section

1 1919(a) of the Social Security Act (42 U.S.C.
2 1396r(a)).

3 (2) SECRETARY.—The term “Secretary” means
4 the Secretary of Health and Human Services.

5 (3) SKILLED NURSING FACILITY.—The term
6 “skilled nursing facility” has the meaning given such
7 term in section 1819(a) of the Social Security Act
8 (42 U.S.C. 1395(a)).

9 (e) AUTHORIZATION OF APPROPRIATIONS.—There
10 are authorized to be appropriated such sums as may be
11 necessary to carry out this section.

12 (f) REPORT.—Not later than 9 months after the com-
13 pletion of the demonstration project, the Secretary shall
14 submit to Congress a report on such project, together with
15 recommendations for such legislation and administrative
16 action as the Secretary determines appropriate.

17 **PART III—IMPROVING STAFF TRAINING**

18 **SEC. 6121. DEMENTIA AND ABUSE PREVENTION TRAINING.**

19 (a) SKILLED NURSING FACILITIES.—

20 (1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I)
21 of the Social Security Act (42 U.S.C. 1395i-
22 3(f)(2)(A)(i)(I)) is amended by inserting “(includ-
23 ing, in the case of initial training and, if the Sec-
24 retary determines appropriate, in the case of ongo-

1 ing training, dementia management training, and
2 patient abuse prevention training” before “, (II)”.

3 (2) CLARIFICATION OF DEFINITION OF NURSE
4 AIDE.—Section 1819(b)(5)(F) of the Social Security
5 Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by
6 adding at the end the following flush sentence:

7 “Such term includes an individual who provides
8 such services through an agency or under a
9 contract with the facility.”.

10 (b) NURSING FACILITIES.—

11 (1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I)
12 of the Social Security Act (42 U.S.C.
13 1396r(f)(2)(A)(i)(I)) is amended by inserting “(in-
14 cluding, in the case of initial training and, if the
15 Secretary determines appropriate, in the case of on-
16 going training, dementia management training, and
17 patient abuse prevention training” before “, (II)”.

18 (2) CLARIFICATION OF DEFINITION OF NURSE
19 AIDE.—Section 1919(b)(5)(F) of the Social Security
20 Act (42 U.S.C. 1396r(b)(5)(F)) is amended by add-
21 ing at the end the following flush sentence:

22 “Such term includes an individual who provides
23 such services through an agency or under a
24 contract with the facility.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall take effect 1 year after the date of the
3 enactment of this Act.

4 **Subtitle C—Nationwide Program**
5 **for National and State Back-**
6 **ground Checks on Direct Pa-**
7 **tient Access Employees of Long-**
8 **term Care Facilities and Pro-**
9 **viders**

10 **SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND**
11 **STATE BACKGROUND CHECKS ON DIRECT PA-**
12 **TIENT ACCESS EMPLOYEES OF LONG-TERM**
13 **CARE FACILITIES AND PROVIDERS.**

14 (a) IN GENERAL.—The Secretary of Health and
15 Human Services (in this section referred to as the “Sec-
16 retary”), shall establish a program to identify efficient, ef-
17 fective, and economical procedures for long term care fa-
18 cilities or providers to conduct background checks on pro-
19 spective direct patient access employees on a nationwide
20 basis (in this subsection, such program shall be referred
21 to as the “nationwide program”). Except for the following
22 modifications, the Secretary shall carry out the nationwide
23 program under similar terms and conditions as the pilot
24 program under section 307 of the Medicare Prescription
25 Drug, Improvement, and Modernization Act of 2003 (Pub-

1 lie Law 108–173; 117 Stat. 2257), including the prohibi-
2 tion on hiring abusive workers and the authorization of
3 the imposition of penalties by a participating State under
4 subsection (b)(3)(A) and (b)(6), respectively, of such sec-
5 tion 307:

6 (1) AGREEMENTS.—

7 (A) NEWLY PARTICIPATING STATES.—The
8 Secretary shall enter into agreements with each
9 State—

10 (i) that the Secretary has not entered
11 into an agreement with under subsection
12 (c)(1) of such section 307;

13 (ii) that agrees to conduct background
14 checks under the nationwide program on a
15 Statewide basis; and

16 (iii) that submits an application to the
17 Secretary containing such information and
18 at such time as the Secretary may specify.

19 (B) CERTAIN PREVIOUSLY PARTICIPATING
20 STATES.—The Secretary shall enter into agree-
21 ments with each State—

22 (i) that the Secretary has entered into
23 an agreement with under such subsection
24 (c)(1), but only in the case where such
25 agreement did not require the State to

1 conduct background checks under the pro-
2 gram established under subsection (a) of
3 such section 307 on a Statewide basis;

4 (ii) that agrees to conduct background
5 checks under the nationwide program on a
6 Statewide basis; and

7 (iii) that submits an application to the
8 Secretary containing such information and
9 at such time as the Secretary may specify.

10 (2) NONAPPLICATION OF SELECTION CRI-
11 TERIA.—The selection criteria required under sub-
12 section (c)(3)(B) of such section 307 shall not apply.

13 (3) REQUIRED FINGERPRINT CHECK AS PART
14 OF CRIMINAL HISTORY BACKGROUND CHECK.—The
15 procedures established under subsection (b)(1) of
16 such section 307 shall—

17 (A) require that the long-term care facility
18 or provider (or the designated agent of the
19 long-term care facility or provider) obtain State
20 and national criminal history background
21 checks on the prospective employee through
22 such means as the Secretary determines appro-
23 priate, efficient, and effective that utilize a
24 search of State-based abuse and neglect reg-
25 istries and databases, including the abuse and

1 neglect registries of another State in the case
2 where a prospective employee previously resided
3 in that State, State criminal history records,
4 the records of any proceedings in the State that
5 may contain disqualifying information about
6 prospective employees (such as proceedings con-
7 ducted by State professional licensing and dis-
8 ciplinary boards and State Medicaid Fraud
9 Control Units), and Federal criminal history
10 records, including a fingerprint check using the
11 Integrated Automated Fingerprint Identifica-
12 tion System of the Federal Bureau of Investiga-
13 tion;

14 (B) require States to describe and test
15 methods that reduce duplicative fingerprinting,
16 including providing for the development of “rap
17 back” capability by the State such that, if a di-
18 rect patient access employee of a long-term care
19 facility or provider is convicted of a crime fol-
20 lowing the initial criminal history background
21 check conducted with respect to such employee,
22 and the employee’s fingerprints match the
23 prints on file with the State law enforcement
24 department, the department will immediately
25 inform the State and the State will immediately

1 inform the long-term care facility or provider
2 which employs the direct patient access em-
3 ployee of such conviction; and

4 (C) require that criminal history back-
5 ground checks conducted under the nationwide
6 program remain valid for a period of time speci-
7 fied by the Secretary.

8 (4) STATE REQUIREMENTS.—An agreement en-
9 tered into under paragraph (1) shall require that a
10 participating State—

11 (A) be responsible for monitoring compli-
12 ance with the requirements of the nationwide
13 program;

14 (B) have procedures in place to—

15 (i) conduct screening and criminal his-
16 tory background checks under the nation-
17 wide program in accordance with the re-
18 quirements of this section;

19 (ii) monitor compliance by long-term
20 care facilities and providers with the proce-
21 dures and requirements of the nationwide
22 program;

23 (iii) as appropriate, provide for a pro-
24 visional period of employment by a long-
25 term care facility or provider of a direct

1 patient access employee, not to exceed 60
2 days, pending completion of the required
3 criminal history background check and, in
4 the case where the employee has appealed
5 the results of such background check,
6 pending completion of the appeals process,
7 during which the employee shall be subject
8 to direct on-site supervision (in accordance
9 with procedures established by the State to
10 ensure that a long-term care facility or
11 provider furnishes such direct on-site su-
12 pervision);

13 (iv) provide an independent process by
14 which a provisional employee or an em-
15 ployee may appeal or dispute the accuracy
16 of the information obtained in a back-
17 ground check performed under the nation-
18 wide program, including the specification
19 of criteria for appeals for direct patient ac-
20 cess employees found to have disqualifying
21 information which shall include consider-
22 ation of the passage of time, extenuating
23 circumstances, demonstration of rehabilita-
24 tion, and relevancy of the particular dis-

1 qualifying information with respect to the
2 current employment of the individual;

3 (v) provide for the designation of a
4 single State agency as responsible for—

5 (I) overseeing the coordination of
6 any State and national criminal his-
7 tory background checks requested by
8 a long-term care facility or provider
9 (or the designated agent of the long-
10 term care facility or provider) utilizing
11 a search of State and Federal crimi-
12 nal history records, including a finger-
13 print check of such records;

14 (II) overseeing the design of ap-
15 propriate privacy and security safe-
16 guards for use in the review of the re-
17 sults of any State or national criminal
18 history background checks conducted
19 regarding a prospective direct patient
20 access employee to determine whether
21 the employee has any conviction for a
22 relevant crime;

23 (III) immediately reporting to
24 the long-term care facility or provider
25 that requested the criminal history

1 background check the results of such
2 review; and

3 (IV) in the case of an employee
4 with a conviction for a relevant crime
5 that is subject to reporting under sec-
6 tion 1128E of the Social Security Act
7 (42 U.S.C. 1320a-7e), reporting the
8 existence of such conviction to the
9 database established under that sec-
10 tion;

11 (vi) determine which individuals are
12 direct patient access employees (as defined
13 in paragraph (6)(B)) for purposes of the
14 nationwide program;

15 (vii) as appropriate, specify offenses,
16 including convictions for violent crimes, for
17 purposes of the nationwide program; and

18 (viii) describe and test methods that
19 reduce duplicative fingerprinting, including
20 providing for the development of “rap
21 back” capability such that, if a direct pa-
22 tient access employee of a long-term care
23 facility or provider is convicted of a crime
24 following the initial criminal history back-
25 ground check conducted with respect to

1 such employee, and the employee's finger-
2 prints match the prints on file with the
3 State law enforcement department—

4 (I) the department will imme-
5 diately inform the State agency des-
6 ignated under clause (v) and such
7 agency will immediately inform the fa-
8 cility or provider which employs the
9 direct patient access employee of such
10 conviction; and

11 (II) the State will provide, or will
12 require the facility to provide, to the
13 employee a copy of the results of the
14 criminal history background check
15 conducted with respect to the em-
16 ployee at no charge in the case where
17 the individual requests such a copy.

18 (5) PAYMENTS.—

19 (A) NEWLY PARTICIPATING STATES.—

20 (i) IN GENERAL.—As part of the ap-
21 plication submitted by a State under para-
22 graph (1)(A)(iii), the State shall guar-
23 antee, with respect to the costs to be in-
24 curred by the State in carrying out the na-
25 tionwide program, that the State will make

1 available (directly or through donations
2 from public or private entities) a particular
3 amount of non-Federal contributions, as a
4 condition of receiving the Federal match
5 under clause (ii).

6 (ii) FEDERAL MATCH.—The payment
7 amount to each State that the Secretary
8 enters into an agreement with under para-
9 graph (1)(A) shall be 3 times the amount
10 that the State guarantees to make avail-
11 able under clause (i), except that in no
12 case may the payment amount exceed
13 \$3,000,000.

14 (B) PREVIOUSLY PARTICIPATING
15 STATES.—

16 (i) IN GENERAL.—As part of the ap-
17 plication submitted by a State under para-
18 graph (1)(B)(iii), the State shall guar-
19 antee, with respect to the costs to be in-
20 curred by the State in carrying out the na-
21 tionwide program, that the State will make
22 available (directly or through donations
23 from public or private entities) a particular
24 amount of non-Federal contributions, as a

1 condition of receiving the Federal match
2 under clause (ii).

3 (ii) FEDERAL MATCH.—The payment
4 amount to each State that the Secretary
5 enters into an agreement with under para-
6 graph (1)(B) shall be 3 times the amount
7 that the State guarantees to make avail-
8 able under clause (i), except that in no
9 case may the payment amount exceed
10 \$1,500,000.

11 (6) DEFINITIONS.—Under the nationwide pro-
12 gram:

13 (A) CONVICTION FOR A RELEVANT
14 CRIME.—The term “conviction for a relevant
15 crime” means any Federal or State criminal
16 conviction for—

17 (i) any offense described in section
18 1128(a) of the Social Security Act (42
19 U.S.C. 1320a-7); or

20 (ii) such other types of offenses as a
21 participating State may specify for pur-
22 poses of conducting the program in such
23 State.

24 (B) DISQUALIFYING INFORMATION.—The
25 term “disqualifying information” means a con-

1 viction for a relevant crime or a finding of pa-
2 tient or resident abuse.

3 (C) FINDING OF PATIENT OR RESIDENT
4 ABUSE.—The term “finding of patient or resi-
5 dent abuse” means any substantiated finding
6 by a State agency under section 1819(g)(1)(C)
7 or 1919(g)(1)(C) of the Social Security Act (42
8 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a
9 Federal agency that a direct patient access em-
10 ployee has committed—

11 (i) an act of patient or resident abuse
12 or neglect or a misappropriation of patient
13 or resident property; or

14 (ii) such other types of acts as a par-
15 ticipating State may specify for purposes
16 of conducting the program in such State.

17 (D) DIRECT PATIENT ACCESS EM-
18 PLOYEE.—The term “direct patient access em-
19 ployee” means any individual who has access to
20 a patient or resident of a long-term care facility
21 or provider through employment or through a
22 contract with such facility or provider and has
23 duties that involve (or may involve) one-on-one
24 contact with a patient or resident of the facility
25 or provider, as determined by the State for pur-

1 poses of the nationwide program. Such term
2 does not include a volunteer unless the volun-
3 teer has duties that are equivalent to the duties
4 of a direct patient access employee and those
5 duties involve (or may involve) one-on-one con-
6 tact with a patient or resident of the long-term
7 care facility or provider.

8 (E) LONG-TERM CARE FACILITY OR PRO-
9 VIDER.—The term “long-term care facility or
10 provider” means the following facilities or pro-
11 viders which receive payment for services under
12 title XVIII or XIX of the Social Security Act:

13 (i) A skilled nursing facility (as de-
14 fined in section 1819(a) of the Social Secu-
15 rity Act (42 U.S.C. 1395i–3(a))).

16 (ii) A nursing facility (as defined in
17 section 1919(a) of such Act (42 U.S.C.
18 1396r(a))).

19 (iii) A home health agency.

20 (iv) A provider of hospice care (as de-
21 fined in section 1861(dd)(1) of such Act
22 (42 U.S.C. 1395x(dd)(1))).

23 (v) A long-term care hospital (as de-
24 scribed in section 1886(d)(1)(B)(iv) of

1 such Act (42 U.S.C.
2 1395ww(d)(1)(B)(iv)).

3 (vi) A provider of personal care serv-
4 ices.

5 (vii) A provider of adult day care.

6 (viii) A residential care provider that
7 arranges for, or directly provides, long-
8 term care services, including an assisted
9 living facility that provides a level of care
10 established by the Secretary.

11 (ix) An intermediate care facility for
12 the mentally retarded (as defined in sec-
13 tion 1905(d) of such Act (42 U.S.C.
14 1396d(d))).

15 (x) Any other facility or provider of
16 long-term care services under such titles as
17 the participating State determines appro-
18 priate.

19 (7) EVALUATION AND REPORT.—

20 (A) EVALUATION.—

21 (i) IN GENERAL.—The Inspector Gen-
22 eral of the Department of Health and
23 Human Services shall conduct an evalua-
24 tion of the nationwide program.

1 (ii) INCLUSION OF SPECIFIC TOP-
2 ICS.—The evaluation conducted under
3 clause (i) shall include the following:

4 (I) A review of the various proce-
5 dures implemented by participating
6 States for long-term care facilities or
7 providers, including staffing agencies,
8 to conduct background checks of di-
9 rect patient access employees under
10 the nationwide program and identi-
11 fication of the most appropriate, effi-
12 cient, and effective procedures for
13 conducting such background checks.

14 (II) An assessment of the costs
15 of conducting such background checks
16 (including start up and administrative
17 costs).

18 (III) A determination of the ex-
19 tent to which conducting such back-
20 ground checks leads to any unin-
21 tended consequences, including a re-
22 duction in the available workforce for
23 long-term care facilities or providers.

24 (IV) An assessment of the impact
25 of the nationwide program on reduc-

1 ing the number of incidents of neglect,
2 abuse, and misappropriation of resi-
3 dent property to the extent prac-
4 ticable.

5 (V) An evaluation of other as-
6 pects of the nationwide program, as
7 determined appropriate by the Sec-
8 retary.

9 (B) REPORT.—Not later than 180 days
10 after the completion of the nationwide program,
11 the Inspector General of the Department of
12 Health and Human Services shall submit a re-
13 port to Congress containing the results of the
14 evaluation conducted under subparagraph (A).

15 (b) FUNDING.—

16 (1) NOTIFICATION.—The Secretary of Health
17 and Human Services shall notify the Secretary of
18 the Treasury of the amount necessary to carry out
19 the nationwide program under this section for the
20 period of fiscal years 2010 through 2012, except
21 that in no case shall such amount exceed
22 \$160,000,000.

23 (2) TRANSFER OF FUNDS.—

24 (A) IN GENERAL.—Out of any funds in the
25 Treasury not otherwise appropriated, the Sec-

1 retary of the Treasury shall provide for the
 2 transfer to the Secretary of Health and Human
 3 Services of the amount specified as necessary to
 4 carry out the nationwide program under para-
 5 graph (1). Such amount shall remain available
 6 until expended.

7 (B) RESERVATION OF FUNDS FOR CON-
 8 DUCT OF EVALUATION.—The Secretary may re-
 9 serve not more than \$3,000,000 of the amount
 10 transferred under subparagraph (A) to provide
 11 for the conduct of the evaluation under sub-
 12 section (a)(7)(A).

13 **Subtitle D—Patient-Centered** 14 **Outcomes Research**

15 **SEC. 6301. PATIENT-CENTERED OUTCOMES RESEARCH.**

16 (a) IN GENERAL.—Title XI of the Social Security Act
 17 (42 U.S.C. 1301 et seq.) is amended by adding at the end
 18 the following new part:

19 “PART D—COMPARATIVE CLINICAL EFFECTIVENESS
 20 RESEARCH

21 “COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH

22 “SEC. 1181. (a) DEFINITIONS.—In this section:

23 “(1) BOARD.—The term ‘Board’ means the
 24 Board of Governors established under subsection (f).

1 “(2) COMPARATIVE CLINICAL EFFECTIVENESS
2 RESEARCH; RESEARCH.—

3 “(A) IN GENERAL.—The terms ‘compara-
4 tive clinical effectiveness research’ and ‘re-
5 search’ mean research evaluating and com-
6 paring health outcomes and the clinical effec-
7 tiveness, risks, and benefits of 2 or more med-
8 ical treatments, services, and items described in
9 subparagraph (B).

10 “(B) MEDICAL TREATMENTS, SERVICES,
11 AND ITEMS DESCRIBED.—The medical treat-
12 ments, services, and items described in this sub-
13 paragraph are health care interventions, proto-
14 cols for treatment, care management, and deliv-
15 ery, procedures, medical devices, diagnostic
16 tools, pharmaceuticals (including drugs and
17 biologicals), integrative health practices, and
18 any other strategies or items being used in the
19 treatment, management, and diagnosis of, or
20 prevention of illness or injury in, individuals.

21 “(3) CONFLICT OF INTEREST.—The term ‘con-
22 flict of interest’ means an association, including a fi-
23 nancial or personal association, that have the poten-
24 tial to bias or have the appearance of biasing an in-

1 individual's decisions in matters related to the Insti-
2 tute or the conduct of activities under this section.

3 “(4) REAL CONFLICT OF INTEREST.—The term
4 ‘real conflict of interest’ means any instance where
5 a member of the Board, the methodology committee
6 established under subsection (d)(6), or an advisory
7 panel appointed under subsection (d)(4), or a close
8 relative of such member, has received or could re-
9 ceive either of the following:

10 “(A) A direct financial benefit of any
11 amount deriving from the result or findings of
12 a study conducted under this section.

13 “(B) A financial benefit from individuals
14 or companies that own or manufacture medical
15 treatments, services, or items to be studied
16 under this section that in the aggregate exceeds
17 \$10,000 per year. For purposes of the pre-
18 ceding sentence, a financial benefit includes
19 honoraria, fees, stock, or other financial benefit
20 and the current value of the member or close
21 relative's already existing stock holdings, in ad-
22 dition to any direct financial benefit deriving
23 from the results or findings of a study con-
24 ducted under this section.

1 “(b) PATIENT-CENTERED OUTCOMES RESEARCH IN-
2 STITUTE.—

3 “(1) ESTABLISHMENT.—There is authorized to
4 be established a nonprofit corporation, to be known
5 as the ‘Patient-Centered Outcomes Research Insti-
6 tute’ (referred to in this section as the ‘Institute’)
7 which is neither an agency nor establishment of the
8 United States Government.

9 “(2) APPLICATION OF PROVISIONS.—The Insti-
10 tute shall be subject to the provisions of this section,
11 and, to the extent consistent with this section, to the
12 District of Columbia Nonprofit Corporation Act.

13 “(3) FUNDING OF COMPARATIVE CLINICAL EF-
14 FECTIVENESS RESEARCH.—For fiscal year 2010 and
15 each subsequent fiscal year, amounts in the Patient-
16 Centered Outcomes Research Trust Fund (referred
17 to in this section as the ‘PCORTF’) under section
18 9511 of the Internal Revenue Code of 1986 shall be
19 available, without further appropriation, to the Insti-
20 tute to carry out this section.

21 “(c) PURPOSE.—The purpose of the Institute is to
22 assist patients, clinicians, purchasers, and policy-makers
23 in making informed health decisions by advancing the
24 quality and relevance of evidence concerning the manner
25 in which diseases, disorders, and other health conditions

1 can effectively and appropriately be prevented, diagnosed,
2 treated, monitored, and managed through research and
3 evidence synthesis that considers variations in patient sub-
4 populations, and the dissemination of research findings
5 with respect to the relative health outcomes, clinical effec-
6 tiveness, and appropriateness of the medical treatments,
7 services, and items described in subsection (a)(2)(B).

8 “(d) DUTIES.—

9 “(1) IDENTIFYING RESEARCH PRIORITIES AND
10 ESTABLISHING RESEARCH PROJECT AGENDA.—

11 “(A) IDENTIFYING RESEARCH PRIOR-
12 ITIES.—The Institute shall identify national
13 priorities for research, taking into account fac-
14 tors of disease incidence, prevalence, and bur-
15 den in the United States (with emphasis on
16 chronic conditions), gaps in evidence in terms of
17 clinical outcomes, practice variations and health
18 disparities in terms of delivery and outcomes of
19 care, the potential for new evidence to improve
20 patient health, well-being, and the quality of
21 care, the effect on national expenditures associ-
22 ated with a health care treatment, strategy, or
23 health conditions, as well as patient needs, out-
24 comes, and preferences, the relevance to pa-
25 tients and clinicians in making informed health

1 decisions, and priorities in the National Strat-
2 egy for quality care established under section
3 399H of the Public Health Service Act that are
4 consistent with this section.

5 “(B) ESTABLISHING RESEARCH PROJECT
6 AGENDA.—The Institute shall establish and up-
7 date a research project agenda for research to
8 address the priorities identified under subpara-
9 graph (A), taking into consideration the types
10 of research that might address each priority
11 and the relative value (determined based on the
12 cost of conducting research compared to the po-
13 tential usefulness of the information produced
14 by research) associated with the different types
15 of research, and such other factors as the Insti-
16 tute determines appropriate.

17 “(2) CARRYING OUT RESEARCH PROJECT AGEN-
18 DA.—

19 “(A) RESEARCH.—The Institute shall
20 carry out the research project agenda estab-
21 lished under paragraph (1)(B) in accordance
22 with the methodological standards adopted
23 under paragraph (9) using methods, including
24 the following:

1 “(i) Systematic reviews and assess-
2 ments of existing and future research and
3 evidence including original research con-
4 ducted subsequent to the date of the enact-
5 ment of this section.

6 “(ii) Primary research, such as ran-
7 domized clinical trials, molecularly in-
8 formed trials, and observational studies.

9 “(iii) Any other methodologies rec-
10 ommended by the methodology committee
11 established under paragraph (6) that are
12 adopted by the Board under paragraph
13 (9).

14 “(B) CONTRACTS FOR THE MANAGEMENT
15 OF FUNDING AND CONDUCT OF RESEARCH.—

16 “(i) CONTRACTS.—

17 “(I) IN GENERAL.—In accord-
18 ance with the research project agenda
19 established under paragraph (1)(B),
20 the Institute shall enter into contracts
21 for the management of funding and
22 conduct of research in accordance
23 with the following:

1 “(aa) Appropriate agencies
2 and instrumentalities of the Fed-
3 eral Government.

4 “(bb) Appropriate academic
5 research, private sector research,
6 or study-conducting entities.

7 “(II) PREFERENCE.—In entering
8 into contracts under subclause (I), the
9 Institute shall give preference to the
10 Agency for Healthcare Research and
11 Quality and the National Institutes of
12 Health, but only if the research to be
13 conducted or managed under such
14 contract is authorized by the gov-
15 erning statutes of such Agency or In-
16 stitutes.

17 “(ii) CONDITIONS FOR CONTRACTS.—
18 A contract entered into under this sub-
19 paragraph shall require that the agency,
20 instrumentality, or other entity—

21 “(I) abide by the transparency
22 and conflicts of interest requirements
23 under subsection (h) that apply to the
24 Institute with respect to the research

1 managed or conducted under such
2 contract;

3 “(II) comply with the methodo-
4 logical standards adopted under para-
5 graph (9) with respect to such re-
6 search;

7 “(III) consult with the expert ad-
8 visory panels for clinical trials and
9 rare disease appointed under clauses
10 (ii) and (iii), respectively, of para-
11 graph (4)(A);

12 “(IV) subject to clause (iv), per-
13 mit a researcher who conducts origi-
14 nal research under the contract for
15 the agency, instrumentality, or other
16 entity to have such research published
17 in a peer-reviewed journal or other
18 publication;

19 “(V) have appropriate processes
20 in place to manage data privacy and
21 meet ethical standards for the re-
22 search;

23 “(VI) comply with the require-
24 ments of the Institute for making the

1 information available to the public
2 under paragraph (8); and

3 “(VII) comply with other terms
4 and conditions determined necessary
5 by the Institute to carry out the re-
6 search agenda adopted under para-
7 graph (2).

8 “(iii) COVERAGE OF COPAYMENTS OR
9 COINSURANCE.—A contract entered into
10 under this subparagraph may allow for the
11 coverage of copayments or coinsurance, or
12 allow for other appropriate measures, to
13 the extent that such coverage or other
14 measures are necessary to preserve the va-
15 lidity of a research project, such as in the
16 case where the research project must be
17 blinded.

18 “(iv) REQUIREMENTS FOR PUBLICA-
19 TION OF RESEARCH.—Any research pub-
20 lished under clause (ii)(IV) shall be within
21 the bounds of and entirely consistent with
22 the evidence and findings produced under
23 the contract with the Institute under this
24 subparagraph. If the Institute determines
25 that those requirements are not met, the

1 Institute shall not enter into another con-
2 tract with the agency, instrumentality, or
3 entity which managed or conducted such
4 research for a period determined appro-
5 priate by the Institute (but not less than
6 5 years).

7 “(C) REVIEW AND UPDATE OF EVI-
8 DENCE.—The Institute shall review and update
9 evidence on a periodic basis as appropriate.

10 “(D) TAKING INTO ACCOUNT POTENTIAL
11 DIFFERENCES.—Research shall be designed, as
12 appropriate, to take into account the potential
13 for differences in the effectiveness of health
14 care treatments, services, and items as used
15 with various subpopulations, such as racial and
16 ethnic minorities, women, age, and groups of
17 individuals with different comorbidities, genetic
18 and molecular sub-types, or quality of life pref-
19 erences and include members of such sub-
20 populations as subjects in the research as fea-
21 sible and appropriate.

22 “(E) DIFFERENCES IN TREATMENT MO-
23 DALITIES.—Research shall be designed, as ap-
24 propriate, to take into account different charac-
25 teristics of treatment modalities that may affect

1 research outcomes, such as the phase of the
2 treatment modality in the innovation cycle and
3 the impact of the skill of the operator of the
4 treatment modality.

5 “(3) DATA COLLECTION.—

6 “(A) IN GENERAL.—The Secretary shall,
7 with appropriate safeguards for privacy, make
8 available to the Institute such data collected by
9 the Centers for Medicare & Medicaid Services
10 under the programs under titles XVIII, XIX,
11 and XXI, as well as provide access to the data
12 networks developed under section 937(f) of the
13 Public Health Service Act, as the Institute and
14 its contractors may require to carry out this
15 section. The Institute may also request and ob-
16 tain data from Federal, State, or private enti-
17 ties, including data from clinical databases and
18 registries.

19 “(B) USE OF DATA.—The Institute shall
20 only use data provided to the Institute under
21 subparagraph (A) in accordance with laws and
22 regulations governing the release and use of
23 such data, including applicable confidentiality
24 and privacy standards.

25 “(4) APPOINTING EXPERT ADVISORY PANELS.—

1 “(A) APPOINTMENT.—

2 “(i) IN GENERAL.—The Institute may
3 appoint permanent or ad hoc expert advi-
4 sory panels as determined appropriate to
5 assist in identifying research priorities and
6 establishing the research project agenda
7 under paragraph (1) and for other pur-
8 poses.

9 “(ii) EXPERT ADVISORY PANELS FOR
10 CLINICAL TRIALS.—The Institute shall ap-
11 point expert advisory panels in carrying
12 out randomized clinical trials under the re-
13 search project agenda under paragraph
14 (2)(A)(ii). Such expert advisory panels
15 shall advise the Institute and the agency,
16 instrumentality, or entity conducting the
17 research on the research question involved
18 and the research design or protocol, includ-
19 ing important patient subgroups and other
20 parameters of the research. Such panels
21 shall be available as a resource for tech-
22 nical questions that may arise during the
23 conduct of such research.

24 “(iii) EXPERT ADVISORY PANEL FOR
25 RARE DISEASE.—In the case of a research

1 study for rare disease, the Institute shall
2 appoint an expert advisory panel for pur-
3 poses of assisting in the design of the re-
4 search study and determining the relative
5 value and feasibility of conducting the re-
6 search study.

7 “(B) COMPOSITION.—An expert advisory
8 panel appointed under subparagraph (A) shall
9 include representatives of practicing and re-
10 search clinicians, patients, and experts in sci-
11 entific and health services research, health serv-
12 ices delivery, and evidence-based medicine who
13 have experience in the relevant topic, and as ap-
14 propriate, experts in integrative health and pri-
15 mary prevention strategies. The Institute may
16 include a technical expert of each manufacturer
17 or each medical technology that is included
18 under the relevant topic, project, or category
19 for which the panel is established.

20 “(5) SUPPORTING PATIENT AND CONSUMER
21 REPRESENTATIVES.—The Institute shall provide
22 support and resources to help patient and consumer
23 representatives effectively participate on the Board
24 and expert advisory panels appointed by the Insti-
25 tute under paragraph (4).

1 “(6) ESTABLISHING METHODOLOGY COM-
2 MITTEE.—

3 “(A) IN GENERAL.—The Institute shall es-
4 tablish a standing methodology committee to
5 carry out the functions described in subpara-
6 graph (C).

7 “(B) APPOINTMENT AND COMPOSITION.—
8 The methodology committee established under
9 subparagraph (A) shall be composed of not
10 more than 15 members appointed by the Comp-
11 troller General of the United States. Members
12 appointed to the methodology committee shall
13 be experts in their scientific field, such as
14 health services research, clinical research, com-
15 parative clinical effectiveness research, bio-
16 statistics, genomics, and research methodolo-
17 gies. Stakeholders with such expertise may be
18 appointed to the methodology committee. In ad-
19 dition to the members appointed under the first
20 sentence, the Directors of the National Insti-
21 tutes of Health and the Agency for Healthcare
22 Research and Quality (or their designees) shall
23 each be included as members of the method-
24 ology committee.

1 “(C) FUNCTIONS.—Subject to subpara-
2 graph (D), the methodology committee shall
3 work to develop and improve the science and
4 methods of comparative clinical effectiveness re-
5 search by, not later than 18 months after the
6 establishment of the Institute, directly or
7 through subcontract, developing and periodi-
8 cally updating the following:

9 “(i) Methodological standards for re-
10 search. Such methodological standards
11 shall provide specific criteria for internal
12 validity, generalizability, feasibility, and
13 timeliness of research and for health out-
14 comes measures, risk adjustment, and
15 other relevant aspects of research and as-
16 sessment with respect to the design of re-
17 search. Any methodological standards de-
18 veloped and updated under this subclause
19 shall be scientifically based and include
20 methods by which new information, data,
21 or advances in technology are considered
22 and incorporated into ongoing research
23 projects by the Institute, as appropriate.
24 The process for developing and updating
25 such standards shall include input from

1 relevant experts, stakeholders, and deci-
2 sionmakers, and shall provide opportunities
3 for public comment. Such standards shall
4 also include methods by which patient sub-
5 populations can be accounted for and eval-
6 uated in different types of research. As ap-
7 propriate, such standards shall build on ex-
8 isting work on methodological standards
9 for defined categories of health interven-
10 tions and for each of the major categories
11 of comparative clinical effectiveness re-
12 search methods (determined as of the date
13 of enactment of the Patient Protection and
14 Affordable Care Act).

15 “(ii) A translation table that is de-
16 signed to provide guidance and act as a
17 reference for the Board to determine re-
18 search methods that are most likely to ad-
19 dress each specific research question.

20 “(D) CONSULTATION AND CONDUCT OF
21 EXAMINATIONS.—The methodology committee
22 may consult and contract with the Institute of
23 Medicine of the National Academies and aca-
24 demic, nonprofit, or other private and govern-
25 mental entities with relevant expertise to carry

1 out activities described in subparagraph (C)
2 and may consult with relevant stakeholders to
3 carry out such activities.

4 “(E) REPORTS.—The methodology com-
5 mittee shall submit reports to the Board on the
6 committee’s performance of the functions de-
7 scribed in subparagraph (C). Reports shall con-
8 tain recommendations for the Institute to adopt
9 methodological standards developed and up-
10 dated by the methodology committee as well as
11 other actions deemed necessary to comply with
12 such methodological standards.

13 “(7) PROVIDING FOR A PEER-REVIEW PROCESS
14 FOR PRIMARY RESEARCH.—

15 “(A) IN GENERAL.—The Institute shall en-
16 sure that there is a process for peer review of
17 primary research described in subparagraph
18 (A)(ii) of paragraph (2) that is conducted under
19 such paragraph. Under such process—

20 “(i) evidence from such primary re-
21 search shall be reviewed to assess scientific
22 integrity and adherence to methodological
23 standards adopted under paragraph (9);
24 and

1 “(ii) a list of the names of individuals
2 contributing to any peer-review process
3 during the preceding year or years shall be
4 made public and included in annual reports
5 in accordance with paragraph (10)(D).

6 “(B) COMPOSITION.—Such peer-review
7 process shall be designed in a manner so as to
8 avoid bias and conflicts of interest on the part
9 of the reviewers and shall be composed of ex-
10 perts in the scientific field relevant to the re-
11 search under review.

12 “(C) USE OF EXISTING PROCESSES.—

13 “(i) PROCESSES OF ANOTHER ENTI-
14 TY.—In the case where the Institute enters
15 into a contract or other agreement with
16 another entity for the conduct or manage-
17 ment of research under this section, the
18 Institute may utilize the peer-review proc-
19 ess of such entity if such process meets the
20 requirements under subparagraphs (A) and
21 (B).

22 “(ii) PROCESSES OF APPROPRIATE
23 MEDICAL JOURNALS.—The Institute may
24 utilize the peer-review process of appro-
25 priate medical journals if such process

1 meets the requirements under subpara-
2 graphs (A) and (B).

3 “(8) RELEASE OF RESEARCH FINDINGS.—

4 “(A) IN GENERAL.—The Institute shall,
5 not later than 90 days after the conduct or re-
6 ceipt of research findings under this part, make
7 such research findings available to clinicians,
8 patients, and the general public. The Institute
9 shall ensure that the research findings—

10 “(i) convey the findings of research in
11 a manner that is comprehensible and use-
12 ful to patients and providers in making
13 health care decisions;

14 “(ii) fully convey findings and discuss
15 considerations specific to certain sub-
16 populations, risk factors, and
17 comorbidities, as appropriate;

18 “(iii) include limitations of the re-
19 search and what further research may be
20 needed as appropriate;

21 “(iv) not be construed as mandates
22 for practice guidelines, coverage rec-
23 ommendations, payment, or policy rec-
24 ommendations; and

1 “(v) not include any data which would
2 violate the privacy of research participants
3 or any confidentiality agreements made
4 with respect to the use of data under this
5 section.

6 “(B) DEFINITION OF RESEARCH FIND-
7 INGS.—In this paragraph, the term ‘research
8 findings’ means the results of a study or assess-
9 ment.

10 “(9) ADOPTION.—Subject to subsection (h)(1),
11 the Institute shall adopt the national priorities iden-
12 tified under paragraph (1)(A), the research project
13 agenda established under paragraph (1)(B), the
14 methodological standards developed and updated by
15 the methodology committee under paragraph
16 (6)(C)(i), and any peer-review process provided
17 under paragraph (7) by majority vote. In the case
18 where the Institute does not adopt such processes in
19 accordance with the preceding sentence, the proc-
20 esses shall be referred to the appropriate staff or en-
21 tity within the Institute (or, in the case of the meth-
22 odological standards, the methodology committee)
23 for further review.

24 “(10) ANNUAL REPORTS.—The Institute shall
25 submit an annual report to Congress and the Presi-

1 dent, and shall make the annual report available to
2 the public. Such report shall contain—

3 “(A) a description of the activities con-
4 ducted under this section, research priorities
5 identified under paragraph (1)(A) and methodo-
6 logical standards developed and updated by the
7 methodology committee under paragraph
8 (6)(C)(i) that are adopted under paragraph (9)
9 during the preceding year;

10 “(B) the research project agenda and
11 budget of the Institute for the following year;

12 “(C) any administrative activities con-
13 ducted by the Institute during the preceding
14 year;

15 “(D) the names of individuals contributing
16 to any peer-review process under paragraph (7),
17 without identifying them with a particular re-
18 search project; and

19 “(E) any other relevant information (in-
20 cluding information on the membership of the
21 Board, expert advisory panels, methodology
22 committee, and the executive staff of the Insti-
23 tute, any conflicts of interest with respect to
24 these individuals, and any bylaws adopted by
25 the Board during the preceding year).

1 “(e) ADMINISTRATION.—

2 “(1) IN GENERAL.—Subject to paragraph (2),
3 the Board shall carry out the duties of the Institute.

4 “(2) NONDELEGABLE DUTIES.—The activities
5 described in subsections (d)(1) and (d)(9) are non-
6 delegable.

7 “(f) BOARD OF GOVERNORS.—

8 “(1) IN GENERAL.—The Institute shall have a
9 Board of Governors, which shall consist of the fol-
10 lowing members:

11 “(A) The Director of Agency for
12 Healthcare Research and Quality (or the Direc-
13 tor’s designee).

14 “(B) The Director of the National Insti-
15 tutes of Health (or the Director’s designee).

16 “(C) Seventeen members appointed, not
17 later than 6 months after the date of enactment
18 of this section, by the Comptroller General of
19 the United States as follows:

20 “(i) 3 members representing patients
21 and health care consumers.

22 “(ii) 5 members representing physi-
23 cians and providers, including at least 1
24 surgeon, nurse, State-licensed integrative

1 health care practitioner, and representative
2 of a hospital.

3 “(iii) 3 members representing private
4 payers, of whom at least 1 member shall
5 represent health insurance issuers and at
6 least 1 member shall represent employers
7 who self-insure employee benefits.

8 “(iv) 3 members representing pharma-
9 ceutical, device, and diagnostic manufac-
10 turers or developers.

11 “(v) 1 member representing quality
12 improvement or independent health service
13 researchers.

14 “(vi) 2 members representing the
15 Federal Government or the States, includ-
16 ing at least 1 member representing a Fed-
17 eral health program or agency.

18 “(2) QUALIFICATIONS.—The Board shall rep-
19 resent a broad range of perspectives and collectively
20 have scientific expertise in clinical health sciences re-
21 search, including epidemiology, decisions sciences,
22 health economics, and statistics. In appointing the
23 Board, the Comptroller General of the United States
24 shall consider and disclose any conflicts of interest
25 in accordance with subsection (h)(4)(B). Members of

1 the Board shall be recused from relevant Institute
2 activities in the case where the member (or an im-
3 mediate family member of such member) has a real
4 conflict of interest directly related to the research
5 project or the matter that could affect or be affected
6 by such participation.

7 “(3) TERMS; VACANCIES.—A member of the
8 Board shall be appointed for a term of 6 years, ex-
9 cept with respect to the members first appointed,
10 whose terms of appointment shall be staggered even-
11 ly over 2-year increments. No individual shall be ap-
12 pointed to the Board for more than 2 terms. Vacan-
13 cies shall be filled in the same manner as the origi-
14 nal appointment was made.

15 “(4) CHAIRPERSON AND VICE-CHAIRPERSON.—
16 The Comptroller General of the United States shall
17 designate a Chairperson and Vice Chairperson of the
18 Board from among the members of the Board. Such
19 members shall serve as Chairperson or Vice Chair-
20 person for a period of 3 years.

21 “(5) COMPENSATION.—Each member of the
22 Board who is not an officer or employee of the Fed-
23 eral Government shall be entitled to compensation
24 (equivalent to the rate provided for level IV of the
25 Executive Schedule under section 5315 of title 5,

1 United States Code) and expenses incurred while
2 performing the duties of the Board. An officer or
3 employee of the Federal government who is a mem-
4 ber of the Board shall be exempt from compensa-
5 tion.

6 “(6) DIRECTOR AND STAFF; EXPERTS AND
7 CONSULTANTS.—The Board may employ and fix the
8 compensation of an Executive Director and such
9 other personnel as may be necessary to carry out the
10 duties of the Institute and may seek such assistance
11 and support of, or contract with, experts and con-
12 sultants that may be necessary for the performance
13 of the duties of the Institute.

14 “(7) MEETINGS AND HEARINGS.—The Board
15 shall meet and hold hearings at the call of the
16 Chairperson or a majority of its members. Meetings
17 not solely concerning matters of personnel shall be
18 advertised at least 7 days in advance and open to
19 the public. A majority of the Board members shall
20 constitute a quorum, but a lesser number of mem-
21 bers may meet and hold hearings.

22 “(g) FINANCIAL AND GOVERNMENTAL OVER-
23 SIGHT.—

24 “(1) CONTRACT FOR AUDIT.—The Institute
25 shall provide for the conduct of financial audits of

1 the Institute on an annual basis by a private entity
2 with expertise in conducting financial audits.

3 “(2) REVIEW AND ANNUAL REPORTS.—

4 “(A) REVIEW.—The Comptroller General
5 of the United States shall review the following:

6 “(i) Not less frequently than on an
7 annual basis, the financial audits con-
8 ducted under paragraph (1).

9 “(ii) Not less frequently than every 5
10 years, the processes established by the In-
11 stitute, including the research priorities
12 and the conduct of research projects, in
13 order to determine whether information
14 produced by such research projects is ob-
15 jective and credible, is produced in a man-
16 ner consistent with the requirements under
17 this section, and is developed through a
18 transparent process.

19 “(iii) Not less frequently than every 5
20 years, the dissemination and training ac-
21 tivities and data networks established
22 under section 937 of the Public Health
23 Service Act, including the methods and
24 products used to disseminate research, the
25 types of training conducted and supported,

1 and the types and functions of the data
2 networks established, in order to determine
3 whether the activities and data are pro-
4 duced in a manner consistent with the re-
5 quirements under such section.

6 “(iv) Not less frequently than every 5
7 years, the overall effectiveness of activities
8 conducted under this section and the dis-
9 semination, training, and capacity building
10 activities conducted under section 937 of
11 the Public Health Service Act. Such review
12 shall include an analysis of the extent to
13 which research findings are used by health
14 care decision-makers, the effect of the dis-
15 semination of such findings on reducing
16 practice variation and disparities in health
17 care, and the effect of the research con-
18 ducted and disseminated on innovation and
19 the health care economy of the United
20 States.

21 “(v) Not later than 8 years after the
22 date of enactment of this section, the ade-
23 quacy and use of the funding for the Insti-
24 tute and the activities conducted under
25 section 937 of the Public Health Service

1 Act, including a determination as to
2 whether, based on the utilization of re-
3 search findings by public and private pay-
4 ers, funding sources for the Patient-Cen-
5 tered Outcomes Research Trust Fund
6 under section 9511 of the Internal Rev-
7 enue Code of 1986 are appropriate and
8 whether such sources of funding should be
9 continued or adjusted.

10 “(B) ANNUAL REPORTS.—Not later than
11 April 1 of each year, the Comptroller General
12 of the United States shall submit to Congress
13 a report containing the results of the review
14 conducted under subparagraph (A) with respect
15 to the preceding year (or years, if applicable),
16 together with recommendations for such legisla-
17 tion and administrative action as the Comp-
18 troller General determines appropriate.

19 “(h) ENSURING TRANSPARENCY, CREDIBILITY, AND
20 ACCESS.—The Institute shall establish procedures to en-
21 sure that the following requirements for ensuring trans-
22 parency, credibility, and access are met:

23 “(1) PUBLIC COMMENT PERIODS.—The Insti-
24 tute shall provide for a public comment period of not
25 less than 45 days and not more than 60 days prior

1 to the adoption under subsection (d)(9) of the na-
2 tional priorities identified under subsection
3 (d)(1)(A), the research project agenda established
4 under subsection (d)(1)(B), the methodological
5 standards developed and updated by the method-
6 ology committee under subsection (d)(6)(C)(i), and
7 the peer-review process provided under paragraph
8 (7), and after the release of draft findings with re-
9 spect to systematic reviews of existing research and
10 evidence.

11 “(2) ADDITIONAL FORUMS.—The Institute shall
12 support forums to increase public awareness and ob-
13 tain and incorporate public input and feedback
14 through media (such as an Internet website) on re-
15 search priorities, research findings, and other duties,
16 activities, or processes the Institute determines ap-
17 propriate.

18 “(3) PUBLIC AVAILABILITY.—The Institute
19 shall make available to the public and disclose
20 through the official public Internet website of the In-
21 stitute the following:

22 “(A) Information contained in research
23 findings as specified in subsection (d)(9).

24 “(B) The process and methods for the con-
25 duct of research, including the identity of the

1 entity and the investigators conducting such re-
2 search and any conflicts of interests of such
3 parties, any direct or indirect links the entity
4 has to industry, and research protocols, includ-
5 ing measures taken, methods of research and
6 analysis, research results, and such other infor-
7 mation the Institute determines appropriate)
8 concurrent with the release of research findings.

9 “(C) Notice of public comment periods
10 under paragraph (1), including deadlines for
11 public comments.

12 “(D) Subsequent comments received dur-
13 ing each of the public comment periods.

14 “(E) In accordance with applicable laws
15 and processes and as the Institute determines
16 appropriate, proceedings of the Institute.

17 “(4) DISCLOSURE OF CONFLICTS OF INTER-
18 EST.—

19 “(A) IN GENERAL.—A conflict of interest
20 shall be disclosed in the following manner:

21 “(i) By the Institute in appointing
22 members to an expert advisory panel under
23 subsection (d)(4), in selecting individuals
24 to contribute to any peer-review process

1 under subsection (d)(7), and for employ-
2 ment as executive staff of the Institute.

3 “(ii) By the Comptroller General in
4 appointing members of the methodology
5 committee under subsection (d)(6);

6 “(iii) By the Institute in the annual
7 report under subsection (d)(10), except
8 that, in the case of individuals contributing
9 to any such peer review process, such de-
10 scription shall be in a manner such that
11 those individuals cannot be identified with
12 a particular research project.

13 “(B) MANNER OF DISCLOSURE.—Conflicts
14 of interest shall be disclosed as described in
15 subparagraph (A) as soon as practicable on the
16 Internet web site of the Institute and of the
17 Government Accountability Office. The informa-
18 tion disclosed under the preceding sentence
19 shall include the type, nature, and magnitude of
20 the interests of the individual involved, except
21 to the extent that the individual recuses himself
22 or herself from participating in the consider-
23 ation of or any other activity with respect to the
24 study as to which the potential conflict exists.

1 “(i) RULES.—The Institute, its Board or staff, shall
2 be prohibited from accepting gifts, bequeaths, or donations
3 of services or property. In addition, the Institute shall be
4 prohibited from establishing a corporation or generating
5 revenues from activities other than as provided under this
6 section.

7 “(j) RULES OF CONSTRUCTION.—

8 “(1) COVERAGE.—Nothing in this section shall
9 be construed—

10 “(A) to permit the Institute to mandate
11 coverage, reimbursement, or other policies for
12 any public or private payer; or

13 “(B) as preventing the Secretary from cov-
14 ering the routine costs of clinical care received
15 by an individual entitled to, or enrolled for, ben-
16 efits under title XVIII, XIX, or XXI in the case
17 where such individual is participating in a clin-
18 ical trial and such costs would otherwise be cov-
19 ered under such title with respect to the bene-
20 ficiary.”.

21 (b) DISSEMINATION AND BUILDING CAPACITY FOR
22 RESEARCH.—Title IX of the Public Health Service Act
23 (42 U.S.C. 299 et seq.), as amended by section 3606, is
24 further amended by inserting after section 936 the fol-
25 lowing:

1 **“SEC. 937. DISSEMINATION AND BUILDING CAPACITY FOR**
2 **RESEARCH.**

3 “(a) IN GENERAL.—

4 “(1) DISSEMINATION.—The Office of Commu-
5 nication and Knowledge Transfer (referred to in this
6 section as the ‘Office’) at the Agency for Healthcare
7 Research and Quality (or any other relevant office
8 designated by Agency for Healthcare Research and
9 Quality), in consultation with the National Institutes
10 of Health, shall broadly disseminate the research
11 findings that are published by the Patient Centered
12 Outcomes Research Institute established under sec-
13 tion 1181(b) of the Social Security Act (referred to
14 in this section as the ‘Institute’) and other govern-
15 ment-funded research relevant to comparative clin-
16 ical effectiveness research. The Office shall create in-
17 formational tools that organize and disseminate re-
18 search findings for physicians, health care providers,
19 patients, payers, and policy makers. The Office shall
20 also develop a publicly available resource database
21 that collects and contains government-funded evi-
22 dence and research from public, private, not-for
23 profit, and academic sources.

24 “(2) REQUIREMENTS.—The Office shall provide
25 for the dissemination of the Institute’s research find-
26 ings and government-funded research relevant to

1 comparative clinical effectiveness research to physi-
2 cians, health care providers, patients, vendors of
3 health information technology focused on clinical de-
4 cision support, appropriate professional associations,
5 and Federal and private health plans. Materials, fo-
6 rums, and media used to disseminate the findings,
7 informational tools, and resource databases shall—

8 “(A) include a description of consider-
9 ations for specific subpopulations, the research
10 methodology, and the limitations of the re-
11 search, and the names of the entities, agencies,
12 instrumentalities, and individuals who con-
13 ducted any research which was published by the
14 Institute; and

15 “(B) not be construed as mandates, guide-
16 lines, or recommendations for payment, cov-
17 erage, or treatment.

18 “(b) INCORPORATION OF RESEARCH FINDINGS.—

19 The Office, in consultation with relevant medical and clin-
20 ical associations, shall assist users of health information
21 technology focused on clinical decision support to promote
22 the timely incorporation of research findings disseminated
23 under subsection (a) into clinical practices and to promote
24 the ease of use of such incorporation.

1 “(c) FEEDBACK.—The Office shall establish a pro-
2 cess to receive feedback from physicians, health care pro-
3 viders, patients, and vendors of health information tech-
4 nology focused on clinical decision support, appropriate
5 professional associations, and Federal and private health
6 plans about the value of the information disseminated and
7 the assistance provided under this section.

8 “(d) RULE OF CONSTRUCTION.—Nothing in this sec-
9 tion shall preclude the Institute from making its research
10 findings publicly available as required under section
11 1181(d)(8) of the Social Security Act.

12 “(e) TRAINING OF RESEARCHERS.—The Agency for
13 Health Care Research and Quality, in consultation with
14 the National Institutes of Health, shall build capacity for
15 comparative clinical effectiveness research by establishing
16 a grant program that provides for the training of research-
17 ers in the methods used to conduct such research, includ-
18 ing systematic reviews of existing research and primary
19 research such as clinical trials. At a minimum, such train-
20 ing shall be in methods that meet the methodological
21 standards adopted under section 1181(d)(9) of the Social
22 Security Act.

23 “(f) BUILDING DATA FOR RESEARCH.—The Sec-
24 retary shall provide for the coordination of relevant Fed-
25 eral health programs to build data capacity for compara-

1 tive clinical effectiveness research, including the develop-
 2 ment and use of clinical registries and health outcomes
 3 research data networks, in order to develop and maintain
 4 a comprehensive, interoperable data network to collect,
 5 link, and analyze data on outcomes and effectiveness from
 6 multiple sources, including electronic health records.

7 “(g) AUTHORITY TO CONTRACT WITH THE INSTI-
 8 TUTE.—Agencies and instrumentalities of the Federal
 9 Government may enter into agreements with the Institute,
 10 and accept and retain funds, for the conduct and support
 11 of research described in this part, provided that the re-
 12 search to be conducted or supported under such agree-
 13 ments is authorized under the governing statutes of such
 14 agencies and instrumentalities.”.

15 (c) IN GENERAL.—Part D of title XI of the Social
 16 Security Act, as added by subsection (a), is amended by
 17 adding at the end the following new section:

18 “LIMITATIONS ON CERTAIN USES OF COMPARATIVE
 19 CLINICAL EFFECTIVENESS RESEARCH

20 “SEC. 1182. (a) The Secretary may only use evidence
 21 and findings from research conducted under section 1181
 22 to make a determination regarding coverage under title
 23 XVIII if such use is through an iterative and transparent
 24 process which includes public comment and considers the
 25 effect on subpopulations.

26 “(b) Nothing in section 1181 shall be construed as—

1 “(1) superceding or modifying the coverage of
2 items or services under title XVIII that the Sec-
3 retary determines are reasonable and necessary
4 under section 1862(l)(1); or

5 “(2) authorizing the Secretary to deny coverage
6 of items or services under such title solely on the
7 basis of comparative clinical effectiveness research.

8 “(c)(1) The Secretary shall not use evidence or find-
9 ings from comparative clinical effectiveness research con-
10 ducted under section 1181 in determining coverage, reim-
11 bursement, or incentive programs under title XVIII in a
12 manner that treats extending the life of an elderly, dis-
13 abled, or terminally ill individual as of lower value than
14 extending the life of an individual who is younger, non-
15 disabled, or not terminally ill.

16 “(2) Paragraph (1) shall not be construed as pre-
17 venting the Secretary from using evidence or findings from
18 such comparative clinical effectiveness research in deter-
19 mining coverage, reimbursement, or incentive programs
20 under title XVIII based upon a comparison of the dif-
21 ference in the effectiveness of alternative treatments in ex-
22 tending an individual’s life due to the individual’s age, dis-
23 ability, or terminal illness.

24 “(d)(1) The Secretary shall not use evidence or find-
25 ings from comparative clinical effectiveness research con-

1 ducted under section 1181 in determining coverage, reim-
2 bursement, or incentive programs under title XVIII in a
3 manner that precludes, or with the intent to discourage,
4 an individual from choosing a health care treatment based
5 on how the individual values the tradeoff between extend-
6 ing the length of their life and the risk of disability.

7 “(2)(A) Paragraph (1) shall not be construed to—

8 “(i) limit the application of differential copay-
9 ments under title XVIII based on factors such as
10 cost or type of service; or

11 “(ii) prevent the Secretary from using evidence
12 or findings from such comparative clinical effective-
13 ness research in determining coverage, reimburse-
14 ment, or incentive programs under such title based
15 upon a comparison of the difference in the effective-
16 ness of alternative health care treatments in extend-
17 ing an individual’s life due to that individual’s age,
18 disability, or terminal illness.

19 “(3) Nothing in the provisions of, or amendments
20 made by the Patient Protection and Affordable Care Act,
21 shall be construed to limit comparative clinical effective-
22 ness research or any other research, evaluation, or dis-
23 semination of information concerning the likelihood that
24 a health care treatment will result in disability.

1 “(e) The Patient-Centered Outcomes Research Insti-
 2 tute established under section 1181(b)(1) shall not develop
 3 or employ a dollars-per-quality adjusted life year (or simi-
 4 lar measure that discounts the value of a life because of
 5 an individual’s disability) as a threshold to establish what
 6 type of health care is cost effective or recommended. The
 7 Secretary shall not utilize such an adjusted life year (or
 8 such a similar measure) as a threshold to determine cov-
 9 erage, reimbursement, or incentive programs under title
 10 XVIII.”.

11 (d) IN GENERAL.—Part D of title XI of the Social
 12 Security Act, as added by subsection (a) and amended by
 13 subsection (c), is amended by adding at the end the fol-
 14 lowing new section:

15 “TRUST FUND TRANSFERS TO PATIENT-CENTERED
 16 OUTCOMES RESEARCH TRUST FUND

17 “SEC. 1183. (a) IN GENERAL.—The Secretary shall
 18 provide for the transfer, from the Federal Hospital Insur-
 19 ance Trust Fund under section 1817 and the Federal Sup-
 20 plementary Medical Insurance Trust Fund under section
 21 1841, in proportion (as estimated by the Secretary) to the
 22 total expenditures during such fiscal year that are made
 23 under title XVIII from the respective trust fund, to the
 24 Patient-Centered Outcomes Research Trust Fund (re-
 25 ferred to in this section as the ‘PCORTF’) under section

1 9511 of the Internal Revenue Code of 1986, of the fol-
2 lowing:

3 “(1) For fiscal year 2013, an amount equal to
4 \$1 multiplied by the average number of individuals
5 entitled to benefits under part A, or enrolled under
6 part B, of title XVIII during such fiscal year.

7 “(2) For each of fiscal years 2014, 2015, 2016,
8 2017, 2018, and 2019, an amount equal to \$2 mul-
9 tplied by the average number of individuals entitled
10 to benefits under part A, or enrolled under part B,
11 of title XVIII during such fiscal year.

12 “(b) ADJUSTMENTS FOR INCREASES IN HEALTH
13 CARE SPENDING.—In the case of any fiscal year begin-
14 ning after September 30, 2014, the dollar amount in effect
15 under subsection (a)(2) for such fiscal year shall be equal
16 to the sum of such dollar amount for the previous fiscal
17 year (determined after the application of this subsection),
18 plus an amount equal to the product of—

19 “(1) such dollar amount for the previous fiscal
20 year, multiplied by

21 “(2) the percentage increase in the projected
22 per capita amount of National Health Expenditures,
23 as most recently published by the Secretary before
24 the beginning of the fiscal year.”.

1 (e) PATIENT-CENTERED OUTCOMES RESEARCH
 2 TRUST FUND; FINANCING FOR TRUST FUND.—

3 (1) ESTABLISHMENT OF TRUST FUND.—

4 (A) IN GENERAL.—Subchapter A of chap-
 5 ter 98 of the Internal Revenue Code of 1986
 6 (relating to establishment of trust funds) is
 7 amended by adding at the end the following
 8 new section:

9 **“SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH**
 10 **TRUST FUND.**

11 “(a) CREATION OF TRUST FUND.—There is estab-
 12 lished in the Treasury of the United States a trust fund
 13 to be known as the ‘Patient-Centered Outcomes Research
 14 Trust Fund’ (hereafter in this section referred to as the
 15 ‘PCORTF’), consisting of such amounts as may be appro-
 16 priated or credited to such Trust Fund as provided in this
 17 section and section 9602(b).

18 “(b) TRANSFERS TO FUND.—

19 “(1) APPROPRIATION.—There are hereby ap-
 20 propriated to the Trust Fund the following:

21 “(A) For fiscal year 2010, \$10,000,000.

22 “(B) For fiscal year 2011, \$50,000,000.

23 “(C) For fiscal year 2012, \$150,000,000.

24 “(D) For fiscal year 2013—

1 “(i) an amount equivalent to the net
2 revenues received in the Treasury from the
3 fees imposed under subchapter B of chap-
4 ter 34 (relating to fees on health insurance
5 and self-insured plans) for such fiscal year;
6 and

7 “(ii) \$150,000,000.

8 “(E) For each of fiscal years 2014, 2015,
9 2016, 2017, 2018, and 2019—

10 “(i) an amount equivalent to the net
11 revenues received in the Treasury from the
12 fees imposed under subchapter B of chap-
13 ter 34 (relating to fees on health insurance
14 and self-insured plans) for such fiscal year;
15 and

16 “(ii) \$150,000,000.

17 The amounts appropriated under subpara-
18 graphs (A), (B), (C), (D)(ii), and (E)(ii) shall
19 be transferred from the general fund of the
20 Treasury, from funds not otherwise appro-
21 priated.

22 “(2) TRUST FUND TRANSFERS.—In addition to
23 the amounts appropriated under paragraph (1),
24 there shall be credited to the PCORTF the amounts

1 transferred under section 1183 of the Social Secu-
2 rity Act.

3 “(3) LIMITATION ON TRANSFERS TO PCORTF.—

4 No amount may be appropriated or transferred to
5 the PCORTF on and after the date of any expendi-
6 ture from the PCORTF which is not an expenditure
7 permitted under this section. The determination of
8 whether an expenditure is so permitted shall be
9 made without regard to—

10 “(A) any provision of law which is not con-
11 tained or referenced in this chapter or in a rev-
12 enue Act, and

13 “(B) whether such provision of law is a
14 subsequently enacted provision or directly or in-
15 directly seeks to waive the application of this
16 paragraph.

17 “(c) TRUSTEE.—The Secretary of the Treasury shall
18 be a trustee of the PCORTF.

19 “(d) EXPENDITURES FROM FUND.—

20 “(1) AMOUNTS AVAILABLE TO THE PATIENT-
21 CENTERED OUTCOMES RESEARCH INSTITUTE.—Sub-
22 ject to paragraph (2), amounts in the PCORTF are
23 available, without further appropriation, to the Pa-
24 tient-Centered Outcomes Research Institute estab-
25 lished under section 1181(b) of the Social Security

1 Act for carrying out part D of title XI of the Social
2 Security Act (as in effect on the date of enactment
3 of such Act).

4 “(2) TRANSFER OF FUNDS.—

5 “(A) IN GENERAL.—The trustee of the
6 PCORTF shall provide for the transfer from
7 the PCORTF of 20 percent of the amounts ap-
8 propriated or credited to the PCORTF for each
9 of fiscal years 2011 through 2019 to the Sec-
10 retary of Health and Human Services to carry
11 out section 937 of the Public Health Service
12 Act.

13 “(B) AVAILABILITY.—Amounts transferred
14 under subparagraph (A) shall remain available
15 until expended.

16 “(C) REQUIREMENTS.—Of the amounts
17 transferred under subparagraph (A) with re-
18 spect to a fiscal year, the Secretary of Health
19 and Human Services shall distribute—

20 “(i) 80 percent to the Office of Com-
21 munication and Knowledge Transfer of the
22 Agency for Healthcare Research and Qual-
23 ity (or any other relevant office designated
24 by Agency for Healthcare Research and
25 Quality) to carry out the activities de-

1 scribed in section 937 of the Public Health
2 Service Act; and

3 “(ii) 20 percent to the Secretary to
4 carry out the activities described in such
5 section 937.

6 “(e) NET REVENUES.—For purposes of this section,
7 the term ‘net revenues’ means the amount estimated by
8 the Secretary of the Treasury based on the excess of—

9 “(1) the fees received in the Treasury under
10 subchapter B of chapter 34, over

11 “(2) the decrease in the tax imposed by chapter
12 1 resulting from the fees imposed by such sub-
13 chapter.

14 “(f) TERMINATION.—No amounts shall be available
15 for expenditure from the PCORTF after September 30,
16 2019, and any amounts in such Trust Fund after such
17 date shall be transferred to the general fund of the Treas-
18 ury.”.

19 (B) CLERICAL AMENDMENT.—The table of
20 sections for subchapter A of chapter 98 of such
21 Code is amended by adding at the end the fol-
22 lowing new item:

“Sec. 9511. Patient-centered outcomes research trust fund.”.

23 (2) FINANCING FOR FUND FROM FEES ON IN-
24 SURED AND SELF-INSURED HEALTH PLANS.—

1 (A) GENERAL RULE.—Chapter 34 of the
2 Internal Revenue Code of 1986 is amended by
3 adding at the end the following new subchapter:

4 **“Subchapter B—Insured and Self-Insured**
5 **Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

6 **“SEC. 4375. HEALTH INSURANCE.**

7 “(a) IMPOSITION OF FEE.—There is hereby imposed
8 on each specified health insurance policy for each policy
9 year ending after September 30, 2012, a fee equal to the
10 product of \$2 (\$1 in the case of policy years ending during
11 fiscal year 2013) multiplied by the average number of lives
12 covered under the policy.

13 “(b) LIABILITY FOR FEE.—The fee imposed by sub-
14 section (a) shall be paid by the issuer of the policy.

15 “(c) SPECIFIED HEALTH INSURANCE POLICY.—For
16 purposes of this section:

17 “(1) IN GENERAL.—Except as otherwise pro-
18 vided in this section, the term ‘specified health in-
19 surance policy’ means any accident or health insur-
20 ance policy (including a policy under a group health
21 plan) issued with respect to individuals residing in
22 the United States.

23 “(2) EXEMPTION FOR CERTAIN POLICIES.—The
24 term ‘specified health insurance policy’ does not in-

1 clude any insurance if substantially all of its cov-
2 erage is of excepted benefits described in section
3 9832(c).

4 “(3) TREATMENT OF PREPAID HEALTH COV-
5 ERAGE ARRANGEMENTS.—

6 “(A) IN GENERAL.—In the case of any ar-
7 rangement described in subparagraph (B), such
8 arrangement shall be treated as a specified
9 health insurance policy, and the person referred
10 to in such subparagraph shall be treated as the
11 issuer.

12 “(B) DESCRIPTION OF ARRANGEMENTS.—
13 An arrangement is described in this subpara-
14 graph if under such arrangement fixed pay-
15 ments or premiums are received as consider-
16 ation for any person’s agreement to provide or
17 arrange for the provision of accident or health
18 coverage to residents of the United States, re-
19 gardless of how such coverage is provided or ar-
20 ranged to be provided.

21 “(d) ADJUSTMENTS FOR INCREASES IN HEALTH
22 CARE SPENDING.—In the case of any policy year ending
23 in any fiscal year beginning after September 30, 2014, the
24 dollar amount in effect under subsection (a) for such pol-
25 icy year shall be equal to the sum of such dollar amount

1 for policy years ending in the previous fiscal year (deter-
 2 mined after the application of this subsection), plus an
 3 amount equal to the product of—

4 “(1) such dollar amount for policy years ending
 5 in the previous fiscal year, multiplied by

6 “(2) the percentage increase in the projected
 7 per capita amount of National Health Expenditures,
 8 as most recently published by the Secretary before
 9 the beginning of the fiscal year.

10 “(e) TERMINATION.—This section shall not apply to
 11 policy years ending after September 30, 2019.

12 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

13 “(a) IMPOSITION OF FEE.—In the case of any appli-
 14 cable self-insured health plan for each plan year ending
 15 after September 30, 2012, there is hereby imposed a fee
 16 equal to \$2 (\$1 in the case of plan years ending during
 17 fiscal year 2013) multiplied by the average number of lives
 18 covered under the plan.

19 “(b) LIABILITY FOR FEE.—

20 “(1) IN GENERAL.—The fee imposed by sub-
 21 section (a) shall be paid by the plan sponsor.

22 “(2) PLAN SPONSOR.—For purposes of para-
 23 graph (1) the term ‘plan sponsor’ means—

24 “(A) the employer in the case of a plan es-
 25 tablished or maintained by a single employer,

1 “(B) the employee organization in the case
2 of a plan established or maintained by an em-
3 ployee organization,

4 “(C) in the case of—

5 “(i) a plan established or maintained
6 by 2 or more employers or jointly by 1 or
7 more employers and 1 or more employee
8 organizations,

9 “(ii) a multiple employer welfare ar-
10 rangement, or

11 “(iii) a voluntary employees’ bene-
12 ficiary association described in section
13 501(c)(9), the association, committee, joint
14 board of trustees, or other similar group of
15 representatives of the parties who establish
16 or maintain the plan, or

17 “(D) the cooperative or association de-
18 scribed in subsection (c)(2)(F) in the case of a
19 plan established or maintained by such a coop-
20 erative or association.

21 “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—

22 For purposes of this section, the term ‘applicable self-in-
23 sured health plan’ means any plan for providing accident
24 or health coverage if—

1 “(1) any portion of such coverage is provided
2 other than through an insurance policy, and

3 “(2) such plan is established or maintained—

4 “(A) by 1 or more employers for the ben-
5 efit of their employees or former employees,

6 “(B) by 1 or more employee organizations
7 for the benefit of their members or former
8 members,

9 “(C) jointly by 1 or more employers and 1
10 or more employee organizations for the benefit
11 of employees or former employees,

12 “(D) by a voluntary employees’ beneficiary
13 association described in section 501(c)(9),

14 “(E) by any organization described in sec-
15 tion 501(c)(6), or

16 “(F) in the case of a plan not described in
17 the preceding subparagraphs, by a multiple em-
18 ployer welfare arrangement (as defined in sec-
19 tion 3(40) of Employee Retirement Income Se-
20 curity Act of 1974), a rural electric cooperative
21 (as defined in section 3(40)(B)(iv) of such Act),
22 or a rural telephone cooperative association (as
23 defined in section 3(40)(B)(v) of such Act).

24 “(d) ADJUSTMENTS FOR INCREASES IN HEALTH
25 CARE SPENDING.—In the case of any plan year ending

1 in any fiscal year beginning after September 30, 2014, the
2 dollar amount in effect under subsection (a) for such plan
3 year shall be equal to the sum of such dollar amount for
4 plan years ending in the previous fiscal year (determined
5 after the application of this subsection), plus an amount
6 equal to the product of—

7 “(1) such dollar amount for plan years ending
8 in the previous fiscal year, multiplied by

9 “(2) the percentage increase in the projected
10 per capita amount of National Health Expenditures,
11 as most recently published by the Secretary before
12 the beginning of the fiscal year.

13 “(e) TERMINATION.—This section shall not apply to
14 plan years ending after September 30, 2019.

15 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

16 “(a) DEFINITIONS.—For purposes of this sub-
17 chapter—

18 “(1) ACCIDENT AND HEALTH COVERAGE.—The
19 term ‘accident and health coverage’ means any cov-
20 erage which, if provided by an insurance policy,
21 would cause such policy to be a specified health in-
22 surance policy (as defined in section 4375(c)).

23 “(2) INSURANCE POLICY.—The term ‘insurance
24 policy’ means any policy or other instrument where-

1 by a contract of insurance is issued, renewed, or ex-
2 tended.

3 “(3) UNITED STATES.—The term ‘United
4 States’ includes any possession of the United States.

5 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

6 “(1) IN GENERAL.—For purposes of this sub-
7 chapter—

8 “(A) the term ‘person’ includes any gov-
9 ernmental entity, and

10 “(B) notwithstanding any other law or rule
11 of law, governmental entities shall not be ex-
12 empt from the fees imposed by this subchapter
13 except as provided in paragraph (2).

14 “(2) TREATMENT OF EXEMPT GOVERNMENTAL
15 PROGRAMS.—In the case of an exempt governmental
16 program, no fee shall be imposed under section 4375
17 or section 4376 on any covered life under such pro-
18 gram.

19 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-
20 FINED.—For purposes of this subchapter, the term
21 ‘exempt governmental program’ means—

22 “(A) any insurance program established
23 under title XVIII of the Social Security Act,

1 “(B) the medical assistance program es-
2 tablished by title XIX or XXI of the Social Se-
3 curity Act,

4 “(C) any program established by Federal
5 law for providing medical care (other than
6 through insurance policies) to individuals (or
7 the spouses and dependents thereof) by reason
8 of such individuals being members of the
9 Armed Forces of the United States or veterans,
10 and

11 “(D) any program established by Federal
12 law for providing medical care (other than
13 through insurance policies) to members of In-
14 dian tribes (as defined in section 4(d) of the In-
15 dian Health Care Improvement Act).

16 “(c) TREATMENT AS TAX.—For purposes of subtitle
17 F, the fees imposed by this subchapter shall be treated
18 as if they were taxes.

19 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-
20 standing any other provision of law, no amount collected
21 under this subchapter shall be covered over to any posses-
22 sion of the United States.”.

23 (B) CLERICAL AMENDMENTS.—

1 (i) Chapter 34 of such Code is amend-
 2 ed by striking the chapter heading and in-
 3 serting the following:

4 **“CHAPTER 34—TAXES ON CERTAIN**
 5 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

6 **“Subchapter A—Policies Issued By Foreign**
 7 **Insurers”.**

8 (ii) The table of chapters for subtitle
 9 D of such Code is amended by striking the
 10 item relating to chapter 34 and inserting
 11 the following new item:

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

12 (f) TAX-EXEMPT STATUS OF THE PATIENT-CEN-
 13 TERED OUTCOMES RESEARCH INSTITUTE.—Subsection
 14 501(l) of the Internal Revenue Code of 1986 is amended
 15 by adding at the end the following new paragraph:

16 “(4) The Patient-Centered Outcomes Research
 17 Institute established under section 1181(b) of the
 18 Social Security Act.”.

19 **SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COM-**
 20 **PARATIVE EFFECTIVENESS RESEARCH.**

21 Notwithstanding any other provision of law, the Fed-
 22 eral Coordinating Council for Comparative Effectiveness
 23 Research established under section 804 of Division A of

1 the American Recovery and Reinvestment Act of 2009 (42
2 U.S.C. 299b–8), including the requirement under sub-
3 section (e)(2) of such section, shall terminate on the date
4 of enactment of this Act.

5 **Subtitle E—Medicare, Medicaid,**
6 **and CHIP Program Integrity**
7 **Provisions**

8 **SEC. 6401. PROVIDER SCREENING AND OTHER ENROLL-**
9 **MENT REQUIREMENTS UNDER MEDICARE,**
10 **MEDICAID, AND CHIP.**

11 (a) **MEDICARE.**—Section 1866(j) of the Social Secu-
12 rity Act (42 U.S.C. 1395cc(j)) is amended—

13 (1) in paragraph (1)(A), by adding at the end
14 the following: “Such process shall include screening
15 of providers and suppliers in accordance with para-
16 graph (2), a provisional period of enhanced oversight
17 in accordance with paragraph (3), disclosure require-
18 ments in accordance with paragraph (4), the imposi-
19 tion of temporary enrollment moratoria in accord-
20 ance with paragraph (5), and the establishment of
21 compliance programs in accordance with paragraph
22 (6).”;

23 (2) by redesignating paragraph (2) as para-
24 graph (7); and

1 (3) by inserting after paragraph (1) the fol-
2 lowing:

3 “(2) PROVIDER SCREENING.—

4 “(A) PROCEDURES.—Not later than 180
5 days after the date of enactment of this para-
6 graph, the Secretary, in consultation with the
7 Inspector General of the Department of Health
8 and Human Services, shall establish procedures
9 under which screening is conducted with respect
10 to providers of medical or other items or serv-
11 ices and suppliers under the program under this
12 title, the Medicaid program under title XIX,
13 and the CHIP program under title XXI.

14 “(B) LEVEL OF SCREENING.—The Sec-
15 retary shall determine the level of screening
16 conducted under this paragraph according to
17 the risk of fraud, waste, and abuse, as deter-
18 mined by the Secretary, with respect to the cat-
19 egory of provider of medical or other items or
20 services or supplier. Such screening—

21 “(i) shall include a licensure check,
22 which may include such checks across
23 States; and

24 “(ii) may, as the Secretary determines
25 appropriate based on the risk of fraud,

1 waste, and abuse described in the pre-
2 ceding sentence, include—

3 “(I) a criminal background
4 check;

5 “(II) fingerprinting;

6 “(III) unscheduled and unan-
7 nounced site visits, including
8 preenrollment site visits;

9 “(IV) database checks (including
10 such checks across States); and

11 “(V) such other screening as the
12 Secretary determines appropriate.

13 “(C) APPLICATION FEES.—

14 “(i) INDIVIDUAL PROVIDERS.—Except
15 as provided in clause (iii), the Secretary
16 shall impose a fee on each individual pro-
17 vider of medical or other items or services
18 or supplier (such as a physician, physician
19 assistant, nurse practitioner, or clinical
20 nurse specialist) with respect to which
21 screening is conducted under this para-
22 graph in an amount equal to—

23 “(I) for 2010, \$200; and

24 “(II) for 2011 and each subse-
25 quent year, the amount determined

1 under this clause for the preceding
2 year, adjusted by the percentage
3 change in the consumer price index
4 for all urban consumers (all items;
5 United States city average) for the
6 12-month period ending with June of
7 the previous year.

8 “(ii) INSTITUTIONAL PROVIDERS.—
9 Except as provided in clause (iii), the Sec-
10 retary shall impose a fee on each institu-
11 tional provider of medical or other items or
12 services or supplier (such as a hospital or
13 skilled nursing facility) with respect to
14 which screening is conducted under this
15 paragraph in an amount equal to—

16 “(I) for 2010, \$500; and

17 “(II) for 2011 and each subse-
18 quent year, the amount determined
19 under this clause for the preceding
20 year, adjusted by the percentage
21 change in the consumer price index
22 for all urban consumers (all items;
23 United States city average) for the
24 12-month period ending with June of
25 the previous year.

1 “(iii) HARDSHIP EXCEPTION; WAIVER
2 FOR CERTAIN MEDICAID PROVIDERS.—The
3 Secretary may, on a case-by-case basis, ex-
4 empt a provider of medical or other items
5 or services or supplier from the imposition
6 of an application fee under this subpara-
7 graph if the Secretary determines that the
8 imposition of the application fee would re-
9 sult in a hardship. The Secretary may
10 waive the application fee under this sub-
11 paragraph for providers enrolled in a State
12 Medicaid program for whom the State
13 demonstrates that imposition of the fee
14 would impede beneficiary access to care.

15 “(iv) USE OF FUNDS.—Amounts col-
16 lected as a result of the imposition of a fee
17 under this subparagraph shall be used by
18 the Secretary for program integrity efforts,
19 including to cover the costs of conducting
20 screening under this paragraph and to
21 carry out this subsection and section
22 1128J.

23 “(D) APPLICATION AND ENFORCEMENT.—

24 “(i) NEW PROVIDERS OF SERVICES
25 AND SUPPLIERS.—The screening under

1 this paragraph shall apply, in the case of
2 a provider of medical or other items or
3 services or supplier who is not enrolled in
4 the program under this title, title XIX , or
5 title XXI as of the date of enactment of
6 this paragraph, on or after the date that is
7 1 year after such date of enactment.

8 “(ii) CURRENT PROVIDERS OF SERV-
9 ICES AND SUPPLIERS.—The screening
10 under this paragraph shall apply, in the
11 case of a provider of medical or other
12 items or services or supplier who is en-
13 rolled in the program under this title, title
14 XIX, or title XXI as of such date of enact-
15 ment, on or after the date that is 2 years
16 after such date of enactment.

17 “(iii) REVALIDATION OF ENROLL-
18 MENT.—Effective beginning on the date
19 that is 180 days after such date of enact-
20 ment, the screening under this paragraph
21 shall apply with respect to the revalidation
22 of enrollment of a provider of medical or
23 other items or services or supplier in the
24 program under this title, title XIX, or title
25 XXI.

1 “(iv) LIMITATION ON ENROLLMENT
2 AND REVALIDATION OF ENROLLMENT.—In
3 no case may a provider of medical or other
4 items or services or supplier who has not
5 been screened under this paragraph be ini-
6 tially enrolled or reenrolled in the program
7 under this title, title XIX, or title XXI on
8 or after the date that is 3 years after such
9 date of enactment.

10 “(E) EXPEDITED RULEMAKING.—The Sec-
11 retary may promulgate an interim final rule to
12 carry out this paragraph.

13 “(3) PROVISIONAL PERIOD OF ENHANCED
14 OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND
15 SUPPLIERS.—

16 “(A) IN GENERAL.—The Secretary shall
17 establish procedures to provide for a provisional
18 period of not less than 30 days and not more
19 than 1 year during which new providers of med-
20 ical or other items or services and suppliers, as
21 the Secretary determines appropriate, including
22 categories of providers or suppliers, would be
23 subject to enhanced oversight, such as prepay-
24 ment review and payment caps, under the pro-
25 gram under this title, the Medicaid program

1 under title XIX. and the CHIP program under
2 title XXI.

3 “(B) IMPLEMENTATION.—The Secretary
4 may establish by program instruction or other-
5 wise the procedures under this paragraph.

6 “(4) INCREASED DISCLOSURE REQUIRE-
7 MENTS.—

8 “(A) DISCLOSURE.—A provider of medical
9 or other items or services or supplier who sub-
10 mits an application for enrollment or revalida-
11 tion of enrollment in the program under this
12 title , title XIX, or title XXI on or after the
13 date that is 1 year after the date of enactment
14 of this paragraph shall disclose (in a form and
15 manner and at such time as determined by the
16 Secretary) any current or previous affiliation
17 (directly or indirectly) with a provider of med-
18 ical or other items or services or supplier that
19 has uncollected debt, has been or is subject to
20 a payment suspension under a Federal health
21 care program (as defined in section 1128B(f)),
22 has been excluded from participation under the
23 program under this title, the Medicaid program
24 under title XIX, or the CHIP program under

1 title XXI, or has had its billing privileges de-
2 nied or revoked.

3 “(B) AUTHORITY TO DENY ENROLL-
4 MENT.—If the Secretary determines that such
5 previous affiliation poses an undue risk of
6 fraud, waste, or abuse, the Secretary may deny
7 such application. Such a denial shall be subject
8 to appeal in accordance with paragraph (7).

9 “(5) AUTHORITY TO ADJUST PAYMENTS OF
10 PROVIDERS OF SERVICES AND SUPPLIERS WITH THE
11 SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE
12 OBLIGATIONS.—

13 “(A) IN GENERAL.—Notwithstanding any
14 other provision of this title, in the case of an
15 applicable provider of services or supplier, the
16 Secretary may make any necessary adjustments
17 to payments to the applicable provider of serv-
18 ices or supplier under the program under this
19 title in order to satisfy any past-due obligations
20 described in subparagraph (B)(ii) of an obli-
21 gated provider of services or supplier.

22 “(B) DEFINITIONS.—In this paragraph:

23 “(i) IN GENERAL.—The term ‘applica-
24 ble provider of services or supplier’ means
25 a provider of services or supplier that has

1 the same taxpayer identification number
2 assigned under section 6109 of the Inter-
3 nal Revenue Code of 1986 as is assigned
4 to the obligated provider of services or sup-
5 plier under such section, regardless of
6 whether the applicable provider of services
7 or supplier is assigned a different billing
8 number or national provider identification
9 number under the program under this title
10 than is assigned to the obligated provider
11 of services or supplier.

12 “(ii) OBLIGATED PROVIDER OF SERV-
13 ICES OR SUPPLIER.—The term ‘obligated
14 provider of services or supplier’ means a
15 provider of services or supplier that owes a
16 past-due obligation under the program
17 under this title (as determined by the Sec-
18 retary).

19 “(6) TEMPORARY MORATORIUM ON ENROLL-
20 MENT OF NEW PROVIDERS.—

21 “(A) IN GENERAL.—The Secretary may
22 impose a temporary moratorium on the enroll-
23 ment of new providers of services and suppliers,
24 including categories of providers of services and
25 suppliers, in the program under this title, under

1 the Medicaid program under title XIX, or
2 under the CHIP program under title XXI if the
3 Secretary determines such moratorium is nec-
4 essary to prevent or combat fraud, waste, or
5 abuse under either such program.

6 “(B) LIMITATION ON REVIEW.—There
7 shall be no judicial review under section 1869,
8 section 1878, or otherwise, of a temporary mor-
9 atorium imposed under subparagraph (A).

10 “(7) COMPLIANCE PROGRAMS.—

11 “(A) IN GENERAL.—On or after the date
12 of implementation determined by the Secretary
13 under subparagraph (C), a provider of medical
14 or other items or services or supplier within a
15 particular industry sector or category shall, as
16 a condition of enrollment in the program under
17 this title, title XIX, or title XXI, establish a
18 compliance program that contains the core ele-
19 ments established under subparagraph (B) with
20 respect to that provider or supplier and indus-
21 try or category.

22 “(B) ESTABLISHMENT OF CORE ELE-
23 MENTS.—The Secretary, in consultation with
24 the Inspector General of the Department of
25 Health and Human Services, shall establish

1 core elements for a compliance program under
2 subparagraph (A) for providers or suppliers
3 within a particular industry or category.

4 “(C) TIMELINE FOR IMPLEMENTATION.—

5 The Secretary shall determine the timeline for
6 the establishment of the core elements under
7 subparagraph (B) and the date of the imple-
8 mentation of subparagraph (A) for providers or
9 suppliers within a particular industry or cat-
10 egory. The Secretary shall, in determining such
11 date of implementation, consider the extent to
12 which the adoption of compliance programs by
13 a provider of medical or other items or services
14 or supplier is widespread in a particular indus-
15 try sector or with respect to a particular pro-
16 vider or supplier category.”.

17 (b) MEDICAID.—

18 (1) STATE PLAN AMENDMENT.—Section
19 1902(a) of the Social Security Act (42 U.S.C.
20 1396a(a)), as amended by section 4302(b), is
21 amended—

22 (A) in subsection (a)—

23 (i) by striking “and” at the end of
24 paragraph (75);

1 (ii) by striking the period at the end
2 of paragraph (76) and inserting a semi-
3 colon; and

4 (iii) by inserting after paragraph (76)
5 the following:

6 “(77) provide that the State shall comply with
7 provider and supplier screening, oversight, and re-
8 porting requirements in accordance with subsection
9 (ii);” and

10 (B) by adding at the end the following:

11 “(ii) PROVIDER AND SUPPLIER SCREENING, OVER-
12 SIGHT, AND REPORTING REQUIREMENTS.—For purposes
13 of subsection (a)(77), the requirements of this subsection
14 are the following:

15 “(1) SCREENING.—The State complies with the
16 process for screening providers and suppliers under
17 this title, as established by the Secretary under sec-
18 tion 1886(j)(2).

19 “(2) PROVISIONAL PERIOD OF ENHANCED
20 OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—
21 The State complies with procedures to provide for a
22 provisional period of enhanced oversight for new pro-
23 viders and suppliers under this title, as established
24 by the Secretary under section 1886(j)(3).

1 “(3) DISCLOSURE REQUIREMENTS.—The State
2 requires providers and suppliers under the State
3 plan or under a waiver of the plan to comply with
4 the disclosure requirements established by the Sec-
5 retary under section 1886(j)(4).

6 “(4) TEMPORARY MORATORIUM ON ENROLL-
7 MENT OF NEW PROVIDERS OR SUPPLIERS.—

8 “(A) TEMPORARY MORATORIUM IMPOSED
9 BY THE SECRETARY.—

10 “(i) IN GENERAL.—Subject to clause
11 (ii), the State complies with any temporary
12 moratorium on the enrollment of new pro-
13 viders or suppliers imposed by the Sec-
14 retary under section 1886(j)(6).

15 “(ii) EXCEPTION.—A State shall not
16 be required to comply with a temporary
17 moratorium described in clause (i) if the
18 State determines that the imposition of
19 such temporary moratorium would ad-
20 versely impact beneficiaries’ access to med-
21 ical assistance.

22 “(B) MORATORIUM ON ENROLLMENT OF
23 PROVIDERS AND SUPPLIERS.—At the option of
24 the State, the State imposes, for purposes of
25 entering into participation agreements with pro-

1 viders or suppliers under the State plan or
2 under a waiver of the plan, periods of enroll-
3 ment moratoria, or numerical caps or other lim-
4 its, for providers or suppliers identified by the
5 Secretary as being at high-risk for fraud, waste,
6 or abuse as necessary to combat fraud, waste,
7 or abuse, but only if the State determines that
8 the imposition of any such period, cap, or other
9 limits would not adversely impact beneficiaries'
10 access to medical assistance.

11 “(5) COMPLIANCE PROGRAMS.—The State re-
12 quires providers and suppliers under the State plan
13 or under a waiver of the plan to establish, in accord-
14 ance with the requirements of section 1866(j)(7), a
15 compliance program that contains the core elements
16 established under subparagraph (B) of that section
17 1866(j)(7) for providers or suppliers within a par-
18 ticular industry or category.

19 “(6) REPORTING OF ADVERSE PROVIDER AC-
20 TIONS.—The State complies with the national sys-
21 tem for reporting criminal and civil convictions,
22 sanctions, negative licensure actions, and other ad-
23 verse provider actions to the Secretary, through the
24 Administrator of the Centers for Medicare & Med-

1 Medicaid Services, in accordance with regulations of the
2 Secretary.

3 “(7) ENROLLMENT AND NPI OF ORDERING OR
4 REFERRING PROVIDERS.—The State requires—

5 “(A) all ordering or referring physicians or
6 other professionals to be enrolled under the
7 State plan or under a waiver of the plan as a
8 participating provider; and

9 “(B) the national provider identifier of any
10 ordering or referring physician or other profes-
11 sional to be specified on any claim for payment
12 that is based on an order or referral of the phy-
13 sician or other professional.

14 “(8) OTHER STATE OVERSIGHT.—Nothing in
15 this subsection shall be interpreted to preclude or
16 limit the ability of a State to engage in provider and
17 supplier screening or enhanced provider and supplier
18 oversight activities beyond those required by the Sec-
19 retary.”.

20 (2) DISCLOSURE OF MEDICARE TERMINATED
21 PROVIDERS AND SUPPLIERS TO STATES.—The Ad-
22 ministrators of the Centers for Medicare & Medicaid
23 Services shall establish a process for making avail-
24 able to the each State agency with responsibility for
25 administering a State Medicaid plan (or a waiver of

1 such plan) under title XIX of the Social Security
2 Act or a child health plan under title XXI the name,
3 national provider identifier, and other identifying in-
4 formation for any provider of medical or other items
5 or services or supplier under the Medicare program
6 under title XVIII or under the CHIP program under
7 title XXI that is terminated from participation
8 under that program within 30 days of the termi-
9 nation (and, with respect to all such providers or
10 suppliers who are terminated from the Medicare pro-
11 gram on the date of enactment of this Act, within
12 90 days of such date).

13 (3) CONFORMING AMENDMENT.—Section
14 1902(a)(23) of the Social Security Act (42 U.S.C.
15 1396a), is amended by inserting before the semi-
16 colon at the end the following: “or by a provider or
17 supplier to which a moratorium under subsection
18 (ii)(4) is applied during the period of such morato-
19 rium”.

20 (c) CHIP.—Section 2107(e)(1) of the Social Security
21 Act (42 U.S.C. 1397gg(e)(1)), as amended by section
22 2101(d), is amended—

23 (1) by redesignating subparagraphs (D)
24 through (M) as subparagraphs (E) through (N), re-
25 spectively; and

1 (2) by inserting after subparagraph (C), the fol-
 2 lowing:

3 “(D) Subsections (a)(77) and (ii) of sec-
 4 tion 1902 (relating to provider and supplier
 5 screening, oversight, and reporting require-
 6 ments).”.

7 **SEC. 6402. ENHANCED MEDICARE AND MEDICAID PRO-**
 8 **GRAM INTEGRITY PROVISIONS.**

9 (a) IN GENERAL.—Part A of title XI of the Social
 10 Security Act (42 U.S.C. 1301 et seq.), as amended by sec-
 11 tions 6002, 6004, and 6102, is amended by inserting after
 12 section 1128I the following new section:

13 **“SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEG-**
 14 **RITY PROVISIONS.**

15 “(a) DATA MATCHING.—

16 “(1) INTEGRATED DATA REPOSITORY.—

17 “(A) INCLUSION OF CERTAIN DATA.—

18 “(i) IN GENERAL.—The Integrated
 19 Data Repository of the Centers for Medi-
 20 care & Medicaid Services shall include, at
 21 a minimum, claims and payment data from
 22 the following:

23 “(I) The programs under titles
 24 XVIII and XIX (including parts A, B,
 25 C, and D of title XVIII).

1 “(II) The program under title
2 XXI.

3 “(III) Health-related programs
4 administered by the Secretary of Vet-
5 erans Affairs.

6 “(IV) Health-related programs
7 administered by the Secretary of De-
8 fense.

9 “(V) The program of old-age,
10 survivors, and disability insurance
11 benefits established under title II.

12 “(VI) The Indian Health Service
13 and the Contract Health Service pro-
14 gram.

15 “(ii) PRIORITY FOR INCLUSION OF
16 CERTAIN DATA.—Inclusion of the data de-
17 scribed in subclause (I) of such clause in
18 the Integrated Data Repository shall be a
19 priority. Data described in subclauses (II)
20 through (VI) of such clause shall be in-
21 cluded in the Integrated Data Repository
22 as appropriate.

23 “(B) DATA SHARING AND MATCHING.—

24 “(i) IN GENERAL.—The Secretary
25 shall enter into agreements with the indi-

1 individuals described in clause (ii) under which
2 such individuals share and match data in
3 the system of records of the respective
4 agencies of such individuals with data in
5 the system of records of the Department of
6 Health and Human Services for the pur-
7 pose of identifying potential fraud, waste,
8 and abuse under the programs under titles
9 XVIII and XIX.

10 “(ii) INDIVIDUALS DESCRIBED.—The
11 following individuals are described in this
12 clause:

13 “(I) The Commissioner of Social
14 Security.

15 “(II) The Secretary of Veterans
16 Affairs.

17 “(III) The Secretary of Defense.

18 “(IV) The Director of the Indian
19 Health Service.

20 “(iii) DEFINITION OF SYSTEM OF
21 RECORDS.—For purposes of this para-
22 graph, the term ‘system of records’ has the
23 meaning given such term in section
24 552a(a)(5) of title 5, United States Code.

1 “(2) ACCESS TO CLAIMS AND PAYMENT DATA-
2 BASES.—For purposes of conducting law enforce-
3 ment and oversight activities and to the extent con-
4 sistent with applicable information, privacy, security,
5 and disclosure laws, including the regulations pro-
6 mulgated under the Health Insurance Portability
7 and Accountability Act of 1996 and section 552a of
8 title 5, United States Code, and subject to any infor-
9 mation systems security requirements under such
10 laws or otherwise required by the Secretary, the In-
11 spector General of the Department of Health and
12 Human Services and the Attorney General shall
13 have access to claims and payment data of the De-
14 partment of Health and Human Services and its
15 contractors related to titles XVIII, XIX, and XXI.

16 “(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

17 “(1) IN GENERAL.—Notwithstanding and in ad-
18 dition to any other provision of law, the Inspector
19 General of the Department of Health and Human
20 Services may, for purposes of protecting the integ-
21 rity of the programs under titles XVIII and XIX,
22 obtain information from any individual (including a
23 beneficiary provided all applicable privacy protec-
24 tions are followed) or entity that—

1 “(A) is a provider of medical or other
2 items or services, supplier, grant recipient, con-
3 tractor, or subcontractor; or

4 “(B) directly or indirectly provides, orders,
5 manufactures, distributes, arranges for, pre-
6 scribes, supplies, or receives medical or other
7 items or services payable by any Federal health
8 care program (as defined in section 1128B(f))
9 regardless of how the item or service is paid
10 for, or to whom such payment is made.

11 “(2) INCLUSION OF CERTAIN INFORMATION.—
12 Information which the Inspector General may obtain
13 under paragraph (1) includes any supporting docu-
14 mentation necessary to validate claims for payment
15 or payments under title XVIII or XIX, including a
16 prescribing physician’s medical records for an indi-
17 vidual who is prescribed an item or service which is
18 covered under part B of title XVIII, a covered part
19 D drug (as defined in section 1860D–2(e)) for which
20 payment is made under an MA–PD plan under part
21 C of such title, or a prescription drug plan under
22 part D of such title, and any records necessary for
23 evaluation of the economy, efficiency, and effective-
24 ness of the programs under titles XVIII and XIX.

1 “(c) ADMINISTRATIVE REMEDY FOR KNOWING PAR-
2 PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD
3 SCHEME.—

4 “(1) IN GENERAL.—In addition to any other
5 applicable remedies, if an applicable individual has
6 knowingly participated in a Federal health care
7 fraud offense or a conspiracy to commit a Federal
8 health care fraud offense, the Secretary shall impose
9 an appropriate administrative penalty commensurate
10 with the offense or conspiracy.

11 “(2) APPLICABLE INDIVIDUAL.—For purposes
12 of paragraph (1), the term ‘applicable individual’
13 means an individual—

14 “(A) entitled to, or enrolled for, benefits
15 under part A of title XVIII or enrolled under
16 part B of such title;

17 “(B) eligible for medical assistance under
18 a State plan under title XIX or under a waiver
19 of such plan; or

20 “(C) eligible for child health assistance
21 under a child health plan under title XXI.

22 “(d) REPORTING AND RETURNING OF OVERPAY-
23 MENTS.—

24 “(1) IN GENERAL.—If a person has received an
25 overpayment, the person shall—

1 “(A) report and return the overpayment to
2 the Secretary, the State, an intermediary, a
3 carrier, or a contractor, as appropriate, at the
4 correct address; and

5 “(B) notify the Secretary, State, inter-
6 mediary, carrier, or contractor to whom the
7 overpayment was returned in writing of the rea-
8 son for the overpayment.

9 “(2) DEADLINE FOR REPORTING AND RETURN-
10 ING OVERPAYMENTS.—An overpayment must be re-
11 ported and returned under paragraph (1) by the
12 later of—

13 “(A) the date which is 60 days after the
14 date on which the overpayment was identified;
15 or

16 “(B) the date any corresponding cost re-
17 port is due, if applicable.

18 “(3) ENFORCEMENT.—Any overpayment re-
19 tained by a person after the deadline for reporting
20 and returning the overpayment under paragraph (2)
21 is an obligation (as defined in section 3729(b)(3) of
22 title 31, United States Code) for purposes of section
23 3729 of such title.

24 “(4) DEFINITIONS.—In this subsection:

1 “(A) KNOWING AND KNOWINGLY.—The
2 terms ‘knowing’ and ‘knowingly’ have the mean-
3 ing given those terms in section 3729(b) of title
4 31, United States Code.

5 “(B) OVERPAYMENT.—The term “overpay-
6 ment” means any funds that a person receives
7 or retains under title XVIII or XIX to which
8 the person, after applicable reconciliation, is not
9 entitled under such title.

10 “(C) PERSON.—

11 “(i) IN GENERAL.—The term ‘person’
12 means a provider of services, supplier,
13 medicaid managed care organization (as
14 defined in section 1903(m)(1)(A)), Medi-
15 care Advantage organization (as defined in
16 section 1859(a)(1)), or PDP sponsor (as
17 defined in section 1860D–41(a)(13)).

18 “(ii) EXCLUSION.—Such term does
19 not include a beneficiary.

20 “(e) INCLUSION OF NATIONAL PROVIDER IDENTI-
21 FIER ON ALL APPLICATIONS AND CLAIMS.—The Sec-
22 retary shall promulgate a regulation that requires, not
23 later than January 1, 2011, all providers of medical or
24 other items or services and suppliers under the programs
25 under titles XVIII and XIX that qualify for a national

1 provider identifier to include their national provider identi-
2 fier on all applications to enroll in such programs and on
3 all claims for payment submitted under such programs.”.

4 (b) ACCESS TO DATA.—

5 (1) MEDICARE PART D.—Section 1860D-
6 15(f)(2) of the Social Security Act (42 U.S.C.
7 1395w-116(f)(2)) is amended by striking “may be
8 used by” and all that follows through the period at
9 the end and inserting “may be used—

10 “(A) by officers, employees, and contrac-
11 tors of the Department of Health and Human
12 Services for the purposes of, and to the extent
13 necessary in—

14 “(i) carrying out this section; and

15 “(ii) conducting oversight, evaluation,
16 and enforcement under this title; and

17 “(B) by the Attorney General and the
18 Comptroller General of the United States for
19 the purposes of, and to the extent necessary in,
20 carrying out health oversight activities.”.

21 (2) DATA MATCHING.—Section 552a(a)(8)(B)
22 of title 5, United States Code, is amended—

23 (A) in clause (vii), by striking “or” at the
24 end;

1 (B) in clause (viii), by inserting “or” after
2 the semicolon; and

3 (C) by adding at the end the following new
4 clause:

5 “(ix) matches performed by the Sec-
6 retary of Health and Human Services or
7 the Inspector General of the Department
8 of Health and Human Services with re-
9 spect to potential fraud, waste, and abuse,
10 including matches of a system of records
11 with non-Federal records;”.

12 (3) MATCHING AGREEMENTS WITH THE COM-
13 MISSIONER OF SOCIAL SECURITY.—Section 205(r) of
14 the Social Security Act (42 U.S.C. 405(r)) is amend-
15 ed by adding at the end the following new para-
16 graph:

17 “(9)(A) The Commissioner of Social Security
18 shall, upon the request of the Secretary or the In-
19 spector General of the Department of Health and
20 Human Services—

21 “(i) enter into an agreement with the Sec-
22 retary or such Inspector General for the pur-
23 pose of matching data in the system of records
24 of the Social Security Administration and the

1 system of records of the Department of Health
2 and Human Services; and

3 “(ii) include in such agreement safeguards
4 to assure the maintenance of the confidentiality
5 of any information disclosed.

6 “(B) For purposes of this paragraph, the term
7 ‘system of records’ has the meaning given such term
8 in section 552a(a)(5) of title 5, United States
9 Code.”.

10 (c) WITHHOLDING OF FEDERAL MATCHING PAY-
11 MENTS FOR STATES THAT FAIL TO REPORT ENROLLEE
12 ENCOUNTER DATA IN THE MEDICAID STATISTICAL IN-
13 FORMATION SYSTEM.—Section 1903(i) of the Social Secu-
14 rity Act (42 U.S.C. 1396b(i)) is amended—

15 (1) in paragraph (23), by striking “or” at the
16 end;

17 (2) in paragraph (24), by striking the period at
18 the end and inserting “; or”; and

19 (3) by adding at the end the following new
20 paragraph:

21 “(25) with respect to any amounts expended for
22 medical assistance for individuals for whom the
23 State does not report enrollee encounter data (as de-
24 fined by the Secretary) to the Medicaid Statistical

1 Information System (MSIS) in a timely manner (as
2 determined by the Secretary).”.

3 (d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY
4 PENALTIES.—

5 (1) PERMISSIVE EXCLUSIONS.—Section 1128(b)
6 of the Social Security Act (42 U.S.C. 1320a–7(b))
7 is amended by adding at the end the following new
8 paragraph:

9 “(16) MAKING FALSE STATEMENTS OR MIS-
10 REPRESENTATION OF MATERIAL FACTS.—Any indi-
11 vidual or entity that knowingly makes or causes to
12 be made any false statement, omission, or misrepre-
13 sentation of a material fact in any application,
14 agreement, bid, or contract to participate or enroll
15 as a provider of services or supplier under a Federal
16 health care program (as defined in section
17 1128B(f)), including Medicare Advantage organiza-
18 tions under part C of title XVIII, prescription drug
19 plan sponsors under part D of title XVIII, medicaid
20 managed care organizations under title XIX, and en-
21 tities that apply to participate as providers of serv-
22 ices or suppliers in such managed care organizations
23 and such plans.”.

24 (2) CIVIL MONETARY PENALTIES.—

1 (A) IN GENERAL.—Section 1128A(a) of
2 the Social Security Act (42 U.S.C. 1320a–
3 7a(a)) is amended—

4 (i) in paragraph (1)(D), by striking
5 “was excluded” and all that follows
6 through the period at the end and insert-
7 ing “was excluded from the Federal health
8 care program (as defined in section
9 1128B(f)) under which the claim was
10 made pursuant to Federal law.”;

11 (ii) in paragraph (6), by striking “or”
12 at the end;

13 (iii) by inserting after paragraph (7),
14 the following new paragraphs:

15 “(8) orders or prescribes a medical or other
16 item or service during a period in which the person
17 was excluded from a Federal health care program
18 (as so defined), in the case where the person knows
19 or should know that a claim for such medical or
20 other item or service will be made under such a pro-
21 gram;

22 “(9) knowingly makes or causes to be made any
23 false statement, omission, or misrepresentation of a
24 material fact in any application, bid, or contract to
25 participate or enroll as a provider of services or a

1 supplier under a Federal health care program (as so
2 defined), including Medicare Advantage organiza-
3 tions under part C of title XVIII, prescription drug
4 plan sponsors under part D of title XVIII, medicaid
5 managed care organizations under title XIX, and en-
6 tities that apply to participate as providers of serv-
7 ices or suppliers in such managed care organizations
8 and such plans;

9 “(10) knows of an overpayment (as defined in
10 paragraph (4) of section 1128J(d)) and does not re-
11 port and return the overpayment in accordance with
12 such section;”;

13 (iv) in the first sentence—

14 (I) by striking the “or” after
15 “prohibited relationship occurs;” and

16 (II) by striking “act)” and in-
17 serting “act; or in cases under para-
18 graph (9), \$50,000 for each false
19 statement or misrepresentation of a
20 material fact)” and

21 (v) in the second sentence, by striking
22 “purpose)” and inserting “purpose; or in
23 cases under paragraph (9), an assessment
24 of not more than 3 times the total amount
25 claimed for each item or service for which

1 payment was made based upon the applica-
2 tion containing the false statement or mis-
3 representation of a material fact)”.
4

5 (B) CLARIFICATION OF TREATMENT OF
6 CERTAIN CHARITABLE AND OTHER INNOCUOUS
7 PROGRAMS.—Section 1128A(i)(6) of the Social
8 Security Act (42 U.S.C. 1320a–7a(i)(6)) is
9 amended—

10 (i) in subparagraph (C), by striking
11 “or” at the end;

12 (ii) in subparagraph (D), as redesign-
13 nated by section 4331(e) of the Balanced
14 Budget Act of 1997 (Public Law 105–33),
15 by striking the period at the end and in-
16 serting a semicolon;

17 (iii) by redesignating subparagraph
18 (D), as added by section 4523(c) of such
19 Act, as subparagraph (E) and striking the
20 period at the end and inserting “; or”; and

21 (iv) by adding at the end the following
22 new subparagraphs:

23 “(F) any other remuneration which pro-
24 motes access to care and poses a low risk of
harm to patients and Federal health care pro-

1 grams (as defined in section 1128B(f) and des-
2 gnated by the Secretary under regulations);

3 “(G) the offer or transfer of items or serv-
4 ices for free or less than fair market value by
5 a person, if—

6 “(i) the items or services consist of
7 coupons, rebates, or other rewards from a
8 retailer;

9 “(ii) the items or services are offered
10 or transferred on equal terms available to
11 the general public, regardless of health in-
12 surance status; and

13 “(iii) the offer or transfer of the items
14 or services is not tied to the provision of
15 other items or services reimbursed in whole
16 or in part by the program under title
17 XVIII or a State health care program (as
18 defined in section 1128(h));

19 “(H) the offer or transfer of items or serv-
20 ices for free or less than fair market value by
21 a person, if—

22 “(i) the items or services are not of-
23 fered as part of any advertisement or solie-
24 itation;

1 “(ii) the items or services are not tied
2 to the provision of other services reim-
3 bursed in whole or in part by the program
4 under title XVIII or a State health care
5 program (as so defined);

6 “(iii) there is a reasonable connection
7 between the items or services and the med-
8 ical care of the individual; and

9 “(iv) the person provides the items or
10 services after determining in good faith
11 that the individual is in financial need; or

12 “(I) effective on a date specified by the
13 Secretary (but not earlier than January 1,
14 2011), the waiver by a PDP sponsor of a pre-
15 scription drug plan under part D of title XVIII
16 or an MA organization offering an MA-PD
17 plan under part C of such title of any copay-
18 ment for the first fill of a covered part D drug
19 (as defined in section 1860D-2(e)) that is a ge-
20 neric drug for individuals enrolled in the pre-
21 scription drug plan or MA-PD plan, respec-
22 tively.”.

23 (e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLU-
24 SION-ONLY CASES.—Section 1128(f) of the Social Secu-

1 rity Act (42 U.S.C. 1320a-7(f)) is amended by adding at
2 the end the following new paragraph:

3 “(4) The provisions of subsections (d) and (e)
4 of section 205 shall apply with respect to this sec-
5 tion to the same extent as they are applicable with
6 respect to title II. The Secretary may delegate the
7 authority granted by section 205(d) (as made appli-
8 cable to this section) to the Inspector General of the
9 Department of Health and Human Services for pur-
10 poses of any investigation under this section.”.

11 (f) HEALTH CARE FRAUD.—

12 (1) KICKBACKS.—Section 1128B of the Social
13 Security Act (42 U.S.C. 1320a-7b) is amended by
14 adding at the end the following new subsection:

15 “(g) In addition to the penalties provided for in this
16 section or section 1128A, a claim that includes items or
17 services resulting from a violation of this section con-
18 stitutes a false or fraudulent claim for purposes of sub-
19 chapter III of chapter 37 of title 31, United States Code.”.

20 (2) REVISING THE INTENT REQUIREMENT.—

21 Section 1128B of the Social Security Act (42 U.S.C.
22 1320a-7b), as amended by paragraph (1), is amend-
23 ed by adding at the end the following new sub-
24 section:

1 “(h) With respect to violations of this section, a per-
2 son need not have actual knowledge of this section or spe-
3 cific intent to commit a violation of this section.”.

4 (g) SURETY BOND REQUIREMENTS.—

5 (1) DURABLE MEDICAL EQUIPMENT.—Section
6 1834(a)(16)(B) of the Social Security Act (42
7 U.S.C. 1395m(a)(16)(B)) is amended by inserting
8 “that the Secretary determines is commensurate
9 with the volume of the billing of the supplier” before
10 the period at the end.

11 (2) HOME HEALTH AGENCIES.—Section
12 1861(o)(7)(C) of the Social Security Act (42 U.S.C.
13 1395x(o)(7)(C)) is amended by inserting “that the
14 Secretary determines is commensurate with the vol-
15 ume of the billing of the home health agency” before
16 the semicolon at the end.

17 (3) REQUIREMENTS FOR CERTAIN OTHER PRO-
18 VIDERS OF SERVICES AND SUPPLIERS.—Section
19 1862 of the Social Security Act (42 U.S.C. 1395y)
20 is amended by adding at the end the following new
21 subsection:

22 “(n) REQUIREMENT OF A SURETY BOND FOR CER-
23 TAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

24 “(1) IN GENERAL.—The Secretary may require
25 a provider of services or supplier described in para-

1 graph (2) to provide the Secretary on a continuing
2 basis with a surety bond in a form specified by the
3 Secretary in an amount (not less than \$50,000) that
4 the Secretary determines is commensurate with the
5 volume of the billing of the provider of services or
6 supplier. The Secretary may waive the requirement
7 of a bond under the preceding sentence in the case
8 of a provider of services or supplier that provides a
9 comparable surety bond under State law.

10 “(2) PROVIDER OF SERVICES OR SUPPLIER DE-
11 SCRIBED.—A provider of services or supplier de-
12 scribed in this paragraph is a provider of services or
13 supplier the Secretary determines appropriate based
14 on the level of risk involved with respect to the pro-
15 vider of services or supplier, and consistent with the
16 surety bond requirements under sections
17 1834(a)(16)(B) and 1861(o)(7)(C).”.

18 (h) SUSPENSION OF MEDICARE AND MEDICAID PAY-
19 MENTS PENDING INVESTIGATION OF CREDIBLE ALLEGA-
20 TIONS OF FRAUD.—

21 (1) MEDICARE.—Section 1862 of the Social Se-
22 curity Act (42 U.S.C. 1395y), as amended by sub-
23 section (g)(3), is amended by adding at the end the
24 following new subsection:

1 “(o) SUSPENSION OF PAYMENTS PENDING INVES-
2 TIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

3 “(1) IN GENERAL.—The Secretary may suspend
4 payments to a provider of services or supplier under
5 this title pending an investigation of a credible alle-
6 gation of fraud against the provider of services or
7 supplier, unless the Secretary determines there is
8 good cause not to suspend such payments.

9 “(2) CONSULTATION.—The Secretary shall con-
10 sult with the Inspector General of the Department
11 of Health and Human Services in determining
12 whether there is a credible allegation of fraud
13 against a provider of services or supplier.

14 “(3) PROMULGATION OF REGULATIONS.—The
15 Secretary shall promulgate regulations to carry out
16 this subsection and section 1903(i)(2)(C).”.

17 (2) MEDICAID.—Section 1903(i)(2) of such Act
18 (42 U.S.C. 1396b(i)(2)) is amended—

19 (A) in subparagraph (A), by striking “or”
20 at the end; and

21 (B) by inserting after subparagraph (B),
22 the following:

23 “(C) by any individual or entity to whom
24 the State has failed to suspend payments under
25 the plan during any period when there is pend-

1 ing an investigation of a credible allegation of
2 fraud against the individual or entity, as deter-
3 mined by the State in accordance with regula-
4 tions promulgated by the Secretary for pur-
5 poses of section 1862(o) and this subparagraph,
6 unless the State determines in accordance with
7 such regulations there is good cause not to sus-
8 pend such payments; or”.

9 (i) INCREASED FUNDING TO FIGHT FRAUD AND
10 ABUSE.—

11 (1) IN GENERAL.—Section 1817(k) of the So-
12 cial Security Act (42 U.S.C. 1395i(k)) is amended—

13 (A) by adding at the end the following new
14 paragraph:

15 “(7) ADDITIONAL FUNDING.—In addition to the
16 funds otherwise appropriated to the Account from
17 the Trust Fund under paragraphs (3) and (4) and
18 for purposes described in paragraphs (3)(C) and
19 (4)(A), there are hereby appropriated an additional
20 \$10,000,000 to such Account from such Trust Fund
21 for each of fiscal years 2011 through 2020. The
22 funds appropriated under this paragraph shall be al-
23 located in the same proportion as the total funding
24 appropriated with respect to paragraphs (3)(A) and
25 (4)(A) was allocated with respect to fiscal year

1 2010, and shall be available without further appro-
2 priation until expended.”; and

3 (B) in paragraph (4)(A), by inserting
4 “until expended” after “appropriation”.

5 (2) INDEXING OF AMOUNTS APPROPRIATED.—

6 (A) DEPARTMENTS OF HEALTH AND
7 HUMAN SERVICES AND JUSTICE.—Section
8 1817(k)(3)(A)(i) of the Social Security Act (42
9 U.S.C. 1395i(k)(3)(A)(i)) is amended—

10 (i) in subclause (III), by inserting
11 “and” at the end;

12 (ii) in subclause (IV)—

13 (I) by striking “for each of fiscal
14 years 2007, 2008, 2009, and 2010”
15 and inserting “for each fiscal year
16 after fiscal year 2006”; and

17 (II) by striking “; and” and in-
18 serting a period; and

19 (iii) by striking subclause (V).

20 (B) OFFICE OF THE INSPECTOR GENERAL
21 OF THE DEPARTMENT OF HEALTH AND HUMAN
22 SERVICES.—Section 1817(k)(3)(A)(ii) of such
23 Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amend-
24 ed—

1 (i) in subclause (VIII), by inserting
2 “and” at the end;

3 (ii) in subclause (IX)—

4 (I) by striking “for each of fiscal
5 years 2008, 2009, and 2010” and in-
6 serting “for each fiscal year after fis-
7 cal year 2007”; and

8 (II) by striking “; and” and in-
9 serting a period; and

10 (iii) by striking subclause (X).

11 (C) FEDERAL BUREAU OF INVESTIGA-
12 TION.—Section 1817(k)(3)(B) of the Social Se-
13 curity Act (42 U.S.C. 1395i(k)(3)(B)) is
14 amended—

15 (i) in clause (vii), by inserting “and”
16 at the end;

17 (ii) in clause (viii)—

18 (I) by striking “for each of fiscal
19 years 2007, 2008, 2009, and 2010”
20 and inserting “for each fiscal year
21 after fiscal year 2006”; and

22 (II) by striking “; and” and in-
23 serting a period; and

24 (iii) by striking clause (ix).

1 (D) MEDICARE INTEGRITY PROGRAM.—
2 Section 1817(k)(4)(C) of the Social Security
3 Act (42 U.S.C. 1395i(k)(4)(C)) is amended by
4 adding at the end the following new clause:

5 “(ii) For each fiscal year after 2010,
6 by the percentage increase in the consumer
7 price index for all urban consumers (all
8 items; United States city average) over the
9 previous year.”.

10 (j) MEDICARE INTEGRITY PROGRAM AND MEDICAID
11 INTEGRITY PROGRAM.—

12 (1) MEDICARE INTEGRITY PROGRAM.—

13 (A) REQUIREMENT TO PROVIDE PERFORM-
14 ANCE STATISTICS.—Section 1893(c) of the So-
15 cial Security Act (42 U.S.C. 1395ddd(c)) is
16 amended—

17 (i) in paragraph (3), by striking
18 “and” at the end;

19 (ii) by redesignating paragraph (4) as
20 paragraph (5); and

21 (iii) by inserting after paragraph (3)
22 the following new paragraph:

23 “(4) the entity agrees to provide the Secretary
24 and the Inspector General of the Department of
25 Health and Human Services with such performance

1 statistics (including the number and amount of over-
2 payments recovered, the number of fraud referrals,
3 and the return on investment of such activities by
4 the entity) as the Secretary or the Inspector General
5 may request; and”.

6 (B) EVALUATIONS AND ANNUAL RE-
7 PORT.—Section 1893 of the Social Security Act
8 (42 U.S.C. 1395ddd) is amended by adding at
9 the end the following new subsection:

10 “(i) EVALUATIONS AND ANNUAL REPORT.—

11 “(1) EVALUATIONS.—The Secretary shall con-
12 duct evaluations of eligible entities which the Sec-
13 retary contracts with under the Program not less
14 frequently than every 3 years.

15 “(2) ANNUAL REPORT.—Not later than 180
16 days after the end of each fiscal year (beginning
17 with fiscal year 2011), the Secretary shall submit a
18 report to Congress which identifies—

19 “(A) the use of funds, including funds
20 transferred from the Federal Hospital Insur-
21 ance Trust Fund under section 1817 and the
22 Federal Supplementary Insurance Trust Fund
23 under section 1841, to carry out this section;
24 and

1 “(B) the effectiveness of the use of such
2 funds.”.

3 (C) FLEXIBILITY IN PURSUING FRAUD
4 AND ABUSE.—Section 1893(a) of the Social Se-
5 curity Act (42 U.S.C. 1395ddd(a)) is amended
6 by inserting “, or otherwise,” after “entities”.

7 (2) MEDICAID INTEGRITY PROGRAM.—

8 (A) REQUIREMENT TO PROVIDE PERFORM-
9 ANCE STATISTICS.—Section 1936(c)(2) of the
10 Social Security Act (42 U.S.C. 1396u–6(c)(2))
11 is amended—

12 (i) by redesignating subparagraph (D)
13 as subparagraph (E); and

14 (ii) by inserting after subparagraph
15 (C) the following new subparagraph:

16 “(D) The entity agrees to provide the Sec-
17 retary and the Inspector General of the Depart-
18 ment of Health and Human Services with such
19 performance statistics (including the number
20 and amount of overpayments recovered, the
21 number of fraud referrals, and the return on in-
22 vestment of such activities by the entity) as the
23 Secretary or the Inspector General may re-
24 quest.”.

1 (B) EVALUATIONS AND ANNUAL RE-
2 PORT.—Section 1936(e) of the Social Security
3 Act (42 U.S.C. 1396u-7(e)) is amended—

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

6 (ii) by inserting after paragraph (3)
7 the following new paragraph:

8 “(4) EVALUATIONS.—The Secretary shall con-
9 duct evaluations of eligible entities which the Sec-
10 retary contracts with under the Program not less
11 frequently than every 3 years.”.

12 (k) EXPANDED APPLICATION OF HARDSHIP WAIV-
13 ERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the So-
14 cial Security Act (42 U.S.C. 1320a-7(c)(3)(B)) is amend-
15 ed by striking “individuals entitled to benefits under part
16 A of title XVIII or enrolled under part B of such title,
17 or both” and inserting “beneficiaries (as defined in section
18 1128A(i)(5)) of that program”.

19 **SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE**
20 **HEALTHCARE INTEGRITY AND PROTECTION**
21 **DATA BANK AND THE NATIONAL PRACTI-**
22 **TIONER DATA BANK.**

23 (a) INFORMATION REPORTED BY FEDERAL AGEN-
24 CIES AND HEALTH PLANS.—Section 1128E of the Social
25 Security Act (42 U.S.C. 1320a-7e) is amended—

1 (1) by striking subsection (a) and inserting the
2 following:

3 “(a) IN GENERAL.—The Secretary shall maintain a
4 national health care fraud and abuse data collection pro-
5 gram under this section for the reporting of certain final
6 adverse actions (not including settlements in which no
7 findings of liability have been made) against health care
8 providers, suppliers, or practitioners as required by sub-
9 section (b), with access as set forth in subsection (d), and
10 shall furnish the information collected under this section
11 to the National Practitioner Data Bank established pursu-
12 ant to the Health Care Quality Improvement Act of 1986
13 (42 U.S.C. 11101 et seq.)”;

14 (2) by striking subsection (d) and inserting the
15 following:

16 “(d) ACCESS TO REPORTED INFORMATION.—

17 “(1) AVAILABILITY.—The information collected
18 under this section shall be available from the Na-
19 tional Practitioner Data Bank to the agencies, au-
20 thorities, and officials which are provided under sec-
21 tion 1921(b) information reported under section
22 1921(a).

23 “(2) FEES FOR DISCLOSURE.—The Secretary
24 may establish or approve reasonable fees for the dis-
25 closure of information under this section. The

1 amount of such a fee may not exceed the costs of
2 processing the requests for disclosure and of pro-
3 viding such information. Such fees shall be available
4 to the Secretary to cover such costs.”;

5 (3) by striking subsection (f) and inserting the
6 following:

7 “(f) APPROPRIATE COORDINATION.—In imple-
8 menting this section, the Secretary shall provide for the
9 maximum appropriate coordination with part B of the
10 Health Care Quality Improvement Act of 1986 (42 U.S.C.
11 11131 et seq.) and section 1921.”; and

12 (4) in subsection (g)—

13 (A) in paragraph (1)(A)—

14 (i) in clause (iii)—

15 (I) by striking “or State” each
16 place it appears;

17 (II) by redesignating subclauses
18 (II) and (III) as subclauses (III) and
19 (IV), respectively; and

20 (III) by inserting after subclause
21 (I) the following new subclause:

22 “(II) any dismissal or closure of
23 the proceedings by reason of the pro-
24 vider, supplier, or practitioner surren-

1 dering their license or leaving the
2 State or jurisdiction”; and

3 (ii) by striking clause (iv) and insert-
4 ing the following:

5 “(iv) Exclusion from participation in a
6 Federal health care program (as defined in
7 section 1128B(f)).”;

8 (B) in paragraph (3)—

9 (i) by striking subparagraphs (D) and
10 (E); and

11 (ii) by redesignating subparagraph
12 (F) as subparagraph (D); and

13 (C) in subparagraph (D) (as so redesign-
14 ated), by striking “or State”.

15 (b) INFORMATION REPORTED BY STATE LAW OR
16 FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the
17 Social Security Act (42 U.S.C. 1396r-2) is amended—

18 (1) in subsection (a)—

19 (A) in paragraph (1)—

20 (i) by striking “SYSTEM.—The State”
21 and all that follows through the semicolon
22 and inserting SYSTEM.—

23 “(A) LICENSING OR CERTIFICATION AC-
24 TIONS.—The State must have in effect a system
25 of reporting the following information with re-

1 spect to formal proceedings (as defined by the
2 Secretary in regulations) concluded against a
3 health care practitioner or entity by a State li-
4 censing or certification agency.”;

5 (ii) by redesignating subparagraphs
6 (A) through (D) as clauses (i) through
7 (iv), respectively, and indenting appro-
8 priately;

9 (iii) in subparagraph (A)(iii) (as so
10 redesignated)—

11 (I) by striking “the license of”
12 and inserting “license or the right to
13 apply for, or renew, a license by”; and

14 (II) by inserting “nonrenew-
15 ability,” after “voluntary surrender,”;
16 and

17 (iv) by adding at the end the following
18 new subparagraph:

19 “(B) OTHER FINAL ADVERSE ACTIONS.—

20 The State must have in effect a system of re-
21 porting information with respect to any final
22 adverse action (not including settlements in
23 which no findings of liability have been made)
24 taken against a health care provider, supplier,

1 or practitioner by a State law or fraud enforce-
2 ment agency.”; and

3 (B) in paragraph (2), by striking “the au-
4 thority described in paragraph (1)” and insert-
5 ing “a State licensing or certification agency or
6 State law or fraud enforcement agency”;

7 (2) in subsection (b)—

8 (A) by striking paragraph (2) and insert-
9 ing the following:

10 “(2) to State licensing or certification agencies
11 and Federal agencies responsible for the licensing
12 and certification of health care providers, suppliers,
13 and licensed health care practitioners;”;

14 (B) in each of paragraphs (4) and (6), by
15 inserting “, but only with respect to information
16 provided pursuant to subsection (a)(1)(A)” be-
17 fore the comma at the end;

18 (C) by striking paragraph (5) and insert-
19 ing the following:

20 “(5) to State law or fraud enforcement agen-
21 cies,”;

22 (D) by redesignating paragraphs (7) and
23 (8) as paragraphs (8) and (9), respectively; and

24 (E) by inserting after paragraph (6) the
25 following new paragraph:

1 “(7) to health plans (as defined in section
2 1128C(c));”;

3 (3) by redesignating subsection (d) as sub-
4 section (h), and by inserting after subsection (e) the
5 following new subsections:

6 “(d) DISCLOSURE AND CORRECTION OF INFORMA-
7 TION.—

8 “(1) DISCLOSURE.—With respect to informa-
9 tion reported pursuant to subsection (a)(1), the Sec-
10 retary shall—

11 “(A) provide for disclosure of the informa-
12 tion, upon request, to the health care practi-
13 tioner who, or the entity that, is the subject of
14 the information reported; and

15 “(B) establish procedures for the case
16 where the health care practitioner or entity dis-
17 putes the accuracy of the information reported.

18 “(2) CORRECTIONS.—Each State licensing or
19 certification agency and State law or fraud enforce-
20 ment agency shall report corrections of information
21 already reported about any formal proceeding or
22 final adverse action described in subsection (a), in
23 such form and manner as the Secretary prescribes
24 by regulation.

1 “(e) FEES FOR DISCLOSURE.—The Secretary may
2 establish or approve reasonable fees for the disclosure of
3 information under this section. The amount of such a fee
4 may not exceed the costs of processing the requests for
5 disclosure and of providing such information. Such fees
6 shall be available to the Secretary to cover such costs.

7 “(f) PROTECTION FROM LIABILITY FOR REPORT-
8 ING.—No person or entity, including any agency des-
9 ignated by the Secretary in subsection (b), shall be held
10 liable in any civil action with respect to any reporting of
11 information as required under this section, without knowl-
12 edge of the falsity of the information contained in the re-
13 port.

14 “(g) REFERENCES.—For purposes of this section:

15 “(1) STATE LICENSING OR CERTIFICATION
16 AGENCY.—The term ‘State licensing or certification
17 agency’ includes any authority of a State (or of a
18 political subdivision thereof) responsible for the li-
19 censing of health care practitioners (or any peer re-
20 view organization or private accreditation entity re-
21 viewing the services provided by health care practi-
22 tioners) or entities.

23 “(2) STATE LAW OR FRAUD ENFORCEMENT
24 AGENCY.—The term ‘State law or fraud enforcement
25 agency’ includes—

1 “(A) a State law enforcement agency; and

2 “(B) a State medicaid fraud control unit

3 (as defined in section 1903(q)).

4 “(3) FINAL ADVERSE ACTION.—

5 “(A) IN GENERAL.—Subject to subpara-

6 graph (B), the term ‘final adverse action’ in-

7 cludes—

8 “(i) civil judgments against a health

9 care provider, supplier, or practitioner in

10 State court related to the delivery of a

11 health care item or service;

12 “(ii) State criminal convictions related

13 to the delivery of a health care item or

14 service;

15 “(iii) exclusion from participation in

16 State health care programs (as defined in

17 section 1128(h));

18 “(iv) any licensing or certification ac-

19 tion described in subsection (a)(1)(A)

20 taken against a supplier by a State licens-

21 ing or certification agency; and

22 “(v) any other adjudicated actions or

23 decisions that the Secretary shall establish

24 by regulation.

1 “(B) EXCEPTION.—Such term does not in-
2 clude any action with respect to a malpractice
3 claim.”; and

4 (4) in subsection (h), as so redesignated, by
5 striking “The Secretary” and all that follows
6 through the period at the end and inserting “In im-
7 plementing this section, the Secretary shall provide
8 for the maximum appropriate coordination with part
9 B of the Health Care Quality Improvement Act of
10 1986 (42 U.S.C. 11131 et seq.) and section
11 1128E.”.

12 (c) CONFORMING AMENDMENT.—Section
13 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-
14 7c(a)(1)) is amended—

15 (1) in subparagraph (C), by adding “and” after
16 the comma at the end;

17 (2) in subparagraph (D), by striking “, and”
18 and inserting a period; and

19 (3) by striking subparagraph (E).

20 (d) TRANSITION PROCESS; EFFECTIVE DATE.—

21 (1) IN GENERAL.—Effective on the date of en-
22 actment of this Act, the Secretary of Health and
23 Human Services (in this section referred to as the
24 “Secretary”) shall implement a transition process
25 under which, by not later than the end of the transi-

1 tion period described in paragraph (5), the Secretary
2 shall cease operating the Healthcare Integrity and
3 Protection Data Bank established under section
4 1128E of the Social Security Act (as in effect before
5 the effective date specified in paragraph (6)) and
6 shall transfer all data collected in the Healthcare In-
7 tegrity and Protection Data Bank to the National
8 Practitioner Data Bank established pursuant to the
9 Health Care Quality Improvement Act of 1986 (42
10 U.S.C. 11101 et seq.). During such transition proc-
11 ess, the Secretary shall have in effect appropriate
12 procedures to ensure that data collection and access
13 to the Healthcare Integrity and Protection Data
14 Bank and the National Practitioner Data Bank are
15 not disrupted.

16 (2) REGULATIONS.—The Secretary shall pro-
17 mulgate regulations to carry out the amendments
18 made by subsections (a) and (b).

19 (3) FUNDING.—

20 (A) AVAILABILITY OF FEES.—Fees col-
21 lected pursuant to section 1128E(d)(2) of the
22 Social Security Act prior to the effective date
23 specified in paragraph (6) for the disclosure of
24 information in the Healthcare Integrity and
25 Protection Data Bank shall be available to the

1 Secretary, without fiscal year limitation, for
2 payment of costs related to the transition pro-
3 cess described in paragraph (1). Any such fees
4 remaining after the transition period is com-
5 plete shall be available to the Secretary, without
6 fiscal year limitation, for payment of the costs
7 of operating the National Practitioner Data
8 Bank.

9 (B) AVAILABILITY OF ADDITIONAL
10 FUNDS.—In addition to the fees described in
11 subparagraph (A), any funds available to the
12 Secretary or to the Inspector General of the
13 Department of Health and Human Services for
14 a purpose related to combating health care
15 fraud, waste, or abuse shall be available to the
16 extent necessary for operating the Healthcare
17 Integrity and Protection Data Bank during the
18 transition period, including systems testing and
19 other activities necessary to ensure that infor-
20 mation formerly reported to the Healthcare In-
21 tegrity and Protection Data Bank will be acces-
22 sible through the National Practitioner Data
23 Bank after the end of such transition period.

1 (4) SPECIAL PROVISION FOR ACCESS TO THE
2 NATIONAL PRACTITIONER DATA BANK BY THE DE-
3 PARTMENT OF VETERANS AFFAIRS.—

4 (A) IN GENERAL.—Notwithstanding any
5 other provision of law, during the 1-year period
6 that begins on the effective date specified in
7 paragraph (6), the information described in
8 subparagraph (B) shall be available from the
9 National Practitioner Data Bank to the Sec-
10 retary of Veterans Affairs without charge.

11 (B) INFORMATION DESCRIBED.—For pur-
12 poses of subparagraph (A), the information de-
13 scribed in this subparagraph is the information
14 that would, but for the amendments made by
15 this section, have been available to the Sec-
16 retary of Veterans Affairs from the Healthcare
17 Integrity and Protection Data Bank.

18 (5) TRANSITION PERIOD DEFINED.—For pur-
19 poses of this subsection, the term “transition pe-
20 riod” means the period that begins on the date of
21 enactment of this Act and ends on the later of—

22 (A) the date that is 1 year after such date
23 of enactment; or

24 (B) the effective date of the regulations
25 promulgated under paragraph (2).

1 (6) EFFECTIVE DATE.—The amendments made
2 by subsections (a), (b), and (c) shall take effect on
3 the first day after the final day of the transition pe-
4 riod.

5 **SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDI-**
6 **CARE CLAIMS REDUCED TO NOT MORE THAN**
7 **12 MONTHS.**

8 (a) REDUCING MAXIMUM PERIOD FOR SUBMIS-
9 SION.—

10 (1) PART A.—Section 1814(a) of the Social Se-
11 curity Act (42 U.S.C. 1395f(a)(1)) is amended—

12 (A) in paragraph (1), by striking “period
13 of 3 calendar years” and all that follows
14 through the semicolon and inserting “period
15 ending 1 calendar year after the date of serv-
16 ice;”; and

17 (B) by adding at the end the following new
18 sentence: “In applying paragraph (1), the Sec-
19 retary may specify exceptions to the 1 calendar
20 year period specified in such paragraph.”

21 (2) PART B.—

22 (A) Section 1842(b)(3) of such Act (42
23 U.S.C. 1395u(b)(3)(B)) is amended—

24 (i) in subparagraph (B), in the flush
25 language following clause (ii), by striking

1 “close of the calendar year following the
2 year in which such service is furnished
3 (deeming any service furnished in the last
4 3 months of any calendar year to have
5 been furnished in the succeeding calendar
6 year)” and inserting “period ending 1 cal-
7 endar year after the date of service”; and

8 (ii) by adding at the end the following
9 new sentence: “In applying subparagraph
10 (B), the Secretary may specify exceptions
11 to the 1 calendar year period specified in
12 such subparagraph.”

13 (B) Section 1835(a) of such Act (42
14 U.S.C. 1395n(a)) is amended—

15 (i) in paragraph (1), by striking “pe-
16 riod of 3 calendar years” and all that fol-
17 lows through the semicolon and inserting
18 “period ending 1 calendar year after the
19 date of service;”; and

20 (ii) by adding at the end the following
21 new sentence: “In applying paragraph (1),
22 the Secretary may specify exceptions to the
23 1 calendar year period specified in such
24 paragraph.”

25 (b) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendments made by
2 subsection (a) shall apply to services furnished on or
3 after January 1, 2010.

4 (2) SERVICES FURNISHED BEFORE 2010.—In
5 the case of services furnished before January 1,
6 2010, a bill or request for payment under section
7 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed
8 not later than December 31, 2010.

9 **SEC. 6405. PHYSICIANS WHO ORDER ITEMS OR SERVICES**
10 **REQUIRED TO BE MEDICARE ENROLLED PHY-**
11 **SICIANS OR ELIGIBLE PROFESSIONALS.**

12 (a) DME.—Section 1834(a)(11)(B) of the Social Se-
13 curity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by
14 striking “physician” and inserting “physician enrolled
15 under section 1866(j) or an eligible professional under sec-
16 tion 1848(k)(3)(B) that is enrolled under section
17 1866(j)”.

18 (b) HOME HEALTH SERVICES.—

19 (1) PART A.—Section 1814(a)(2) of such Act
20 (42 U.S.C. 1395(a)(2)) is amended in the matter
21 preceding subparagraph (A) by inserting “in the
22 case of services described in subparagraph (C), a
23 physician enrolled under section 1866(j) or an eligi-
24 ble professional under section 1848(k)(3)(B),” be-
25 fore “or, in the case of services”.

1 (2) PART B.—Section 1835(a)(2) of such Act
2 (42 U.S.C. 1395n(a)(2)) is amended in the matter
3 preceding subparagraph (A) by inserting “, or in the
4 case of services described in subparagraph (A), a
5 physician enrolled under section 1866(j) or an eligi-
6 ble professional under section 1848(k)(3)(B),” after
7 “a physician”.

8 (c) APPLICATION TO OTHER ITEMS OR SERVICES.—
9 The Secretary may extend the requirement applied by the
10 amendments made by subsections (a) and (b) to durable
11 medical equipment and home health services (relating to
12 requiring certifications and written orders to be made by
13 enrolled physicians and health professions) to all other
14 categories of items or services under title XVIII of the
15 Social Security Act (42 U.S.C. 1395 et seq.), including
16 covered part D drugs as defined in section 1860D–2(e)
17 of such Act (42 U.S.C. 1395w–102), that are ordered, pre-
18 scribed, or referred by a physician enrolled under section
19 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible
20 professional under section 1848(k)(3)(B) of such Act (42
21 U.S.C. 1395w–4(k)(3)(B)).

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to written orders and certifications
24 made on or after July 1, 2010.

1 **SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE**
2 **DOCUMENTATION ON REFERRALS TO PRO-**
3 **GRAMS AT HIGH RISK OF WASTE AND ABUSE.**

4 (a) PHYSICIANS AND OTHER SUPPLIERS.—Section
5 1842(h) of the Social Security Act (42 U.S.C. 1395u(h))
6 is amended by adding at the end the following new para-
7 graph

8 “(9) The Secretary may revoke enrollment, for a pe-
9 riod of not more than one year for each act, for a physi-
10 cian or supplier under section 1866(j) if such physician
11 or supplier fails to maintain and, upon request of the Sec-
12 retary, provide access to documentation relating to written
13 orders or requests for payment for durable medical equip-
14 ment, certifications for home health services, or referrals
15 for other items or services written or ordered by such phy-
16 sician or supplier under this title, as specified by the Sec-
17 retary.”.

18 (b) PROVIDERS OF SERVICES.—Section 1866(a)(1)
19 of such Act (42 U.S.C. 1395cc) is further amended—

20 (1) in subparagraph (U), by striking at the end
21 “and”;

22 (2) in subparagraph (V), by striking the period
23 at the end and adding “; and”; and

24 (3) by adding at the end the following new sub-
25 paragraph:

1 (A) by striking “and such services” and in-
2 serting “such services”; and

3 (B) by inserting after “care of a physi-
4 cian” the following: “, and, in the case of a cer-
5 tification made by a physician after January 1,
6 2010, prior to making such certification the
7 physician must document that the physician
8 himself or herself has had a face-to-face en-
9 counter (including through use of telehealth,
10 subject to the requirements in section 1834(m),
11 and other than with respect to encounters that
12 are incident to services involved) with the indi-
13 vidual within a reasonable timeframe as deter-
14 mined by the Secretary”.

15 (2) PART B.—Section 1835(a)(2)(A) of the So-
16 cial Security Act is amended—

17 (A) by striking “and” before “(iii)”; and

18 (B) by inserting after “care of a physi-
19 cian” the following: “, and (iv) in the case of
20 a certification after January 1, 2010, prior to
21 making such certification the physician must
22 document that the physician has had a face-to-
23 face encounter (including through use of tele-
24 health and other than with respect to encoun-
25 ters that are incident to services involved) with

1 the individual during the 6-month period pre-
2 ceeding such certification, or other reasonable
3 timeframe as determined by the Secretary”.

4 (b) CONDITION OF PAYMENT FOR DURABLE MED-
5 ICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social
6 Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended—

7 (1) by striking “ORDER.—The Secretary” and
8 inserting “ORDER.—

9 “(i) IN GENERAL.—The Secretary”;

10 and

11 (2) by adding at the end the following new
12 clause:

13 “(ii) REQUIREMENT FOR FACE TO
14 FACE ENCOUNTER.—The Secretary shall
15 require that such an order be written pur-
16 suant to the physician documenting that a
17 physician, a physician assistant, a nurse
18 practitioner, or a clinical nurse specialist
19 (as those terms are defined in section
20 1861(aa)(5)) has had a face-to-face en-
21 counter (including through use of tele-
22 health under subsection (m) and other
23 than with respect to encounters that are
24 incident to services involved) with the indi-
25 vidual involved during the 6-month period

1 preceding such written order, or other rea-
2 sonable timeframe as determined by the
3 Secretary.”.

4 (c) APPLICATION TO OTHER AREAS UNDER MEDI-
5 CARE.—The Secretary may apply the face-to-face encoun-
6 ter requirement described in the amendments made by
7 subsections (a) and (b) to other items and services for
8 which payment is provided under title XVIII of the Social
9 Security Act based upon a finding that such an decision
10 would reduce the risk of waste, fraud, or abuse.

11 (d) APPLICATION TO MEDICAID.—The requirements
12 pursuant to the amendments made by subsections (a) and
13 (b) shall apply in the case of physicians making certifi-
14 cations for home health services under title XIX of the
15 Social Security Act in the same manner and to the same
16 extent as such requirements apply in the case of physi-
17 cians making such certifications under title XVIII of such
18 Act.

19 **SEC. 6408. ENHANCED PENALTIES.**

20 (a) CIVIL MONETARY PENALTIES FOR FALSE STATE-
21 MENTS OR DELAYING INSPECTIONS.—Section 1128A(a)
22 of the Social Security Act (42 U.S.C. 1320a–7a(a)), as
23 amended by section 5002(d)(2)(A), is amended—

24 (1) in paragraph (6), by striking “or” at the
25 end; and

1 (2) by inserting after paragraph (7) the fol-
2 lowing new paragraphs:

3 “(8) knowingly makes, uses, or causes to be
4 made or used, a false record or statement material
5 to a false or fraudulent claim for payment for items
6 and services furnished under a Federal health care
7 program; or

8 “(9) fails to grant timely access, upon reason-
9 able request (as defined by the Secretary in regula-
10 tions), to the Inspector General of the Department
11 of Health and Human Services, for the purpose of
12 audits, investigations, evaluations, or other statutory
13 functions of the Inspector General of the Depart-
14 ment of Health and Human Services;” and

15 (3) in the first sentence—

16 (A) by striking “or in cases under para-
17 graph (7)” and inserting “in cases under para-
18 graph (7)”; and

19 (B) by striking “act)” and inserting “act,
20 in cases under paragraph (8), \$50,000 for each
21 false record or statement, or in cases under
22 paragraph (9), \$15,000 for each day of the fail-
23 ure described in such paragraph)”.

24 (b) MEDICARE ADVANTAGE AND PART D PLANS.—

1 (1) ENSURING TIMELY INSPECTIONS RELATING
2 TO CONTRACTS WITH MA ORGANIZATIONS.—Section
3 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2))
4 is amended—

5 (A) in subparagraph (A), by inserting
6 “timely” before “inspect”; and

7 (B) in subparagraph (B), by inserting
8 “timely” before “audit and inspect”.

9 (2) MARKETING VIOLATIONS.—Section
10 1857(g)(1) of the Social Security Act (42 U.S.C.
11 1395w—27(g)(1)) is amended—

12 (A) in subparagraph (F), by striking “or”
13 at the end;

14 (B) by inserting after subparagraph (G)
15 the following new subparagraphs:

16 “(H) except as provided under subpara-
17 graph (C) or (D) of section 1860D–1(b)(1), en-
18 rolls an individual in any plan under this part
19 without the prior consent of the individual or
20 the designee of the individual;

21 “(I) transfers an individual enrolled under
22 this part from one plan to another without the
23 prior consent of the individual or the designee
24 of the individual or solely for the purpose of
25 earning a commission;

1 “(J) fails to comply with marketing re-
2 strictions described in subsections (h) and (j) of
3 section 1851 or applicable implementing regula-
4 tions or guidance; or

5 “(K) employs or contracts with any indi-
6 vidual or entity who engages in the conduct de-
7 scribed in subparagraphs (A) through (J) of
8 this paragraph;” and

9 (C) by adding at the end the following new
10 sentence: “The Secretary may provide, in addi-
11 tion to any other remedies authorized by law,
12 for any of the remedies described in paragraph
13 (2), if the Secretary determines that any em-
14 ployee or agent of such organization, or any
15 provider or supplier who contracts with such or-
16 ganization, has engaged in any conduct de-
17 scribed in subparagraphs (A) through (K) of
18 this paragraph.”.

19 (3) PROVISION OF FALSE INFORMATION.—Sec-
20 tion 1857(g)(2)(A) of the Social Security Act (42
21 U.S.C. 1395w—27(g)(2)(A)) is amended by insert-
22 ing “except with respect to a determination under
23 subparagraph (E), an assessment of not more than
24 the amount claimed by such plan or plan sponsor
25 based upon the misrepresentation or falsified infor-

1 mation involved,” after “for each such determina-
2 tion,”.

3 (c) OBSTRUCTION OF PROGRAM AUDITS.—Section
4 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a-
5 7(b)(2)) is amended—

6 (1) in the heading, by inserting “OR AUDIT”
7 after “INVESTIGATION”; and

8 (2) by striking “investigation into” and all that
9 follows through the period and inserting “investiga-
10 tion or audit related to—”

11 “(i) any offense described in para-
12 graph (1) or in subsection (a); or

13 “(ii) the use of funds received, directly
14 or indirectly, from any Federal health care
15 program (as defined in section
16 1128B(f)).”.

17 (d) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Except as provided in para-
19 graph (2), the amendments made by this section
20 shall apply to acts committed on or after January 1,
21 2010.

22 (2) EXCEPTION.—The amendments made by
23 subsection (b)(1) take effect on the date of enact-
24 ment of this Act.

1 **SEC. 6409. MEDICARE SELF-REFERRAL DISCLOSURE PRO-**
2 **TOCOL.**

3 (a) DEVELOPMENT OF SELF-REFERRAL DISCLO-
4 SURE PROTOCOL.—

5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services, in cooperation with the Inspector
7 General of the Department of Health and Human
8 Services, shall establish, not later than 6 months
9 after the date of the enactment of this Act, a pro-
10 tocol to enable health care providers of services and
11 suppliers to disclose an actual or potential violation
12 of section 1877 of the Social Security Act (42
13 U.S.C. 1395nn) pursuant to a self-referral disclosure
14 protocol (in this section referred to as an “SRDP”).
15 The SRDP shall include direction to health care pro-
16 viders of services and suppliers on—

17 (A) a specific person, official, or office to
18 whom such disclosures shall be made; and

19 (B) instruction on the implication of the
20 SRDP on corporate integrity agreements and
21 corporate compliance agreements.

22 (2) PUBLICATION ON INTERNET WEBSITE OF
23 SRDP INFORMATION.—The Secretary of Health and
24 Human Services shall post information on the public
25 Internet website of the Centers for Medicare & Med-
26 icaid Services to inform relevant stakeholders of how

1 to disclose actual or potential violations pursuant to
2 an SRDP.

3 (3) RELATION TO ADVISORY OPINIONS.—The
4 SRDP shall be separate from the advisory opinion
5 process set forth in regulations implementing section
6 1877(g) of the Social Security Act.

7 (b) REDUCTION IN AMOUNTS OWED.—The Secretary
8 of Health and Human Services is authorized to reduce the
9 amount due and owing for all violations under section
10 1877 of the Social Security Act to an amount less than
11 that specified in subsection (g) of such section. In estab-
12 lishing such amount for a violation, the Secretary may
13 consider the following factors:

14 (1) The nature and extent of the improper or
15 illegal practice.

16 (2) The timeliness of such self-disclosure.

17 (3) The cooperation in providing additional in-
18 formation related to the disclosure.

19 (4) Such other factors as the Secretary con-
20 siders appropriate.

21 (c) REPORT.—Not later than 18 months after the
22 date on which the SRDP protocol is established under sub-
23 section (a)(1), the Secretary shall submit to Congress a
24 report on the implementation of this section. Such report
25 shall include—

1 (1) the number of health care providers of serv-
 2 ices and suppliers making disclosures pursuant to
 3 the SRDP;

4 (2) the amounts collected pursuant to the
 5 SRDP;

6 (3) the types of violations reported under the
 7 SRDP; and

8 (4) such other information as may be necessary
 9 to evaluate the impact of this section.

10 **SEC. 6410. ADJUSTMENTS TO THE MEDICARE DURABLE**
 11 **MEDICAL EQUIPMENT, PROSTHETICS,**
 12 **ORTHOTICS, AND SUPPLIES COMPETITIVE**
 13 **ACQUISITION PROGRAM.**

14 (a) **EXPANSION OF ROUND 2 OF THE DME COM-**
 15 **PETITIVE BIDDING PROGRAM.**—Section 1847(a)(1) of the
 16 Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amend-
 17 ed—

18 (1) in subparagraph (B)(i)(II), by striking “70”
 19 and inserting “91”; and

20 (2) in subparagraph (D)(ii)—

21 (A) in subclause (I), by striking “and” at
 22 the end;

23 (B) by redesignating subclause (II) as sub-
 24 clause (III); and

1 (C) by inserting after subclause (I) the fol-
2 lowing new subclause:

3 “(II) the Secretary shall include
4 the next 21 largest metropolitan sta-
5 tistical areas by total population
6 (after those selected under subclause
7 (I)) for such round; and”.

8 (b) REQUIREMENT TO EITHER COMPETITIVELY BID
9 AREAS OR USE COMPETITIVE BID PRICES BY 2016.—
10 Section 1834(a)(1)(F) of the Social Security Act (42
11 U.S.C. 1395m(a)(1)(F)) is amended—

12 (1) in clause (i), by striking “and” at the end;
13 (2) in clause (ii)—

14 (A) by inserting “(and, in the case of cov-
15 ered items furnished on or after January 1,
16 2016, subject to clause (iii), shall)” after
17 “may”; and

18 (B) by striking the period at the end and
19 inserting “; and”; and

20 (3) by adding at the end the following new
21 clause:

22 “(iii) in the case of covered items fur-
23 nished on or after January 1, 2016, the
24 Secretary shall continue to make such ad-
25 justments described in clause (ii) as, under

1 such competitive acquisition programs, ad-
 2 ditional covered items are phased in or in-
 3 formation is updated as contracts under
 4 section 1847 are recompeted in accordance
 5 with section 1847(b)(3)(B).”.

6 **SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CON-**
 7 **TRACTOR (RAC) PROGRAM.**

8 (a) EXPANSION TO MEDICAID.—

9 (1) STATE PLAN AMENDMENT.—Section
 10 1902(a)(42) of the Social Security Act (42 U.S.C.
 11 1396a(a)(42)) is amended—

12 (A) by striking “that the records” and in-
 13 serting “that—

14 “(A) the records”;

15 (B) by inserting “and” after the semicolon;

16 and

17 (C) by adding at the end the following:

18 “(B) not later than December 31, 2010,

19 the State shall—

20 “(i) establish a program under which
 21 the State contracts (consistent with State
 22 law and in the same manner as the Sec-
 23 retary enters into contracts with recovery
 24 audit contractors under section 1893(h),
 25 subject to such exceptions or requirements

1 as the Secretary may require for purposes
2 of this title or a particular State) with 1
3 or more recovery audit contractors for the
4 purpose of identifying underpayments and
5 overpayments and recouping overpayments
6 under the State plan and under any waiver
7 of the State plan with respect to all serv-
8 ices for which payment is made to any en-
9 tity under such plan or waiver; and

10 “(ii) provide assurances satisfactory
11 to the Secretary that—

12 “(I) under such contracts, pay-
13 ment shall be made to such a con-
14 tractor only from amounts recovered;

15 “(II) from such amounts recov-
16 ered, payment—

17 “(aa) shall be made on a
18 contingent basis for collecting
19 overpayments; and

20 “(bb) may be made in such
21 amounts as the State may specify
22 for identifying underpayments;

23 “(III) the State has an adequate
24 process for entities to appeal any ad-

1 verse determination made by such
2 contractors; and

3 “(IV) such program is carried
4 out in accordance with such require-
5 ments as the Secretary shall specify,
6 including—

7 “(aa) for purposes of section
8 1903(a)(7), that amounts ex-
9 pended by the State to carry out
10 the program shall be considered
11 amounts expended as necessary
12 for the proper and efficient ad-
13 ministration of the State plan or
14 a waiver of the plan;

15 “(bb) that section 1903(d)
16 shall apply to amounts recovered
17 under the program; and

18 “(cc) that the State and any
19 such contractors under contract
20 with the State shall coordinate
21 such recovery audit efforts with
22 other contractors or entities per-
23 forming audits of entities receiv-
24 ing payments under the State
25 plan or waiver in the State, in-

1 including efforts with Federal and
2 State law enforcement with re-
3 spect to the Department of Jus-
4 tice, including the Federal Bu-
5 reau of Investigations, the In-
6 spector General of the Depart-
7 ment of Health and Human
8 Services, and the State medicaid
9 fraud control unit; and”.

10 (2) COORDINATION; REGULATIONS.—

11 (A) IN GENERAL.—The Secretary of
12 Health and Human Services, acting through the
13 Administrator of the Centers for Medicare &
14 Medicaid Services, shall coordinate the expan-
15 sion of the Recovery Audit Contractor program
16 to Medicaid with States, particularly with re-
17 spect to each State that enters into a contract
18 with a recovery audit contractor for purposes of
19 the State’s Medicaid program prior to Decem-
20 ber 31, 2010.

21 (B) REGULATIONS.—The Secretary of
22 Health and Human Services shall promulgate
23 regulations to carry out this subsection and the
24 amendments made by this subsection, including

1 with respect to conditions of Federal financial
2 participation, as specified by the Secretary.

3 (b) EXPANSION TO MEDICARE PARTS C AND D.—
4 Section 1893(h) of the Social Security Act (42 U.S.C.
5 1395ddd(h)) is amended—

6 (1) in paragraph (1), in the matter preceding
7 subparagraph (A), by striking “part A or B” and in-
8 serting “this title”;

9 (2) in paragraph (2), by striking “parts A and
10 B” and inserting “this title”;

11 (3) in paragraph (3), by inserting “(not later
12 than December 31, 2010, in the case of contracts re-
13 lating to payments made under part C or D)” after
14 “2010”;

15 (4) in paragraph (4), in the matter preceding
16 subparagraph (A), by striking “part A or B” and in-
17 serting “this title”; and

18 (5) by adding at the end the following:

19 “(9) SPECIAL RULES RELATING TO PARTS C
20 AND D.—The Secretary shall enter into contracts
21 under paragraph (1) to require recovery audit con-
22 tractors to—

23 “(A) ensure that each MA plan under part
24 C has an anti- fraud plan in effect and to re-

1 view the effectiveness of each such anti-fraud
2 plan;

3 “(B) ensure that each prescription drug
4 plan under part D has an anti- fraud plan in
5 effect and to review the effectiveness of each
6 such anti-fraud plan;

7 “(C) examine claims for reinsurance pay-
8 ments under section 1860D–15(b) to determine
9 whether prescription drug plans submitting
10 such claims incurred costs in excess of the al-
11 lowable reinsurance costs permitted under para-
12 graph (2) of that section; and

13 “(D) review estimates submitted by pre-
14 scription drug plans by private plans with re-
15 spect to the enrollment of high cost bene-
16 ficiaries (as defined by the Secretary) and to
17 compare such estimates with the numbers of
18 such beneficiaries actually enrolled by such
19 plans.”.

20 (c) ANNUAL REPORT.—The Secretary of Health and
21 Human Services, acting through the Administrator of the
22 Centers for Medicare & Medicaid Services, shall submit
23 an annual report to Congress concerning the effectiveness
24 of the Recovery Audit Contractor program under Medicaid

1 and Medicare and shall include such reports recommenda-
2 tions for expanding or improving the program.

3 **Subtitle F—Additional Medicaid**
4 **Program Integrity Provisions**

5 **SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION**
6 **UNDER MEDICAID IF TERMINATED UNDER**
7 **MEDICARE OR OTHER STATE PLAN.**

8 Section 1902(a)(39) of the Social Security Act (42
9 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after
10 “1128A,” the following: “terminate the participation of
11 any individual or entity in such program if (subject to
12 such exceptions as are permitted with respect to exclusion
13 under sections 1128(e)(3)(B) and 1128(d)(3)(B)) partici-
14 pation of such individual or entity is terminated under title
15 XVIII or any other State plan under this title,”.

16 **SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION**
17 **RELATING TO CERTAIN OWNERSHIP, CON-**
18 **TROL, AND MANAGEMENT AFFILIATIONS.**

19 Section 1902(a) of the Social Security Act (42 U.S.C.
20 1396a(a)), as amended by section 6401(b), is amended by
21 inserting after paragraph (77) the following:

22 “(78) provide that the State agency described
23 in paragraph (9) exclude, with respect to a period,
24 any individual or entity from participation in the
25 program under the State plan if such individual or

1 entity owns, controls, or manages an entity that (or
2 if such entity is owned, controlled, or managed by an
3 individual or entity that)—

4 “(A) has unpaid overpayments (as defined
5 by the Secretary) under this title during such
6 period determined by the Secretary or the State
7 agency to be delinquent;

8 “(B) is suspended or excluded from par-
9 ticipation under or whose participation is termi-
10 nated under this title during such period; or

11 “(C) is affiliated with an individual or enti-
12 ty that has been suspended or excluded from
13 participation under this title or whose participa-
14 tion is terminated under this title during such
15 period;”.

16 **SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER**
17 **ALTERNATE PAYEES REQUIRED TO REG-**
18 **ISTER UNDER MEDICAID.**

19 (a) IN GENERAL.—Section 1902(a) of the Social Se-
20 curity Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended
21 by section 6502(a), is amended by inserting after para-
22 graph (78), the following:

23 “(79) provide that any agent, clearinghouse, or
24 other alternate payee (as defined by the Secretary)
25 that submits claims on behalf of a health care pro-

1 vider must register with the State and the Secretary
2 in a form and manner specified by the Secretary;”.

3 **SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF**
4 **DATA ELEMENTS UNDER MMIS TO DETECT**
5 **FRAUD AND ABUSE.**

6 (a) IN GENERAL.—Section 1903(r)(1)(F) of the So-
7 cial Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended
8 by inserting after “necessary” the following: “and includ-
9 ing, for data submitted to the Secretary on or after Janu-
10 ary 1, 2010, data elements from the automated data sys-
11 tem that the Secretary determines to be necessary for pro-
12 gram integrity, program oversight, and administration, at
13 such frequency as the Secretary shall determine”.

14 (b) MANAGED CARE ORGANIZATIONS.—

15 (1) IN GENERAL.—Section 1903(m)(2)(A)(xi)
16 of the Social Security Act (42 U.S.C.
17 1396b(m)(2)(A)(xi)) is amended by inserting “and
18 for the provision of such data to the State at a fre-
19 quency and level of detail to be specified by the Sec-
20 retary” after “patients”.

21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply with respect to contract
23 years beginning on or after January 1, 2010.

1 **SEC. 6505. PROHIBITION ON PAYMENTS TO INSTITUTIONS**
2 **OR ENTITIES LOCATED OUTSIDE OF THE**
3 **UNITED STATES.**

4 Section 1902(a) of the Social Security Act (42 U.S.C.
5 1396b(a)), as amended by section 6503, is amended by
6 inserting after paragraph (79) the following new para-
7 graph:

8 “(80) provide that the State shall not provide
9 any payments for items or services provided under
10 the State plan or under a waiver to any financial in-
11 stitution or entity located outside of the United
12 States;”.

13 **SEC. 6506. OVERPAYMENTS.**

14 (a) **EXTENSION OF PERIOD FOR COLLECTION OF**
15 **OVERPAYMENTS DUE TO FRAUD.—**

16 (1) **IN GENERAL.—**Section 1903(d)(2) of the
17 Social Security Act (42 U.S.C. 1396b(d)(2)) is
18 amended—

19 (A) in subparagraph (C)—

20 (i) in the first sentence, by striking
21 “60 days” and inserting “1 year”; and

22 (ii) in the second sentence, by striking
23 “60 days” and inserting “1-year period”;

24 and

25 (B) in subparagraph (D)—

26 (i) in inserting “(i)” after “(D)”; and

1 (ii) by adding at the end the fol-
2 lowing:

3 “(ii) In any case where the State is unable to recover
4 a debt which represents an overpayment (or any portion
5 thereof) made to a person or other entity due to fraud
6 within 1 year of discovery because there is not a final de-
7 termination of the amount of the overpayment under an
8 administrative or judicial process (as applicable), includ-
9 ing as a result of a judgment being under appeal, no ad-
10 justment shall be made in the Federal payment to such
11 State on account of such overpayment (or portion thereof)
12 before the date that is 30 days after the date on which
13 a final judgment (including, if applicable, a final deter-
14 mination on an appeal) is made.”.

15 (2) EFFECTIVE DATE.—The amendments made
16 by this subsection take effect on the date of enact-
17 ment of this Act and apply to overpayments discov-
18 ered on or after that date.

19 (b) CORRECTIVE ACTION.—The Secretary shall pro-
20 mulgate regulations that require States to correct Feder-
21 ally identified claims overpayments, of an ongoing or re-
22 curring nature, with new Medicaid Management Informa-
23 tion System (MMIS) edits, audits, or other appropriate
24 corrective action.

1 **SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT**
2 **CODING INITIATIVE.**

3 Section 1903(r) of the Social Security Act (42 U.S.C.
4 1396b(r)) is amended—

5 (1) in paragraph (1)(B)—

6 (A) in clause (ii), by striking “and” at the
7 end;

8 (B) in clause (iii), by adding “and” after
9 the semi-colon; and

10 (C) by adding at the end the following new
11 clause:

12 “(iv) effective for claims filed on or
13 after October 1, 2010, incorporate compat-
14 ible methodologies of the National Correct
15 Coding Initiative administered by the Sec-
16 retary (or any successor initiative to pro-
17 mote correct coding and to control im-
18 proper coding leading to inappropriate pay-
19 ment) and such other methodologies of
20 that Initiative (or such other national cor-
21 rect coding methodologies) as the Sec-
22 retary identifies in accordance with para-
23 graph (4);” and

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

1 “(4) For purposes of paragraph (1)(B)(iv), the Sec-
2 retary shall do the following:

3 “(A) Not later than September 1, 2010:

4 “(i) Identify those methodologies of the
5 National Correct Coding Initiative administered
6 by the Secretary (or any successor initiative to
7 promote correct coding and to control improper
8 coding leading to inappropriate payment) which
9 are compatible to claims filed under this title.

10 “(ii) Identify those methodologies of such
11 Initiative (or such other national correct coding
12 methodologies) that should be incorporated into
13 claims filed under this title with respect to
14 items or services for which States provide med-
15 ical assistance under this title and no national
16 correct coding methodologies have been estab-
17 lished under such Initiative with respect to title
18 XVIII.

19 “(iii) Notify States of—

20 “(I) the methodologies identified
21 under subparagraphs (A) and (B) (and of
22 any other national correct coding meth-
23 odologies identified under subparagraph
24 (B)); and

1 “(II) how States are to incorporate
2 such methodologies into claims filed under
3 this title.

4 “(B) Not later than March 1, 2011, submit a
5 report to Congress that includes the notice to States
6 under clause (iii) of subparagraph (A) and an anal-
7 ysis supporting the identification of the methodolo-
8 gies made under clauses (i) and (ii) of subparagraph
9 (A).”.

10 **SEC. 6508. GENERAL EFFECTIVE DATE.**

11 (a) IN GENERAL.—Except as otherwise provided in
12 this subtitle, this subtitle and the amendments made by
13 this subtitle take effect on January 1, 2011, without re-
14 gard to whether final regulations to carry out such amend-
15 ments and subtitle have been promulgated by that date.

16 (b) DELAY IF STATE LEGISLATION REQUIRED.—In
17 the case of a State plan for medical assistance under title
18 XIX of the Social Security Act or a child health plan
19 under title XXI of such Act which the Secretary of Health
20 and Human Services determines requires State legislation
21 (other than legislation appropriating funds) in order for
22 the plan to meet the additional requirement imposed by
23 the amendments made by this subtitle, the State plan or
24 child health plan shall not be regarded as failing to comply
25 with the requirements of such title solely on the basis of

1 its failure to meet this additional requirement before the
 2 first day of the first calendar quarter beginning after the
 3 close of the first regular session of the State legislature
 4 that begins after the date of the enactment of this Act.
 5 For purposes of the previous sentence, in the case of a
 6 State that has a 2-year legislative session, each year of
 7 such session shall be deemed to be a separate regular ses-
 8 sion of the State legislature.

9 **Subtitle G—Additional Program** 10 **Integrity Provisions**

11 **SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REP-** 12 **RESENTATIONS.**

13 (a) PROHIBITION.—Part 5 of subtitle B of title I of
 14 the Employee Retirement Income Security Act of 1974
 15 (29 U.S.C. 1131 et seq.) is amended by adding at the end
 16 the following:

17 **“SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REP-** 18 **RESENTATIONS.**

19 “No person, in connection with a plan or other ar-
 20 rangement that is multiple employer welfare arrangement
 21 described in section 3(40), shall make a false statement
 22 or false representation of fact, knowing it to be false, in
 23 connection with the marketing or sale of such plan or ar-
 24 rangement, to any employee, any member of an employee
 25 organization, any beneficiary, any employer, any employee

1 organization, the Secretary, or any State, or the represent-
2 ative or agent of any such person, State, or the Secretary,
3 concerning—

4 “(1) the financial condition or solvency of such
5 plan or arrangement;

6 “(2) the benefits provided by such plan or ar-
7 rangement;

8 “(3) the regulatory status of such plan or other
9 arrangement under any Federal or State law gov-
10 erning collective bargaining, labor management rela-
11 tions, or intern union affairs; or

12 “(4) the regulatory status of such plan or other
13 arrangement regarding exemption from state regu-
14 latory authority under this Act.

15 This section shall not apply to any plan or arrangement
16 that does not fall within the meaning of the term ‘multiple
17 employer welfare arrangement’ under section 3(40)(A).”.

18 (b) CRIMINAL PENALTIES.—Section 501 of the Em-
19 ployee Retirement Income Security Act of 1974 (29
20 U.S.C. 1131) is amended—

21 (1) by inserting “(a)” before “Any person”; and

22 (2) by adding at the end the following:

23 “(b) Any person that violates section 519 shall upon
24 conviction be imprisoned not more than 10 years or fined
25 under title 18, United States Code, or both.”.

1 (c) CONFORMING AMENDMENT.—The table of sec-
 2 tions for part 5 of subtitle B of title I of the Employee
 3 Retirement Income Security Act of 1974 is amended by
 4 adding at the end the following:

“Sec. 519. Prohibition on false statement and representations.”.

5 **SEC. 6602. CLARIFYING DEFINITION.**

6 Section 24(a)(2) of title 18, United States Code, is
 7 amended by inserting “or section 411, 518, or 511 of the
 8 Employee Retirement Income Security Act of 1974,” after
 9 “1954 of this title”.

10 **SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT**
 11 **FORM.**

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

15 **“SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FOR-**
 16 **MAT.**

17 “The Secretary shall request the National Associa-
 18 tion of Insurance Commissioners to develop a model uni-
 19 form report form for private health insurance issuer seek-
 20 ing to refer suspected fraud and abuse to State insurance
 21 departments or other responsible State agencies for inves-
 22 tigation. The Secretary shall request that the National As-
 23 sociation of Insurance Commissioners develop rec-
 24 ommendations for uniform reporting standards for such
 25 referrals.”.

1 **SEC. 6604. APPLICABILITY OF STATE LAW TO COMBAT**
2 **FRAUD AND ABUSE.**

3 (a) **IN GENERAL.**—Part 5 of subtitle B of title I of
4 the Employee Retirement Income Security Act of 1974
5 (29 U.S.C. 1131 et seq.), as amended by section 6601,
6 is further amended by adding at the end the following:

7 **“SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT**
8 **FRAUD AND ABUSE.**

9 “The Secretary may, for the purpose of identifying,
10 preventing, or prosecuting fraud and abuse, adopt regu-
11 latory standards establishing, or issue an order relating
12 to a specific person establishing, that a person engaged
13 in the business of providing insurance through a multiple
14 employer welfare arrangement described in section 3(40)
15 is subject to the laws of the States in which such person
16 operates which regulate insurance in such State, notwith-
17 standing section 514(b)(6) of this Act or the Liability Risk
18 Retention Act of 1986, and regardless of whether the law
19 of the State is otherwise preempted under any of such pro-
20 visions. This section shall not apply to any plan or ar-
21 rangement that does not fall within the meaning of the
22 term ‘multiple employer welfare arrangement’ under sec-
23 tion 3(40(A)).”

24 (b) **CONFORMING AMENDMENT.**—The table of sec-
25 tions for part 5 of subtitle B of title I of the Employee
26 Retirement Income Security Act of 1974, as amended by

1 section 6601, is further amended by adding at the end
2 the following:

“Sec. 520. Applicability of State law to combat fraud and abuse.”.

3 **SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO**
4 **ISSUE ADMINISTRATIVE SUMMARY CEASE**
5 **AND DESIST ORDERS AND SUMMARY SEI-**
6 **ZURES ORDERS AGAINST PLANS THAT ARE IN**
7 **FINANCIALLY HAZARDOUS CONDITION.**

8 (a) IN GENERAL.—Part 5 of subtitle B of title I of
9 the Employee Retirement Income Security Act of 1974
10 (29 U.S.C. 1131 et seq.), as amended by section 6604,
11 is further amended by adding at the end the following:

12 **“SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST**
13 **ORDERS AND SUMMARY SEIZURE ORDERS**
14 **AGAINST MULTIPLE EMPLOYER WELFARE**
15 **ARRANGEMENTS IN FINANCIALLY HAZ-**
16 **ARDOUS CONDITION.**

17 “(a) IN GENERAL.—The Secretary may issue a cease
18 and desist (ex parte) order under this title if it appears
19 to the Secretary that the alleged conduct of a multiple em-
20 ployer welfare arrangement described in section 3(40),
21 other than a plan or arrangement described in subsection
22 (g), is fraudulent, or creates an immediate danger to the
23 public safety or welfare, or is causing or can be reasonably
24 expected to cause significant, imminent, and irreparable
25 public injury.

1 “(b) HEARING.—A person that is adversely affected
2 by the issuance of a cease and desist order under sub-
3 section (a) may request a hearing by the Secretary regard-
4 ing such order. The Secretary may require that a pro-
5 ceeding under this section, including all related informa-
6 tion and evidence, be conducted in a confidential manner.

7 “(c) BURDEN OF PROOF.—The burden of proof in
8 any hearing conducted under subsection (b) shall be on
9 the party requesting the hearing to show cause why the
10 cease and desist order should be set aside.

11 “(d) DETERMINATION.—Based upon the evidence
12 presented at a hearing under subsection (b), the cease and
13 desist order involved may be affirmed, modified, or set
14 aside by the Secretary in whole or in part.

15 “(e) SEIZURE.—The Secretary may issue a summary
16 seizure order under this title if it appears that a multiple
17 employer welfare arrangement is in a financially haz-
18 ardous condition.

19 “(f) REGULATIONS.—The Secretary may promulgate
20 such regulations or other guidance as may be necessary
21 or appropriate to carry out this section.

22 “(g) EXCEPTION.—This section shall not apply to
23 any plan or arrangement that does not fall within the
24 meaning of the term ‘multiple employer welfare arrange-
25 ment’ under section 3(40(A)).”.

1 (b) CONFORMING AMENDMENT.—The table of sec-
 2 tions for part 5 of subtitle B of title I of the Employee
 3 Retirement Income Security Act of 1974, as amended by
 4 section 6604, is further amended by adding at the end
 5 the following:

“Sec. 521. Administrative summary cease and desist orders and summary sei-
 zure orders against health plans in financially hazardous condi-
 tion.”.

6 **SEC. 6606. MEWA PLAN REGISTRATION WITH DEPARTMENT**
 7 **OF LABOR.**

8 Section 101(g) of the Employee Retirement Income
 9 Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

10 (1) by striking “Secretary may” and inserting
 11 “Secretary shall”; and

12 (2) by inserting “to register with the Secretary
 13 prior to operating in a State and may, by regulation,
 14 require such multiple employer welfare arrange-
 15 ments” after “not group health plans”.

16 **SEC. 6607. PERMITTING EVIDENTIARY PRIVILEGE AND**
 17 **CONFIDENTIAL COMMUNICATIONS.**

18 Section 504 of the Employee Retirement Income Se-
 19 curity Act of 1974 (29 U.S.C. 1134) is amended by adding
 20 at the end the following:

21 “(d) The Secretary may promulgate a regulation that
 22 provides an evidentiary privilege for, and provides for the
 23 confidentiality of communications between or among, any

1 of the following entities or their agents, consultants, or
2 employees:

3 “(1) A State insurance department.

4 “(2) A State attorney general.

5 “(3) The National Association of Insurance
6 Commissioners.

7 “(4) The Department of Labor.

8 “(5) The Department of the Treasury.

9 “(6) The Department of Justice.

10 “(7) The Department of Health and Human
11 Services.

12 “(8) Any other Federal or State authority that
13 the Secretary determines is appropriate for the pur-
14 poses of enforcing the provisions of this title.

15 “(e) The privilege established under subsection (d)
16 shall apply to communications related to any investigation,
17 audit, examination, or inquiry conducted or coordinated
18 by any of the agencies. A communication that is privileged
19 under subsection (d) shall not waive any privilege other-
20 wise available to the communicating agency or to any per-
21 son who provided the information that is communicated.”.

22 **Subtitle H—Elder Justice Act**

23 **SEC. 6701. SHORT TITLE OF SUBTITLE.**

24 This subtitle may be cited as the “Elder Justice Act
25 of 2009”.

1 **SEC. 6702. DEFINITIONS.**

2 Except as otherwise specifically provided, any term
3 that is defined in section 2011 of the Social Security Act
4 (as added by section 6703(a)) and is used in this subtitle
5 has the meaning given such term by such section.

6 **SEC. 6703. ELDER JUSTICE.**

7 (a) ELDER JUSTICE.—

8 (1) IN GENERAL.—Title XX of the Social Secu-
9 rity Act (42 U.S.C. 1397 et seq.) is amended—

10 (A) in the heading, by inserting “**AND**
11 **ELDER JUSTICE**” after “**SOCIAL**
12 **SERVICES**”;

13 (B) by inserting before section 2001 the
14 following:

15 **“Subtitle A—Block Grants to States**
16 **for Social Services”;**

17 and

18 (C) by adding at the end the following:

19 **“Subtitle B—Elder Justice**

20 **“SEC. 2011. DEFINITIONS.**

21 “In this subtitle:

22 “(1) ABUSE.—The term ‘abuse’ means the
23 knowing infliction of physical or psychological harm
24 or the knowing deprivation of goods or services that
25 are necessary to meet essential needs or to avoid
26 physical or psychological harm.

1 “(2) ADULT PROTECTIVE SERVICES.—The term
2 ‘adult protective services’ means such services pro-
3 vided to adults as the Secretary may specify and in-
4 cludes services such as—

5 “(A) receiving reports of adult abuse, ne-
6 glect, or exploitation;

7 “(B) investigating the reports described in
8 subparagraph (A);

9 “(C) case planning, monitoring, evaluation,
10 and other case work and services; and

11 “(D) providing, arranging for, or facili-
12 tating the provision of medical, social service,
13 economic, legal, housing, law enforcement, or
14 other protective, emergency, or support services.

15 “(3) CAREGIVER.—The term ‘caregiver’ means
16 an individual who has the responsibility for the care
17 of an elder, either voluntarily, by contract, by receipt
18 of payment for care, or as a result of the operation
19 of law, and means a family member or other indi-
20 vidual who provides (on behalf of such individual or
21 of a public or private agency, organization, or insti-
22 tution) compensated or uncompensated care to an
23 elder who needs supportive services in any setting.

24 “(4) DIRECT CARE.—The term ‘direct care’
25 means care by an employee or contractor who pro-

1 vides assistance or long-term care services to a re-
2 cipient.

3 “(5) ELDER.—The term ‘elder’ means an indi-
4 vidual age 60 or older.

5 “(6) ELDER JUSTICE.—The term ‘elder justice’
6 means—

7 “(A) from a societal perspective, efforts
8 to—

9 “(i) prevent, detect, treat, intervene
10 in, and prosecute elder abuse, neglect, and
11 exploitation; and

12 “(ii) protect elders with diminished
13 capacity while maximizing their autonomy;
14 and

15 “(B) from an individual perspective, the
16 recognition of an elder’s rights, including the
17 right to be free of abuse, neglect, and exploi-
18 tation.

19 “(7) ELIGIBLE ENTITY.—The term ‘eligible en-
20 tity’ means a State or local government agency, In-
21 dian tribe or tribal organization, or any other public
22 or private entity that is engaged in and has expertise
23 in issues relating to elder justice or in a field nec-
24 essary to promote elder justice efforts.

1 “(8) EXPLOITATION.—The term ‘exploitation’
2 means the fraudulent or otherwise illegal, unauthor-
3 ized, or improper act or process of an individual, in-
4 cluding a caregiver or fiduciary, that uses the re-
5 sources of an elder for monetary or personal benefit,
6 profit, or gain, or that results in depriving an elder
7 of rightful access to, or use of, benefits, resources,
8 belongings, or assets.

9 “(9) FIDUCIARY.—The term ‘fiduciary’—

10 “(A) means a person or entity with the
11 legal responsibility—

12 “(i) to make decisions on behalf of
13 and for the benefit of another person; and

14 “(ii) to act in good faith and with
15 fairness; and

16 “(B) includes a trustee, a guardian, a con-
17 servator, an executor, an agent under a finan-
18 cial power of attorney or health care power of
19 attorney, or a representative payee.

20 “(10) GRANT.—The term ‘grant’ includes a
21 contract, cooperative agreement, or other mechanism
22 for providing financial assistance.

23 “(11) GUARDIANSHIP.—The term ‘guardian-
24 ship’ means—

1 “(A) the process by which a State court
2 determines that an adult individual lacks capac-
3 ity to make decisions about self-care or prop-
4 erty, and appoints another individual or entity
5 known as a guardian, as a conservator, or by a
6 similar term, as a surrogate decisionmaker;

7 “(B) the manner in which the court-ap-
8 pointed surrogate decisionmaker carries out du-
9 ties to the individual and the court; or

10 “(C) the manner in which the court exer-
11 cises oversight of the surrogate decisionmaker.

12 “(12) INDIAN TRIBE.—

13 “(A) IN GENERAL.—The term ‘Indian
14 tribe’ has the meaning given such term in sec-
15 tion 4 of the Indian Self-Determination and
16 Education Assistance Act (25 U.S.C. 450b).

17 “(B) INCLUSION OF PUEBLO AND
18 RANCHERIA.—The term ‘Indian tribe’ includes
19 any Pueblo or Rancheria.

20 “(13) LAW ENFORCEMENT.—The term ‘law en-
21 forcement’ means the full range of potential re-
22 sponders to elder abuse, neglect, and exploitation in-
23 cluding—

24 “(A) police, sheriffs, detectives, public safe-
25 ty officers, and corrections personnel;

1 “(B) prosecutors;

2 “(C) medical examiners;

3 “(D) investigators; and

4 “(E) coroners.

5 “(14) LONG-TERM CARE.—

6 “(A) IN GENERAL.—The term ‘long-term
7 care’ means supportive and health services spec-
8 ified by the Secretary for individuals who need
9 assistance because the individuals have a loss of
10 capacity for self-care due to illness, disability,
11 or vulnerability.

12 “(B) LOSS OF CAPACITY FOR SELF-
13 CARE.—For purposes of subparagraph (A), the
14 term ‘loss of capacity for self-care’ means an in-
15 ability to engage in 1 or more activities of daily
16 living, including eating, dressing, bathing, man-
17 agement of one’s financial affairs, and other ac-
18 tivities the Secretary determines appropriate.

19 “(15) LONG-TERM CARE FACILITY.—The term
20 ‘long-term care facility’ means a residential care pro-
21 vider that arranges for, or directly provides, long-
22 term care.

23 “(16) NEGLECT.—The term ‘neglect’ means—

24 “(A) the failure of a caregiver or fiduciary
25 to provide the goods or services that are nec-

1 essary to maintain the health or safety of an
2 elder; or

3 “(B) self-neglect.

4 “(17) NURSING FACILITY.—

5 “(A) IN GENERAL.—The term ‘nursing fa-
6 cility’ has the meaning given such term under
7 section 1919(a).

8 “(B) INCLUSION OF SKILLED NURSING FA-
9 CILITY.—The term ‘nursing facility’ includes a
10 skilled nursing facility (as defined in section
11 1819(a)).

12 “(18) SELF-NEGLECT.—The term ‘self-neglect’
13 means an adult’s inability, due to physical or mental
14 impairment or diminished capacity, to perform es-
15 sential self-care tasks including—

16 “(A) obtaining essential food, clothing,
17 shelter, and medical care;

18 “(B) obtaining goods and services nec-
19 essary to maintain physical health, mental
20 health, or general safety; or

21 “(C) managing one’s own financial affairs.

22 “(19) SERIOUS BODILY INJURY.—

23 “(A) IN GENERAL.—The term ‘serious
24 bodily injury’ means an injury—

25 “(i) involving extreme physical pain;

1 “(ii) involving substantial risk of
2 death;

3 “(iii) involving protracted loss or im-
4 pairment of the function of a bodily mem-
5 ber, organ, or mental faculty; or

6 “(iv) requiring medical intervention
7 such as surgery, hospitalization, or phys-
8 ical rehabilitation.

9 “(B) CRIMINAL SEXUAL ABUSE.—Serious
10 bodily injury shall be considered to have oc-
11 curred if the conduct causing the injury is con-
12 duct described in section 2241 (relating to ag-
13 gravated sexual abuse) or 2242 (relating to sex-
14 ual abuse) of title 18, United States Code, or
15 any similar offense under State law.

16 “(20) SOCIAL.—The term ‘social’, when used
17 with respect to a service, includes adult protective
18 services.

19 “(21) STATE LEGAL ASSISTANCE DEVEL-
20 OPER.—The term ‘State legal assistance developer’
21 means an individual described in section 731 of the
22 Older Americans Act of 1965.

23 “(22) STATE LONG-TERM CARE OMBUDSMAN.—
24 The term ‘State Long-Term Care Ombudsman’
25 means the State Long-Term Care Ombudsman de-

1 scribed in section 712(a)(2) of the Older Americans
2 Act of 1965.

3 **“SEC. 2012. GENERAL PROVISIONS.**

4 “(a) PROTECTION OF PRIVACY.—In pursuing activi-
5 ties under this subtitle, the Secretary shall ensure the pro-
6 tection of individual health privacy consistent with the reg-
7 ulations promulgated under section 264(c) of the Health
8 Insurance Portability and Accountability Act of 1996 and
9 applicable State and local privacy regulations.

10 “(b) RULE OF CONSTRUCTION.—Nothing in this sub-
11 title shall be construed to interfere with or abridge an el-
12 der’s right to practice his or her religion through reliance
13 on prayer alone for healing when this choice—

14 “(1) is contemporaneously expressed, either
15 orally or in writing, with respect to a specific illness
16 or injury which the elder has at the time of the deci-
17 sion by an elder who is competent at the time of the
18 decision;

19 “(2) is previously set forth in a living will,
20 health care proxy, or other advance directive docu-
21 ment that is validly executed and applied under
22 State law; or

23 “(3) may be unambiguously deduced from the
24 elder’s life history.

1 **“PART I—NATIONAL COORDINATION OF ELDER**
2 **JUSTICE ACTIVITIES AND RESEARCH**
3 **“Subpart A—Elder Justice Coordinating Council and**
4 **Advisory Board on Elder Abuse, Neglect, and Ex-**
5 **ploitation**

6 **“SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.**

7 “(a) ESTABLISHMENT.—There is established within
8 the Office of the Secretary an Elder Justice Coordinating
9 Council (in this section referred to as the ‘Council’).

10 “(b) MEMBERSHIP.—

11 “(1) IN GENERAL.—The Council shall be com-
12 posed of the following members:

13 “(A) The Secretary (or the Secretary’s
14 designee).

15 “(B) The Attorney General (or the Attor-
16 ney General’s designee).

17 “(C) The head of each Federal department
18 or agency or other governmental entity identi-
19 fied by the Chair referred to in subsection (d)
20 as having responsibilities, or administering pro-
21 grams, relating to elder abuse, neglect, and ex-
22 ploitation.

23 “(2) REQUIREMENT.—Each member of the
24 Council shall be an officer or employee of the Fed-
25 eral Government.

1 “(c) VACANCIES.—Any vacancy in the Council shall
2 not affect its powers, but shall be filled in the same man-
3 ner as the original appointment was made.

4 “(d) CHAIR.—The member described in subsection
5 (b)(1)(A) shall be Chair of the Council.

6 “(e) MEETINGS.—The Council shall meet at least 2
7 times per year, as determined by the Chair.

8 “(f) DUTIES.—

9 “(1) IN GENERAL.—The Council shall make
10 recommendations to the Secretary for the coordina-
11 tion of activities of the Department of Health and
12 Human Services, the Department of Justice, and
13 other relevant Federal, State, local, and private
14 agencies and entities, relating to elder abuse, ne-
15 glect, and exploitation and other crimes against el-
16 ders.

17 “(2) REPORT.—Not later than the date that is
18 2 years after the date of enactment of the Elder
19 Justice Act of 2009 and every 2 years thereafter,
20 the Council shall submit to the Committee on Fi-
21 nance of the Senate and the Committee on Ways
22 and Means and the Committee on Energy and Com-
23 merce of the House of Representatives a report
24 that—

1 “(A) describes the activities and accom-
2 plishments of, and challenges faced by—

3 “(i) the Council; and

4 “(ii) the entities represented on the
5 Council; and

6 “(B) makes such recommendations for leg-
7 islation, model laws, or other action as the
8 Council determines to be appropriate.

9 “(g) POWERS OF THE COUNCIL.—

10 “(1) INFORMATION FROM FEDERAL AGEN-
11 CIES.—Subject to the requirements of section
12 2012(a), the Council may secure directly from any
13 Federal department or agency such information as
14 the Council considers necessary to carry out this sec-
15 tion. Upon request of the Chair of the Council, the
16 head of such department or agency shall furnish
17 such information to the Council.

18 “(2) POSTAL SERVICES.—The Council may use
19 the United States mails in the same manner and
20 under the same conditions as other departments and
21 agencies of the Federal Government.

22 “(h) TRAVEL EXPENSES.—The members of the
23 Council shall not receive compensation for the perform-
24 ance of services for the Council. The members shall be
25 allowed travel expenses, including per diem in lieu of sub-

1 sistence, at rates authorized for employees of agencies
2 under subchapter I of chapter 57 of title 5, United States
3 Code, while away from their homes or regular places of
4 business in the performance of services for the Council.
5 Notwithstanding section 1342 of title 31, United States
6 Code, the Secretary may accept the voluntary and uncom-
7 pensated services of the members of the Council.

8 “(i) **DETAIL OF GOVERNMENT EMPLOYEES.**—Any
9 Federal Government employee may be detailed to the
10 Council without reimbursement, and such detail shall be
11 without interruption or loss of civil service status or privi-
12 lege.

13 “(j) **STATUS AS PERMANENT COUNCIL.**—Section 14
14 of the Federal Advisory Committee Act (5 U.S.C. App.)
15 shall not apply to the Council.

16 “(k) **AUTHORIZATION OF APPROPRIATIONS.**—There
17 are authorized to be appropriated such sums as are nec-
18 essary to carry out this section.

19 **“SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT,**
20 **AND EXPLOITATION.**

21 “(a) **ESTABLISHMENT.**—There is established a board
22 to be known as the ‘Advisory Board on Elder Abuse, Ne-
23 glect, and Exploitation’ (in this section referred to as the
24 ‘Advisory Board’) to create short- and long-term multi-
25 disciplinary strategic plans for the development of the field

1 of elder justice and to make recommendations to the Elder
2 Justice Coordinating Council established under section
3 2021.

4 “(b) COMPOSITION.—The Advisory Board shall be
5 composed of 27 members appointed by the Secretary from
6 among members of the general public who are individuals
7 with experience and expertise in elder abuse, neglect, and
8 exploitation prevention, detection, treatment, intervention,
9 or prosecution.

10 “(c) SOLICITATION OF NOMINATIONS.—The Sec-
11 retary shall publish a notice in the Federal Register solie-
12 iting nominations for the appointment of members of the
13 Advisory Board under subsection (b).

14 “(d) TERMS.—

15 “(1) IN GENERAL.—Each member of the Advi-
16 sory Board shall be appointed for a term of 3 years,
17 except that, of the members first appointed—

18 “(A) 9 shall be appointed for a term of 3
19 years;

20 “(B) 9 shall be appointed for a term of 2
21 years; and

22 “(C) 9 shall be appointed for a term of 1
23 year.

24 “(2) VACANCIES.—

1 “(A) IN GENERAL.—Any vacancy on the
2 Advisory Board shall not affect its powers, but
3 shall be filled in the same manner as the origi-
4 nal appointment was made.

5 “(B) FILLING UNEXPIRED TERM.—An in-
6 dividual chosen to fill a vacancy shall be ap-
7 pointed for the unexpired term of the member
8 replaced.

9 “(3) EXPIRATION OF TERMS.—The term of any
10 member shall not expire before the date on which
11 the member’s successor takes office.

12 “(e) ELECTION OF OFFICERS.—The Advisory Board
13 shall elect a Chair and Vice Chair from among its mem-
14 bers. The Advisory Board shall elect its initial Chair and
15 Vice Chair at its initial meeting.

16 “(f) DUTIES.—

17 “(1) ENHANCE COMMUNICATION ON PRO-
18 MOTING QUALITY OF, AND PREVENTING ABUSE, NE-
19 GLECT, AND EXPLOITATION IN, LONG-TERM CARE.—
20 The Advisory Board shall develop collaborative and
21 innovative approaches to improve the quality of, in-
22 cluding preventing abuse, neglect, and exploitation
23 in, long-term care.

1 “(2) COLLABORATIVE EFFORTS TO DEVELOP
2 CONSENSUS AROUND THE MANAGEMENT OF CER-
3 TAIN QUALITY-RELATED FACTORS.—

4 “(A) IN GENERAL.—The Advisory Board
5 shall establish multidisciplinary panels to ad-
6 dress, and develop consensus on, subjects relat-
7 ing to improving the quality of long-term care.
8 At least 1 such panel shall address, and develop
9 consensus on, methods for managing resident-
10 to-resident abuse in long-term care.

11 “(B) ACTIVITIES CONDUCTED.—The multi-
12 disciplinary panels established under subpara-
13 graph (A) shall examine relevant research and
14 data, identify best practices with respect to the
15 subject of the panel, determine the best way to
16 carry out those best practices in a practical and
17 feasible manner, and determine an effective
18 manner of distributing information on such
19 subject.

20 “(3) REPORT.—Not later than the date that is
21 18 months after the date of enactment of the Elder
22 Justice Act of 2009, and annually thereafter, the
23 Advisory Board shall prepare and submit to the
24 Elder Justice Coordinating Council, the Committee
25 on Finance of the Senate, and the Committee on

1 Ways and Means and the Committee on Energy and
2 Commerce of the House of Representatives a report
3 containing—

4 “(A) information on the status of Federal,
5 State, and local public and private elder justice
6 activities;

7 “(B) recommendations (including rec-
8 ommended priorities) regarding—

9 “(i) elder justice programs, research,
10 training, services, practice, enforcement,
11 and coordination;

12 “(ii) coordination between entities
13 pursuing elder justice efforts and those in-
14 volved in related areas that may inform or
15 overlap with elder justice efforts, such as
16 activities to combat violence against women
17 and child abuse and neglect; and

18 “(iii) activities relating to adult fidu-
19 ciary systems, including guardianship and
20 other fiduciary arrangements;

21 “(C) recommendations for specific modi-
22 fications needed in Federal and State laws (in-
23 cluding regulations) or for programs, research,
24 and training to enhance prevention, detection,
25 and treatment (including diagnosis) of, inter-

1 vention in (including investigation of), and
2 prosecution of elder abuse, neglect, and exploi-
3 tation;

4 “(D) recommendations on methods for the
5 most effective coordinated national data collec-
6 tion with respect to elder justice, and elder
7 abuse, neglect, and exploitation; and

8 “(E) recommendations for a multidisci-
9 plinary strategic plan to guide the effective and
10 efficient development of the field of elder jus-
11 tice.

12 “(g) POWERS OF THE ADVISORY BOARD.—

13 “(1) INFORMATION FROM FEDERAL AGEN-
14 CIES.—Subject to the requirements of section
15 2012(a), the Advisory Board may secure directly
16 from any Federal department or agency such infor-
17 mation as the Advisory Board considers necessary to
18 carry out this section. Upon request of the Chair of
19 the Advisory Board, the head of such department or
20 agency shall furnish such information to the Advi-
21 sory Board.

22 “(2) SHARING OF DATA AND REPORTS.—The
23 Advisory Board may request from any entity pur-
24 suing elder justice activities under the Elder Justice
25 Act of 2009 or an amendment made by that Act,

1 any data, reports, or recommendations generated in
2 connection with such activities.

3 “(3) POSTAL SERVICES.—The Advisory Board
4 may use the United States mails in the same man-
5 ner and under the same conditions as other depart-
6 ments and agencies of the Federal Government.

7 “(h) TRAVEL EXPENSES.—The members of the Advi-
8 sory Board shall not receive compensation for the perform-
9 ance of services for the Advisory Board. The members
10 shall be allowed travel expenses for up to 4 meetings per
11 year, including per diem in lieu of subsistence, at rates
12 authorized for employees of agencies under subchapter I
13 of chapter 57 of title 5, United States Code, while away
14 from their homes or regular places of business in the per-
15 formance of services for the Advisory Board. Notwith-
16 standing section 1342 of title 31, United States Code, the
17 Secretary may accept the voluntary and uncompensated
18 services of the members of the Advisory Board.

19 “(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any
20 Federal Government employee may be detailed to the Ad-
21 visory Board without reimbursement, and such detail shall
22 be without interruption or loss of civil service status or
23 privilege.

1 “(j) STATUS AS PERMANENT ADVISORY COM-
2 MITTEE.—Section 14 of the Federal Advisory Committee
3 Act (5 U.S.C. App.) shall not apply to the advisory board.

4 “(k) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated such sums as are nec-
6 essary to carry out this section.

7 **“SEC. 2023. RESEARCH PROTECTIONS.**

8 “(a) GUIDELINES.—The Secretary shall promulgate
9 guidelines to assist researchers working in the area of
10 elder abuse, neglect, and exploitation, with issues relating
11 to human subject protections.

12 “(b) DEFINITION OF LEGALLY AUTHORIZED REP-
13 RESENTATIVE FOR APPLICATION OF REGULATIONS.—For
14 purposes of the application of subpart A of part 46 of title
15 45, Code of Federal Regulations, to research conducted
16 under this subpart, the term ‘legally authorized represent-
17 ative’ means, unless otherwise provided by law, the indi-
18 vidual or judicial or other body authorized under the appli-
19 cable law to consent to medical treatment on behalf of an-
20 other person.

21 **“SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.**

22 ““There are authorized to be appropriated to carry out
23 this subpart—

24 “(1) for fiscal year 2011, \$6,500,000; and

1 ceives a grant under this section shall use funds
2 made available through the grant to assist in deter-
3 mining whether abuse, neglect, or exploitation oc-
4 curred and whether a crime was committed and to
5 conduct research to describe and disseminate infor-
6 mation on—

7 “(A) forensic markers that indicate a case
8 in which elder abuse, neglect, or exploitation
9 may have occurred; and

10 “(B) methodologies for determining, in
11 such a case, when and how health care, emer-
12 gency service, social and protective services, and
13 legal service providers should intervene and
14 when the providers should report the case to
15 law enforcement authorities.

16 “(2) DEVELOPMENT OF FORENSIC EXPER-
17 TISE.—An eligible entity that receives a grant under
18 this section shall use funds made available through
19 the grant to develop forensic expertise regarding
20 elder abuse, neglect, and exploitation in order to
21 provide medical and forensic evaluation, therapeutic
22 intervention, victim support and advocacy, case re-
23 view, and case tracking.

24 “(3) COLLECTION OF EVIDENCE.—The Sec-
25 retary, in coordination with the Attorney General,

1 shall use data made available by grant recipients
2 under this section to develop the capacity of geriatric
3 health care professionals and law enforcement to col-
4 lect forensic evidence, including collecting forensic
5 evidence relating to a potential determination of
6 elder abuse, neglect, or exploitation.

7 “(e) APPLICATION.—To be eligible to receive a grant
8 under this section, an entity shall submit an application
9 to the Secretary at such time, in such manner, and con-
10 taining such information as the Secretary may require.

11 “(f) AUTHORIZATION OF APPROPRIATIONS.—There
12 are authorized to be appropriated to carry out this sec-
13 tion—

14 “(1) for fiscal year 2011, \$4,000,000;

15 “(2) for fiscal year 2012, \$6,000,000; and

16 “(3) for each of fiscal years 2013 and 2014,
17 \$8,000,000.

18 **“PART II—PROGRAMS TO PROMOTE ELDER**

19 **JUSTICE**

20 **“SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.**

21 “(a) GRANTS AND INCENTIVES FOR LONG-TERM
22 CARE STAFFING.—

23 “(1) IN GENERAL.—The Secretary shall carry
24 out activities, including activities described in para-
25 graphs (2) and (3), to provide incentives for individ-

1 uals to train for, seek, and maintain employment
2 providing direct care in long-term care.

3 “(2) SPECIFIC PROGRAMS TO ENHANCE TRAIN-
4 ING, RECRUITMENT, AND RETENTION OF STAFF.—

5 “(A) COORDINATION WITH SECRETARY OF
6 LABOR TO RECRUIT AND TRAIN LONG-TERM
7 CARE STAFF.—The Secretary shall coordinate
8 activities under this subsection with the Sec-
9 retary of Labor in order to provide incentives
10 for individuals to train for and seek employ-
11 ment providing direct care in long-term care.

12 “(B) CAREER LADDERS AND WAGE OR
13 BENEFIT INCREASES TO INCREASE STAFFING IN
14 LONG-TERM CARE.—

15 “(i) IN GENERAL.—The Secretary
16 shall make grants to eligible entities to
17 carry out programs through which the en-
18 tities—

19 “(I) offer, to employees who pro-
20 vide direct care to residents of an eli-
21 gible entity or individuals receiving
22 community-based long-term care from
23 an eligible entity, continuing training
24 and varying levels of certification,
25 based on observed clinical care prac-

1 tices and the amount of time the em-
2 ployees spend providing direct care;
3 and

4 “(II) provide, or make arrange-
5 ments to provide, bonuses or other in-
6 creased compensation or benefits to
7 employees who achieve certification
8 under such a program.

9 “(ii) APPLICATION.—To be eligible to
10 receive a grant under this subparagraph,
11 an eligible entity shall submit an applica-
12 tion to the Secretary at such time, in such
13 manner, and containing such information
14 as the Secretary may require (which may
15 include evidence of consultation with the
16 State in which the eligible entity is located
17 with respect to carrying out activities fund-
18 ed under the grant).

19 “(iii) AUTHORITY TO LIMIT NUMBER
20 OF APPLICANTS.—Nothing in this subpara-
21 graph shall be construed as prohibiting the
22 Secretary from limiting the number of ap-
23 plicants for a grant under this subpara-
24 graph.

1 “(3) SPECIFIC PROGRAMS TO IMPROVE MAN-
2 AGEMENT PRACTICES.—

3 “(A) IN GENERAL.—The Secretary shall
4 make grants to eligible entities to enable the en-
5 tities to provide training and technical assist-
6 ance.

7 “(B) AUTHORIZED ACTIVITIES.—An eligi-
8 ble entity that receives a grant under subpara-
9 graph (A) shall use funds made available
10 through the grant to provide training and tech-
11 nical assistance regarding management prac-
12 tices using methods that are demonstrated to
13 promote retention of individuals who provide di-
14 rect care, such as—

15 “(i) the establishment of standard
16 human resource policies that reward high
17 performance, including policies that pro-
18 vide for improved wages and benefits on
19 the basis of job reviews;

20 “(ii) the establishment of motivational
21 and thoughtful work organization prac-
22 tices;

23 “(iii) the creation of a workplace cul-
24 ture that respects and values caregivers
25 and their needs;

1 “(iv) the promotion of a workplace
2 culture that respects the rights of residents
3 of an eligible entity or individuals receiving
4 community-based long-term care from an
5 eligible entity and results in improved care
6 for the residents or the individuals; and

7 “(v) the establishment of other pro-
8 grams that promote the provision of high
9 quality care, such as a continuing edu-
10 cation program that provides additional
11 hours of training, including on-the-job
12 training, for employees who are certified
13 nurse aides.

14 “(C) APPLICATION.—To be eligible to re-
15 ceive a grant under this paragraph, an eligible
16 entity shall submit an application to the Sec-
17 retary at such time, in such manner, and con-
18 taining such information as the Secretary may
19 require (which may include evidence of con-
20 sultation with the State in which the eligible en-
21 tity is located with respect to carrying out ac-
22 tivities funded under the grant).

23 “(D) AUTHORITY TO LIMIT NUMBER OF
24 APPLICANTS.—Nothing in this paragraph shall
25 be construed as prohibiting the Secretary from

1 limiting the number of applicants for a grant
2 under this paragraph.

3 “(4) ACCOUNTABILITY MEASURES.—The Sec-
4 retary shall develop accountability measures to en-
5 sure that the activities conducted using funds made
6 available under this subsection benefit individuals
7 who provide direct care and increase the stability of
8 the long-term care workforce.

9 “(5) DEFINITIONS.—In this subsection:

10 “(A) COMMUNITY-BASED LONG-TERM
11 CARE.—The term ‘community-based long-term
12 care’ has the meaning given such term by the
13 Secretary.

14 “(B) ELIGIBLE ENTITY.—The term ‘eligi-
15 ble entity’ means the following:

16 “(i) A long-term care facility.

17 “(ii) A community-based long-term
18 care entity (as defined by the Secretary).

19 “(b) CERTIFIED EHR TECHNOLOGY GRANT PRO-
20 GRAM.—

21 “(1) GRANTS AUTHORIZED.—The Secretary is
22 authorized to make grants to long-term care facili-
23 ties for the purpose of assisting such entities in off-
24 setting the costs related to purchasing, leasing, de-
25 veloping, and implementing certified EHR tech-

1 nology (as defined in section 1848(o)(4)) designed to
2 improve patient safety and reduce adverse events
3 and health care complications resulting from medica-
4 tion errors.

5 “(2) USE OF GRANT FUNDS.—Funds provided
6 under grants under this subsection may be used for
7 any of the following:

8 “(A) Purchasing, leasing, and installing
9 computer software and hardware, including
10 handheld computer technologies.

11 “(B) Making improvements to existing
12 computer software and hardware.

13 “(C) Making upgrades and other improve-
14 ments to existing computer software and hard-
15 ware to enable e-prescribing.

16 “(D) Providing education and training to
17 eligible long-term care facility staff on the use
18 of such technology to implement the electronic
19 transmission of prescription and patient infor-
20 mation.

21 “(3) APPLICATION.—

22 “(A) IN GENERAL.—To be eligible to re-
23 ceive a grant under this subsection, a long-term
24 care facility shall submit an application to the
25 Secretary at such time, in such manner, and

1 containing such information as the Secretary
2 may require (which may include evidence of
3 consultation with the State in which the long-
4 term care facility is located with respect to car-
5 rying out activities funded under the grant).

6 “(B) AUTHORITY TO LIMIT NUMBER OF
7 APPLICANTS.—Nothing in this subsection shall
8 be construed as prohibiting the Secretary from
9 limiting the number of applicants for a grant
10 under this subsection.

11 “(4) PARTICIPATION IN STATE HEALTH EX-
12 CHANGES.—A long-term care facility that receives a
13 grant under this subsection shall, where available,
14 participate in activities conducted by a State or a
15 qualified State-designated entity (as defined in sec-
16 tion 3013(f) of the Public Health Service Act) under
17 a grant under section 3013 of the Public Health
18 Service Act to coordinate care and for other pur-
19 poses determined appropriate by the Secretary.

20 “(5) ACCOUNTABILITY MEASURES.—The Sec-
21 retary shall develop accountability measures to en-
22 sure that the activities conducted using funds made
23 available under this subsection help improve patient
24 safety and reduce adverse events and health care
25 complications resulting from medication errors.

1 “(c) ADOPTION OF STANDARDS FOR TRANSACTIONS
2 INVOLVING CLINICAL DATA BY LONG-TERM CARE FA-
3 CILITIES.—

4 “(1) STANDARDS AND COMPATIBILITY.—The
5 Secretary shall adopt electronic standards for the ex-
6 change of clinical data by long-term care facilities,
7 including, where available, standards for messaging
8 and nomenclature. Standards adopted by the Sec-
9 retary under the preceding sentence shall be compat-
10 ible with standards established under part C of title
11 XI, standards established under subsections
12 (b)(2)(B)(i) and (e)(4) of section 1860D–4, stand-
13 ards adopted under section 3004 of the Public
14 Health Service Act, and general health information
15 technology standards.

16 “(2) ELECTRONIC SUBMISSION OF DATA TO
17 THE SECRETARY.—

18 “(A) IN GENERAL.—Not later than 10
19 years after the date of enactment of the Elder
20 Justice Act of 2009, the Secretary shall have
21 procedures in place to accept the optional elec-
22 tronic submission of clinical data by long-term
23 care facilities pursuant to the standards adopt-
24 ed under paragraph (1).

1 “(B) RULE OF CONSTRUCTION.—Nothing
2 in this subsection shall be construed to require
3 a long-term care facility to submit clinical data
4 electronically to the Secretary.

5 “(3) REGULATIONS.—The Secretary shall pro-
6 mulgate regulations to carry out this subsection.
7 Such regulations shall require a State, as a condi-
8 tion of the receipt of funds under this part, to con-
9 duct such data collection and reporting as the Sec-
10 retary determines are necessary to satisfy the re-
11 quirements of this subsection.

12 “(d) AUTHORIZATION OF APPROPRIATIONS.—There
13 are authorized to be appropriated to carry out this sec-
14 tion—

15 “(1) for fiscal year 2011, \$20,000,000;
16 “(2) for fiscal year 2012, \$17,500,000; and
17 “(3) for each of fiscal years 2013 and 2014,
18 \$15,000,000.

19 **“SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND**
20 **GRANT PROGRAMS.**

21 “(a) SECRETARIAL RESPONSIBILITIES.—

22 “(1) IN GENERAL.—The Secretary shall ensure
23 that the Department of Health and Human Serv-
24 ices—

1 “(A) provides funding authorized by this
2 part to State and local adult protective services
3 offices that investigate reports of the abuse, ne-
4 glect, and exploitation of elders;

5 “(B) collects and disseminates data annu-
6 ally relating to the abuse, exploitation, and ne-
7 glect of elders in coordination with the Depart-
8 ment of Justice;

9 “(C) develops and disseminates informa-
10 tion on best practices regarding, and provides
11 training on, carrying out adult protective serv-
12 ices;

13 “(D) conducts research related to the pro-
14 vision of adult protective services; and

15 “(E) provides technical assistance to
16 States and other entities that provide or fund
17 the provision of adult protective services, in-
18 cluding through grants made under subsections
19 (b) and (c).

20 “(2) AUTHORIZATION OF APPROPRIATIONS.—
21 There are authorized to be appropriated to carry out
22 this subsection, \$3,000,000 for fiscal year 2011 and
23 \$4,000,000 for each of fiscal years 2012 through
24 2014.

1 “(b) GRANTS TO ENHANCE THE PROVISION OF
2 ADULT PROTECTIVE SERVICES.—

3 “(1) ESTABLISHMENT.—There is established an
4 adult protective services grant program under which
5 the Secretary shall annually award grants to States
6 in the amounts calculated under paragraph (2) for
7 the purposes of enhancing adult protective services
8 provided by States and local units of government.

9 “(2) AMOUNT OF PAYMENT.—

10 “(A) IN GENERAL.—Subject to the avail-
11 ability of appropriations and subparagraphs (B)
12 and (C), the amount paid to a State for a fiscal
13 year under the program under this subsection
14 shall equal the amount appropriated for that
15 year to carry out this subsection multiplied by
16 the percentage of the total number of elders
17 who reside in the United States who reside in
18 that State.

19 “(B) GUARANTEED MINIMUM PAYMENT
20 AMOUNT.—

21 “(i) 50 STATES.—Subject to clause
22 (ii), if the amount determined under sub-
23 paragraph (A) for a State for a fiscal year
24 is less than 0.75 percent of the amount ap-
25 propriated for such year, the Secretary

1 shall increase such determined amount so
2 that the total amount paid under this sub-
3 section to the State for the year is equal
4 to 0.75 percent of the amount so appro-
5 priated.

6 “(ii) TERRITORIES.—In the case of a
7 State other than 1 of the 50 States, clause
8 (i) shall be applied as if each reference to
9 ‘0.75’ were a reference to ‘0.1’.

10 “(C) PRO RATA REDUCTIONS.—The Sec-
11 retary shall make such pro rata reductions to
12 the amounts described in subparagraph (A) as
13 are necessary to comply with the requirements
14 of subparagraph (B).

15 “(3) AUTHORIZED ACTIVITIES.—

16 “(A) ADULT PROTECTIVE SERVICES.—
17 Funds made available pursuant to this sub-
18 section may only be used by States and local
19 units of government to provide adult protective
20 services and may not be used for any other pur-
21 pose.

22 “(B) USE BY AGENCY.—Each State receiv-
23 ing funds pursuant to this subsection shall pro-
24 vide such funds to the agency or unit of State

1 government having legal responsibility for pro-
2 viding adult protective services within the State.

3 “(C) SUPPLEMENT NOT SUPPLANT.—Each
4 State or local unit of government shall use
5 funds made available pursuant to this sub-
6 section to supplement and not supplant other
7 Federal, State, and local public funds expended
8 to provide adult protective services in the State.

9 “(4) STATE REPORTS.—Each State receiving
10 funds under this subsection shall submit to the Sec-
11 retary, at such time and in such manner as the Sec-
12 retary may require, a report on the number of elders
13 served by the grants awarded under this subsection.

14 “(5) AUTHORIZATION OF APPROPRIATIONS.—
15 There are authorized to be appropriated to carry out
16 this subsection, \$100,000,000 for each of fiscal
17 years 2011 through 2014.

18 “(c) STATE DEMONSTRATION PROGRAMS.—

19 “(1) ESTABLISHMENT.—The Secretary shall
20 award grants to States for the purposes of con-
21 ducting demonstration programs in accordance with
22 paragraph (2).

23 “(2) DEMONSTRATION PROGRAMS.—Funds
24 made available pursuant to this subsection may be

1 used by States and local units of government to con-
2 duct demonstration programs that test—

3 “(A) training modules developed for the
4 purpose of detecting or preventing elder abuse;

5 “(B) methods to detect or prevent financial
6 exploitation of elders;

7 “(C) methods to detect elder abuse;

8 “(D) whether training on elder abuse
9 forensics enhances the detection of elder abuse
10 by employees of the State or local unit of gov-
11 ernment; or

12 “(E) other matters relating to the detec-
13 tion or prevention of elder abuse.

14 “(3) APPLICATION.—To be eligible to receive a
15 grant under this subsection, a State shall submit an
16 application to the Secretary at such time, in such
17 manner, and containing such information as the Sec-
18 retary may require.

19 “(4) STATE REPORTS.—Each State that re-
20 ceives funds under this subsection shall submit to
21 the Secretary a report at such time, in such manner,
22 and containing such information as the Secretary
23 may require on the results of the demonstration pro-
24 gram conducted by the State using funds made
25 available under this subsection.

1 “(5) AUTHORIZATION OF APPROPRIATIONS.—
2 There are authorized to be appropriated to carry out
3 this subsection, \$25,000,000 for each of fiscal years
4 2011 through 2014.

5 **“SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM**
6 **GRANTS AND TRAINING.**

7 “(a) GRANTS TO SUPPORT THE LONG-TERM CARE
8 OMBUDSMAN PROGRAM.—

9 “(1) IN GENERAL.—The Secretary shall make
10 grants to eligible entities with relevant expertise and
11 experience in abuse and neglect in long-term care fa-
12 cilities or long-term care ombudsman programs and
13 responsibilities, for the purpose of—

14 “(A) improving the capacity of State long-
15 term care ombudsman programs to respond to
16 and resolve complaints about abuse and neglect;

17 “(B) conducting pilot programs with State
18 long-term care ombudsman offices or local om-
19 budsman entities; and

20 “(C) providing support for such State
21 long-term care ombudsman programs and such
22 pilot programs (such as through the establish-
23 ment of a national long-term care ombudsman
24 resource center).

1 “(2) AUTHORIZATION OF APPROPRIATIONS.—
2 There are authorized to be appropriated to carry out
3 this subsection—

4 “(A) for fiscal year 2011, \$5,000,000;

5 “(B) for fiscal year 2012, \$7,500,000; and

6 “(C) for each of fiscal years 2013 and
7 2014, \$10,000,000.

8 “(b) OMBUDSMAN TRAINING PROGRAMS.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish programs to provide and improve ombudsman
11 training with respect to elder abuse, neglect, and ex-
12 ploitation for national organizations and State long-
13 term care ombudsman programs.

14 “(2) AUTHORIZATION OF APPROPRIATIONS.—
15 There are authorized to be appropriated to carry out
16 this subsection, for each of fiscal years 2011
17 through 2014, \$10,000,000.

18 **“SEC. 2044. PROVISION OF INFORMATION REGARDING, AND**
19 **EVALUATIONS OF, ELDER JUSTICE PRO-**
20 **GRAMS.**

21 “(a) PROVISION OF INFORMATION.—To be eligible to
22 receive a grant under this part, an applicant shall agree—

23 “(1) except as provided in paragraph (2), to
24 provide the eligible entity conducting an evaluation
25 under subsection (b) of the activities funded through

1 the grant with such information as the eligible entity
2 may require in order to conduct such evaluation; or

3 “(2) in the case of an applicant for a grant
4 under section 2041(b), to provide the Secretary with
5 such information as the Secretary may require to
6 conduct an evaluation or audit under subsection (c).

7 “(b) USE OF ELIGIBLE ENTITIES TO CONDUCT
8 EVALUATIONS.—

9 “(1) EVALUATIONS REQUIRED.—Except as pro-
10 vided in paragraph (2), the Secretary shall—

11 “(A) reserve a portion (not less than 2 per-
12 cent) of the funds appropriated with respect to
13 each program carried out under this part; and

14 “(B) use the funds reserved under sub-
15 paragraph (A) to provide assistance to eligible
16 entities to conduct evaluations of the activities
17 funded under each program carried out under
18 this part.

19 “(2) CERTIFIED EHR TECHNOLOGY GRANT PRO-
20 GRAM NOT INCLUDED.—The provisions of this sub-
21 section shall not apply to the certified EHR tech-
22 nology grant program under section 2041(b).

23 “(3) AUTHORIZED ACTIVITIES.—A recipient of
24 assistance described in paragraph (1)(B) shall use
25 the funds made available through the assistance to

1 conduct a validated evaluation of the effectiveness of
2 the activities funded under a program carried out
3 under this part.

4 “(4) APPLICATIONS.—To be eligible to receive
5 assistance under paragraph (1)(B), an entity shall
6 submit an application to the Secretary at such time,
7 in such manner, and containing such information as
8 the Secretary may require, including a proposal for
9 the evaluation.

10 “(5) REPORTS.—Not later than a date specified
11 by the Secretary, an eligible entity receiving assist-
12 ance under paragraph (1)(B) shall submit to the
13 Secretary, the Committee on Ways and Means and
14 the Committee on Energy and Commerce of the
15 House of Representatives, and the Committee on Fi-
16 nance of the Senate a report containing the results
17 of the evaluation conducted using such assistance to-
18 gether with such recommendations as the entity de-
19 termines to be appropriate.

20 “(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR
21 TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

22 “(1) EVALUATIONS.—The Secretary shall con-
23 duct an evaluation of the activities funded under the
24 certified EHR technology grant program under sec-
25 tion 2041(b). Such evaluation shall include an eval-

1 uation of whether the funding provided under the
2 grant is expended only for the purposes for which it
3 is made.

4 “(2) AUDITS.—The Secretary shall conduct ap-
5 propriate audits of grants made under section
6 2041(b).

7 **“SEC. 2045. REPORT.**

8 “Not later than October 1, 2014, the Secretary shall
9 submit to the Elder Justice Coordinating Council estab-
10 lished under section 2021, the Committee on Ways and
11 Means and the Committee on Energy and Commerce of
12 the House of Representatives, and the Committee on Fi-
13 nance of the Senate a report—

14 “(1) compiling, summarizing, and analyzing the
15 information contained in the State reports submitted
16 under subsections (b)(4) and (c)(4) of section 2042;
17 and

18 “(2) containing such recommendations for legis-
19 lative or administrative action as the Secretary de-
20 termines to be appropriate.

21 **“SEC. 2046. RULE OF CONSTRUCTION.**

22 “Nothing in this subtitle shall be construed as—

23 “(1) limiting any cause of action or other relief
24 related to obligations under this subtitle that is

1 available under the law of any State, or political sub-
2 division thereof; or

3 “(2) creating a private cause of action for a vio-
4 lation of this subtitle.”.

5 (2) OPTION FOR STATE PLAN UNDER PROGRAM
6 FOR TEMPORARY ASSISTANCE FOR NEEDY FAMI-
7 LIES.—

8 (A) IN GENERAL.—Section 402(a)(1)(B) of
9 the Social Security Act (42 U.S.C.
10 602(a)(1)(B)) is amended by adding at the end
11 the following new clause:

12 “(v) The document shall indicate
13 whether the State intends to assist individ-
14 uals to train for, seek, and maintain em-
15 ployment—

16 “(I) providing direct care in a
17 long-term care facility (as such terms
18 are defined under section 2011); or

19 “(II) in other occupations related
20 to elder care determined appropriate
21 by the State for which the State iden-
22 tifies an unmet need for service per-
23 sonnel,

24 and, if so, shall include an overview of such
25 assistance.”.

1 (B) EFFECTIVE DATE.—The amendment
2 made by subparagraph (A) shall take effect on
3 January 1, 2011.

4 (b) PROTECTING RESIDENTS OF LONG-TERM CARE
5 FACILITIES.—

6 (1) NATIONAL TRAINING INSTITUTE FOR SUR-
7 VEYORS.—

8 (A) IN GENERAL.—The Secretary of
9 Health and Human Services shall enter into a
10 contract with an entity for the purpose of estab-
11 lishing and operating a National Training Insti-
12 tute for Federal and State surveyors. Such In-
13 stitute shall provide and improve the training of
14 surveyors with respect to investigating allega-
15 tions of abuse, neglect, and misappropriation of
16 property in programs and long-term care facili-
17 ties that receive payments under title XVIII or
18 XIX of the Social Security Act.

19 (B) ACTIVITIES CARRIED OUT BY THE IN-
20 STITUTE.—The contract entered into under
21 subparagraph (A) shall require the Institute es-
22 tablished and operated under such contract to
23 carry out the following activities:

24 (i) Assess the extent to which State
25 agencies use specialized surveyors for the

1 investigation of reported allegations of
2 abuse, neglect, and misappropriation of
3 property in such programs and long-term
4 care facilities.

5 (ii) Evaluate how the competencies of
6 surveyors may be improved to more effec-
7 tively investigate reported allegations of
8 such abuse, neglect, and misappropriation
9 of property, and provide feedback to Fed-
10 eral and State agencies on the evaluations
11 conducted.

12 (iii) Provide a national program of
13 training, tools, and technical assistance to
14 Federal and State surveyors on inves-
15 tivating reports of such abuse, neglect, and
16 misappropriation of property.

17 (iv) Develop and disseminate informa-
18 tion on best practices for the investigation
19 of such abuse, neglect, and misappropria-
20 tion of property.

21 (v) Assess the performance of State
22 complaint intake systems, in order to en-
23 sure that the intake of complaints occurs
24 24 hours per day, 7 days a week (including
25 holidays).

1 (vi) To the extent approved by the
2 Secretary of Health and Human Services,
3 provide a national 24 hours per day, 7
4 days a week (including holidays), back-up
5 system to State complaint intake systems
6 in order to ensure optimum national re-
7 sponsiveness to complaints of such abuse,
8 neglect, and misappropriation of property.

9 (vii) Analyze and report annually on
10 the following:

11 (I) The total number and sources
12 of complaints of such abuse, neglect,
13 and misappropriation of property.

14 (II) The extent to which such
15 complaints are referred to law en-
16 forcement agencies.

17 (III) General results of Federal
18 and State investigations of such com-
19 plaints.

20 (viii) Conduct a national study of the
21 cost to State agencies of conducting com-
22 plaint investigations of skilled nursing fa-
23 cilities and nursing facilities under sections
24 1819 and 1919, respectively, of the Social
25 Security Act (42 U.S.C. 1395i-3; 1396r),

1 and making recommendations to the Sec-
2 retary of Health and Human Services with
3 respect to options to increase the efficiency
4 and cost-effectiveness of such investiga-
5 tions.

6 (C) AUTHORIZATION.—There are author-
7 ized to be appropriated to carry out this para-
8 graph, for the period of fiscal years 2011
9 through 2014, \$12,000,000.

10 (2) GRANTS TO STATE SURVEY AGENCIES.—

11 (A) IN GENERAL.—The Secretary of
12 Health and Human Services shall make grants
13 to State agencies that perform surveys of
14 skilled nursing facilities or nursing facilities
15 under sections 1819 or 1919, respectively, of
16 the Social Security Act (42 U.S.C. 1395i–3;
17 1395r).

18 (B) USE OF FUNDS.—A grant awarded
19 under subparagraph (A) shall be used for the
20 purpose of designing and implementing com-
21 plaint investigations systems that—

22 (i) promptly prioritize complaints in
23 order to ensure a rapid response to the
24 most serious and urgent complaints;

1 (ii) respond to complaints with opti-
2 mum effectiveness and timeliness; and

3 (iii) optimize the collaboration be-
4 tween local authorities, consumers, and
5 providers, including—

6 (I) such State agency;

7 (II) the State Long-Term Care
8 Ombudsman;

9 (III) local law enforcement agen-
10 cies;

11 (IV) advocacy and consumer or-
12 ganizations;

13 (V) State aging units;

14 (VI) Area Agencies on Aging;

15 and

16 (VII) other appropriate entities.

17 (C) AUTHORIZATION.—There are author-
18 ized to be appropriated to carry out this para-
19 graph, for each of fiscal years 2011 through
20 2014, \$5,000,000.

21 (3) REPORTING OF CRIMES IN FEDERALLY
22 FUNDED LONG-TERM CARE FACILITIES.—Part A of
23 title XI of the Social Security Act (42 U.S.C. 1301
24 et seq.), as amended by section 6005, is amended by

1 inserting after section 1150A the following new sec-
2 tion:

3 “REPORTING TO LAW ENFORCEMENT OF CRIMES OCCUR-
4 RING IN FEDERALLY FUNDED LONG-TERM CARE FA-
5 CILITIES

6 “SEC. 1150B. (a) DETERMINATION AND NOTIFICA-
7 TION.—

8 “(1) DETERMINATION.—The owner or operator
9 of each long-term care facility that receives Federal
10 funds under this Act shall annually determine
11 whether the facility received at least \$10,000 in such
12 Federal funds during the preceding year.

13 “(2) NOTIFICATION.—If the owner or operator
14 determines under paragraph (1) that the facility re-
15 ceived at least \$10,000 in such Federal funds during
16 the preceding year, such owner or operator shall an-
17 nually notify each covered individual (as defined in
18 paragraph (3)) of that individual’s obligation to
19 comply with the reporting requirements described in
20 subsection (b).

21 “(3) COVERED INDIVIDUAL DEFINED.—In this
22 section, the term ‘covered individual’ means each in-
23 dividual who is an owner, operator, employee, man-
24 ager, agent, or contractor of a long-term care facility
25 that is the subject of a determination described in
26 paragraph (1).

1 “(b) REPORTING REQUIREMENTS.—

2 “(1) IN GENERAL.—Each covered individual
3 shall report to the Secretary and 1 or more law en-
4 forcement entities for the political subdivision in
5 which the facility is located any reasonable suspicion
6 of a crime (as defined by the law of the applicable
7 political subdivision) against any individual who is a
8 resident of, or is receiving care from, the facility.

9 “(2) TIMING.—If the events that cause the sus-
10 picion—

11 “(A) result in serious bodily injury, the in-
12 dividual shall report the suspicion immediately,
13 but not later than 2 hours after forming the
14 suspicion; and

15 “(B) do not result in serious bodily injury,
16 the individual shall report the suspicion not
17 later than 24 hours after forming the suspicion.

18 “(c) PENALTIES.—

19 “(1) IN GENERAL.—If a covered individual vio-
20 lates subsection (b)—

21 “(A) the covered individual shall be subject
22 to a civil money penalty of not more than
23 \$200,000; and

24 “(B) the Secretary may make a determina-
25 tion in the same proceeding to exclude the cov-

1 ered individual from participation in any Fed-
2 eral health care program (as defined in section
3 1128B(f)).

4 “(2) INCREASED HARM.—If a covered indi-
5 vidual violates subsection (b) and the violation exac-
6 erbates the harm to the victim of the crime or re-
7 sults in harm to another individual—

8 “(A) the covered individual shall be subject
9 to a civil money penalty of not more than
10 \$300,000; and

11 “(B) the Secretary may make a determina-
12 tion in the same proceeding to exclude the cov-
13 ered individual from participation in any Fed-
14 eral health care program (as defined in section
15 1128B(f)).

16 “(3) EXCLUDED INDIVIDUAL.—During any pe-
17 riod for which a covered individual is classified as an
18 excluded individual under paragraph (1)(B) or
19 (2)(B), a long-term care facility that employs such
20 individual shall be ineligible to receive Federal funds
21 under this Act.

22 “(4) EXTENUATING CIRCUMSTANCES.—

23 “(A) IN GENERAL.—The Secretary may
24 take into account the financial burden on pro-
25 viders with underserved populations in deter-

1 mining any penalty to be imposed under this
2 subsection.

3 “(B) UNDERSERVED POPULATION DE-
4 FINED.—In this paragraph, the term ‘under-
5 served population’ means the population of an
6 area designated by the Secretary as an area
7 with a shortage of elder justice programs or a
8 population group designated by the Secretary
9 as having a shortage of such programs. Such
10 areas or groups designated by the Secretary
11 may include—

12 “(i) areas or groups that are geo-
13 graphically isolated (such as isolated in a
14 rural area);

15 “(ii) racial and ethnic minority popu-
16 lations; and

17 “(iii) populations underserved because
18 of special needs (such as language barriers,
19 disabilities, alien status, or age).

20 “(d) ADDITIONAL PENALTIES FOR RETALIATION.—

21 “(1) IN GENERAL.—A long-term care facility
22 may not—

23 “(A) discharge, demote, suspend, threaten,
24 harass, or deny a promotion or other employ-
25 ment-related benefit to an employee, or in any

1 other manner discriminate against an employee
2 in the terms and conditions of employment be-
3 cause of lawful acts done by the employee; or

4 “(B) file a complaint or a report against a
5 nurse or other employee with the appropriate
6 State professional disciplinary agency because
7 of lawful acts done by the nurse or employee,
8 for making a report, causing a report to be made,
9 or for taking steps in furtherance of making a report
10 pursuant to subsection (b)(1).

11 “(2) PENALTIES FOR RETALIATION.—If a long-
12 term care facility violates subparagraph (A) or (B)
13 of paragraph (1) the facility shall be subject to a
14 civil money penalty of not more than \$200,000 or
15 the Secretary may classify the entity as an excluded
16 entity for a period of 2 years pursuant to section
17 1128(b), or both.

18 “(3) REQUIREMENT TO POST NOTICE.—Each
19 long-term care facility shall post conspicuously in an
20 appropriate location a sign (in a form specified by
21 the Secretary) specifying the rights of employees
22 under this section. Such sign shall include a state-
23 ment that an employee may file a complaint with the
24 Secretary against a long-term care facility that vio-
25 lates the provisions of this subsection and informa-

1 tion with respect to the manner of filing such a com-
2 plaint.

3 “(e) PROCEDURE.—The provisions of section 1128A
4 (other than subsections (a) and (b) and the second sen-
5 tence of subsection (f)) shall apply to a civil money penalty
6 or exclusion under this section in the same manner as such
7 provisions apply to a penalty or proceeding under section
8 1128A(a).

9 “(f) DEFINITIONS.—In this section, the terms ‘elder
10 justice’, ‘long-term care facility’, and ‘law enforcement’
11 have the meanings given those terms in section 2011.”.

12 (c) NATIONAL NURSE AIDE REGISTRY.—

13 (1) DEFINITION OF NURSE AIDE.—In this sub-
14 section, the term “nurse aide” has the meaning
15 given that term in sections 1819(b)(5)(F) and
16 1919(b)(5)(F) of the Social Security Act (42 U.S.C.
17 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

18 (2) STUDY AND REPORT.—

19 (A) IN GENERAL.—The Secretary, in con-
20 sultation with appropriate government agencies
21 and private sector organizations, shall conduct
22 a study on establishing a national nurse aide
23 registry.

1 (B) AREAS EVALUATED.—The study con-
2 ducted under this subsection shall include an
3 evaluation of—

4 (i) who should be included in the reg-
5 istry;

6 (ii) how such a registry would comply
7 with Federal and State privacy laws and
8 regulations;

9 (iii) how data would be collected for
10 the registry;

11 (iv) what entities and individuals
12 would have access to the data collected;

13 (v) how the registry would provide ap-
14 propriate information regarding violations
15 of Federal and State law by individuals in-
16 cluded in the registry;

17 (vi) how the functions of a national
18 nurse aide registry would be coordinated
19 with the nationwide program for national
20 and State background checks on direct pa-
21 tient access employees of long-term care
22 facilities and providers under section 4301;
23 and

24 (vii) how the information included in
25 State nurse aide registries developed and

1 maintained under sections 1819(e)(2) and
2 1919(e)(2) of the Social Security Act (42
3 U.S.C. 1395i-3(e)(2); 1396r(e)(2)(2))
4 would be provided as part of a national
5 nurse aide registry.

6 (C) CONSIDERATIONS.—In conducting the
7 study and preparing the report required under
8 this subsection, the Secretary shall take into
9 consideration the findings and conclusions of
10 relevant reports and other relevant resources,
11 including the following:

12 (i) The Department of Health and
13 Human Services Office of Inspector Gen-
14 eral Report, Nurse Aide Registries: State
15 Compliance and Practices (February
16 2005).

17 (ii) The General Accounting Office
18 (now known as the Government Account-
19 ability Office) Report, Nursing Homes:
20 More Can Be Done to Protect Residents
21 from Abuse (March 2002).

22 (iii) The Department of Health and
23 Human Services Office of the Inspector
24 General Report, Nurse Aide Registries:

1 Long-Term Care Facility Compliance and
2 Practices (July 2005).

3 (iv) The Department of Health and
4 Human Services Health Resources and
5 Services Administration Report, Nursing
6 Aides, Home Health Aides, and Related
7 Health Care Occupations—National and
8 Local Workforce Shortages and Associated
9 Data Needs (2004) (in particular with re-
10 spect to chapter 7 and appendix F).

11 (v) The 2001 Report to CMS from
12 the School of Rural Public Health, Texas
13 A&M University, Preventing Abuse and
14 Neglect in Nursing Homes: The Role of
15 Nurse Aide Registries.

16 (vi) Information included in State
17 nurse aide registries developed and main-
18 tained under sections 1819(e)(2) and
19 1919(e)(2) of the Social Security Act (42
20 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

21 (D) REPORT.—Not later than 18 months
22 after the date of enactment of this Act, the Sec-
23 retary shall submit to the Elder Justice Coordi-
24 nating Council established under section 2021
25 of the Social Security Act, as added by section

1 1805(a), the Committee on Finance of the Sen-
2 ate, and the Committee on Ways and Means
3 and the Committee on Energy and Commerce
4 of the House of Representatives a report con-
5 taining the findings and recommendations of
6 the study conducted under this paragraph.

7 (E) FUNDING LIMITATION.—Funding for
8 the study conducted under this subsection shall
9 not exceed \$500,000.

10 (3) CONGRESSIONAL ACTION.—After receiving
11 the report submitted by the Secretary under para-
12 graph (2)(D), the Committee on Finance of the Sen-
13 ate and the Committee on Ways and Means and the
14 Committee on Energy and Commerce of the House
15 of Representatives shall, as they deem appropriate,
16 take action based on the recommendations contained
17 in the report.

18 (4) AUTHORIZATION OF APPROPRIATIONS.—
19 There are authorized to be appropriated such sums
20 as are necessary for the purpose of carrying out this
21 subsection.

22 (d) CONFORMING AMENDMENTS.—

23 (1) TITLE XX.—Title XX of the Social Security
24 Act (42 U.S.C. 1397 et seq.), as amended by section
25 6703(a), is amended—

1 (A) in the heading of section 2001, by
2 striking “TITLE” and inserting “SUBTITLE”;
3 and

4 (B) in subtitle 1, by striking “this title”
5 each place it appears and inserting “this sub-
6 title”.

7 (2) TITLE IV.—Title IV of the Social Security
8 Act (42 U.S.C. 601 et seq.) is amended—

9 (A) in section 404(d)—

10 (i) in paragraphs (1)(A), (2)(A), and
11 (3)(B), by inserting “subtitle 1 of” before
12 “title XX” each place it appears;

13 (ii) in the heading of paragraph (2),
14 by inserting “SUBTITLE 1 OF” before
15 “TITLE XX”; and

16 (iii) in the heading of paragraph
17 (3)(B), by inserting “SUBTITLE 1 OF” be-
18 fore “TITLE XX”; and

19 (B) in sections 422(b), 471(a)(4),
20 472(h)(1), and 473(b)(2), by inserting “subtitle
21 1 of” before “title XX” each place it appears.

22 (3) TITLE XI.—Title XI of the Social Security
23 Act (42 U.S.C. 1301 et seq.) is amended—

24 (A) in section 1128(h)(3)—

- 1 (i) by inserting “subtitle 1 of” before
2 “title XX”; and
3 (ii) by striking “such title” and in-
4 sserting “such subtitle”; and
5 (B) in section 1128A(i)(1), by inserting
6 “subtitle 1 of” before “title XX”.

7 **Subtitle I—Sense of the Senate**
8 **Regarding Medical Malpractice**

9 **SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL**
10 **MALPRACTICE.**

11 It is the sense of the Senate that—

12 (1) health care reform presents an opportunity
13 to address issues related to medical malpractice and
14 medical liability insurance;

15 (2) States should be encouraged to develop and
16 test alternatives to the existing civil litigation system
17 as a way of improving patient safety, reducing med-
18 ical errors, encouraging the efficient resolution of
19 disputes, increasing the availability of prompt and
20 fair resolution of disputes, and improving access to
21 liability insurance, while preserving an individual’s
22 right to seek redress in court; and

23 (3) Congress should consider establishing a
24 State demonstration program to evaluate alter-

1 natives to the existing civil litigation system with re-
 2 spect to the resolution of medical malpractice claims.

3 **TITLE VII—IMPROVING ACCESS**
 4 **TO INNOVATIVE MEDICAL**
 5 **THERAPIES**

6 **Subtitle A—Biologics Price**
 7 **Competition and Innovation**

8 **SEC. 7001. SHORT TITLE.**

9 (a) IN GENERAL.—This subtitle may be cited as the
 10 “Biologics Price Competition and Innovation Act of
 11 2009”.

12 (b) SENSE OF THE SENATE.—It is the sense of the
 13 Senate that a biosimilars pathway balancing innovation
 14 and consumer interests should be established.

15 **SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGI-**
 16 **CAL PRODUCTS.**

17 (a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIO-
 18 SIMILAR OR INTERCHANGEABLE.—Section 351 of the
 19 Public Health Service Act (42 U.S.C. 262) is amended—

20 (1) in subsection (a)(1)(A), by inserting “under
 21 this subsection or subsection (k)” after “biologics li-
 22 cense”; and

23 (2) by adding at the end the following:

24 “(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIO-
 25 SIMILAR OR INTERCHANGEABLE.—

1 “(1) IN GENERAL.—Any person may submit an
2 application for licensure of a biological product
3 under this subsection.

4 “(2) CONTENT.—

5 “(A) IN GENERAL.—

6 “(i) REQUIRED INFORMATION.—An
7 application submitted under this subsection
8 shall include information demonstrating
9 that—

10 “(I) the biological product is bio-
11 similar to a reference product based
12 upon data derived from—

13 “(aa) analytical studies that
14 demonstrate that the biological
15 product is highly similar to the
16 reference product notwith-
17 standing minor differences in
18 clinically inactive components;

19 “(bb) animal studies (includ-
20 ing the assessment of toxicity);
21 and

22 “(cc) a clinical study or
23 studies (including the assessment
24 of immunogenicity and phar-
25 macokinetics or

1 pharmacodynamics) that are suf-
2 ficient to demonstrate safety, pu-
3 rity, and potency in 1 or more
4 appropriate conditions of use for
5 which the reference product is li-
6 censed and intended to be used
7 and for which licensure is sought
8 for the biological product;

9 “(II) the biological product and
10 reference product utilize the same
11 mechanism or mechanisms of action
12 for the condition or conditions of use
13 prescribed, recommended, or sug-
14 gested in the proposed labeling, but
15 only to the extent the mechanism or
16 mechanisms of action are known for
17 the reference product;

18 “(III) the condition or conditions
19 of use prescribed, recommended, or
20 suggested in the labeling proposed for
21 the biological product have been pre-
22 viously approved for the reference
23 product;

24 “(IV) the route of administra-
25 tion, the dosage form, and the

1 strength of the biological product are
2 the same as those of the reference
3 product; and

4 “(V) the facility in which the bio-
5 logical product is manufactured, proc-
6 essed, packed, or held meets stand-
7 ards designed to assure that the bio-
8 logical product continues to be safe,
9 pure, and potent.

10 “(ii) DETERMINATION BY SEC-
11 RETARY.—The Secretary may determine,
12 in the Secretary’s discretion, that an ele-
13 ment described in clause (i)(I) is unneces-
14 sary in an application submitted under this
15 subsection.

16 “(iii) ADDITIONAL INFORMATION.—
17 An application submitted under this sub-
18 section—

19 “(I) shall include publicly-avail-
20 able information regarding the Sec-
21 retary’s previous determination that
22 the reference product is safe, pure,
23 and potent; and

24 “(II) may include any additional
25 information in support of the applica-

1 tion, including publicly-available infor-
2 mation with respect to the reference
3 product or another biological product.

4 “(B) INTERCHANGEABILITY.—An applica-
5 tion (or a supplement to an application) sub-
6 mitted under this subsection may include infor-
7 mation demonstrating that the biological prod-
8 uct meets the standards described in paragraph
9 (4).

10 “(3) EVALUATION BY SECRETARY.—Upon re-
11 view of an application (or a supplement to an appli-
12 cation) submitted under this subsection, the Sec-
13 retary shall license the biological product under this
14 subsection if—

15 “(A) the Secretary determines that the in-
16 formation submitted in the application (or the
17 supplement) is sufficient to show that the bio-
18 logical product—

19 “(i) is biosimilar to the reference
20 product; or

21 “(ii) meets the standards described in
22 paragraph (4), and therefore is inter-
23 changeable with the reference product; and

24 “(B) the applicant (or other appropriate
25 person) consents to the inspection of the facility

1 that is the subject of the application, in accord-
2 ance with subsection (c).

3 “(4) SAFETY STANDARDS FOR DETERMINING
4 INTERCHANGEABILITY.—Upon review of an applica-
5 tion submitted under this subsection or any supple-
6 ment to such application, the Secretary shall deter-
7 mine the biological product to be interchangeable
8 with the reference product if the Secretary deter-
9 mines that the information submitted in the applica-
10 tion (or a supplement to such application) is suffi-
11 cient to show that—

12 “(A) the biological product—

13 “(i) is biosimilar to the reference
14 product; and

15 “(ii) can be expected to produce the
16 same clinical result as the reference prod-
17 uct in any given patient; and

18 “(B) for a biological product that is ad-
19 ministered more than once to an individual, the
20 risk in terms of safety or diminished efficacy of
21 alternating or switching between use of the bio-
22 logical product and the reference product is not
23 greater than the risk of using the reference
24 product without such alternation or switch.

25 “(5) GENERAL RULES.—

1 “(A) ONE REFERENCE PRODUCT PER AP-
2 PLICATION.—A biological product, in an appli-
3 cation submitted under this subsection, may not
4 be evaluated against more than 1 reference
5 product.

6 “(B) REVIEW.—An application submitted
7 under this subsection shall be reviewed by the
8 division within the Food and Drug Administra-
9 tion that is responsible for the review and ap-
10 proval of the application under which the ref-
11 erence product is licensed.

12 “(C) RISK EVALUATION AND MITIGATION
13 STRATEGIES.—The authority of the Secretary
14 with respect to risk evaluation and mitigation
15 strategies under the Federal Food, Drug, and
16 Cosmetic Act shall apply to biological products
17 licensed under this subsection in the same man-
18 ner as such authority applies to biological prod-
19 ucts licensed under subsection (a).

20 “(6) EXCLUSIVITY FOR FIRST INTERCHANGE-
21 ABLE BIOLOGICAL PRODUCT.—Upon review of an
22 application submitted under this subsection relying
23 on the same reference product for which a prior bio-
24 logical product has received a determination of inter-
25 changeability for any condition of use, the Secretary

1 shall not make a determination under paragraph (4)
2 that the second or subsequent biological product is
3 interchangeable for any condition of use until the
4 earlier of—

5 “(A) 1 year after the first commercial
6 marketing of the first interchangeable bio-
7 similar biological product to be approved as
8 interchangeable for that reference product;

9 “(B) 18 months after—

10 “(i) a final court decision on all pat-
11 ents in suit in an action instituted under
12 subsection (l)(6) against the applicant that
13 submitted the application for the first ap-
14 proved interchangeable biosimilar biological
15 product; or

16 “(ii) the dismissal with or without
17 prejudice of an action instituted under sub-
18 section (l)(6) against the applicant that
19 submitted the application for the first ap-
20 proved interchangeable biosimilar biological
21 product; or

22 “(C)(i) 42 months after approval of the
23 first interchangeable biosimilar biological prod-
24 uct if the applicant that submitted such appli-
25 cation has been sued under subsection (l)(6)

1 and such litigation is still ongoing within such
2 42-month period; or

3 “(ii) 18 months after approval of the first
4 interchangeable biosimilar biological product if
5 the applicant that submitted such application
6 has not been sued under subsection (l)(6).

7 For purposes of this paragraph, the term ‘final court
8 decision’ means a final decision of a court from
9 which no appeal (other than a petition to the United
10 States Supreme Court for a writ of certiorari) has
11 been or can be taken.

12 “(7) EXCLUSIVITY FOR REFERENCE PROD-
13 UCT.—

14 “(A) EFFECTIVE DATE OF BIOSIMILAR AP-
15 PPLICATION APPROVAL.—Approval of an applica-
16 tion under this subsection may not be made ef-
17 fective by the Secretary until the date that is
18 12 years after the date on which the reference
19 product was first licensed under subsection (a).

20 “(B) FILING PERIOD.—An application
21 under this subsection may not be submitted to
22 the Secretary until the date that is 4 years
23 after the date on which the reference product
24 was first licensed under subsection (a).

1 “(C) FIRST LICENSURE.—Subparagraphs
2 (A) and (B) shall not apply to a license for or
3 approval of—

4 “(i) a supplement for the biological
5 product that is the reference product; or

6 “(ii) a subsequent application filed by
7 the same sponsor or manufacturer of the
8 biological product that is the reference
9 product (or a licensor, predecessor in inter-
10 est, or other related entity) for—

11 “(I) a change (not including a
12 modification to the structure of the bi-
13 ological product) that results in a new
14 indication, route of administration,
15 dosing schedule, dosage form, delivery
16 system, delivery device, or strength; or

17 “(II) a modification to the struc-
18 ture of the biological product that
19 does not result in a change in safety,
20 purity, or potency.

21 “(8) GUIDANCE DOCUMENTS.—

22 “(A) IN GENERAL.—The Secretary may,
23 after opportunity for public comment, issue
24 guidance in accordance, except as provided in
25 subparagraph (B)(i), with section 701(h) of the

1 Federal Food, Drug, and Cosmetic Act with re-
2 spect to the licensure of a biological product
3 under this subsection. Any such guidance may
4 be general or specific.

5 “(B) PUBLIC COMMENT.—

6 “(i) IN GENERAL.—The Secretary
7 shall provide the public an opportunity to
8 comment on any proposed guidance issued
9 under subparagraph (A) before issuing
10 final guidance.

11 “(ii) INPUT REGARDING MOST VALU-
12 ABLE GUIDANCE.—The Secretary shall es-
13 tablish a process through which the public
14 may provide the Secretary with input re-
15 garding priorities for issuing guidance.

16 “(C) NO REQUIREMENT FOR APPLICATION
17 CONSIDERATION.—The issuance (or non-
18 issuance) of guidance under subparagraph (A)
19 shall not preclude the review of, or action on,
20 an application submitted under this subsection.

21 “(D) REQUIREMENT FOR PRODUCT CLASS-
22 SPECIFIC GUIDANCE.—If the Secretary issues
23 product class-specific guidance under subpara-
24 graph (A), such guidance shall include a de-
25 scription of—

1 “(i) the criteria that the Secretary will
2 use to determine whether a biological prod-
3 uct is highly similar to a reference product
4 in such product class; and

5 “(ii) the criteria, if available, that the
6 Secretary will use to determine whether a
7 biological product meets the standards de-
8 scribed in paragraph (4).

9 “(E) CERTAIN PRODUCT CLASSES.—

10 “(i) GUIDANCE.—The Secretary may
11 indicate in a guidance document that the
12 science and experience, as of the date of
13 such guidance, with respect to a product or
14 product class (not including any recom-
15 binant protein) does not allow approval of
16 an application for a license as provided
17 under this subsection for such product or
18 product class.

19 “(ii) MODIFICATION OR REVERSAL.—
20 The Secretary may issue a subsequent
21 guidance document under subparagraph
22 (A) to modify or reverse a guidance docu-
23 ment under clause (i).

24 “(iii) NO EFFECT ON ABILITY TO
25 DENY LICENSE.—Clause (i) shall not be

1 construed to require the Secretary to ap-
2 prove a product with respect to which the
3 Secretary has not indicated in a guidance
4 document that the science and experience,
5 as described in clause (i), does not allow
6 approval of such an application.

7 “(l) PATENTS.—

8 “(1) CONFIDENTIAL ACCESS TO SUBSECTION
9 (k) APPLICATION.—

10 “(A) APPLICATION OF PARAGRAPH.—Un-
11 less otherwise agreed to by a person that sub-
12 mits an application under subsection (k) (re-
13 ferred to in this subsection as the ‘subsection
14 (k) applicant’) and the sponsor of the applica-
15 tion for the reference product (referred to in
16 this subsection as the ‘reference product spon-
17 sor’), the provisions of this paragraph shall
18 apply to the exchange of information described
19 in this subsection.

20 “(B) IN GENERAL.—

21 “(i) PROVISION OF CONFIDENTIAL IN-
22 FORMATION.—When a subsection (k) ap-
23 plicant submits an application under sub-
24 section (k), such applicant shall provide to
25 the persons described in clause (ii), subject

1 to the terms of this paragraph, confidential
2 access to the information required to be
3 produced pursuant to paragraph (2) and
4 any other information that the subsection
5 (k) applicant determines, in its sole discre-
6 tion, to be appropriate (referred to in this
7 subsection as the ‘confidential informa-
8 tion’).

9 “(ii) RECIPIENTS OF INFORMATION.—

10 The persons described in this clause are
11 the following:

12 “(I) OUTSIDE COUNSEL.—One or
13 more attorneys designated by the ref-
14 erence product sponsor who are em-
15 ployees of an entity other than the
16 reference product sponsor (referred to
17 in this paragraph as the ‘outside
18 counsel’), provided that such attor-
19 neys do not engage, formally or infor-
20 mally, in patent prosecution relevant
21 or related to the reference product.

22 “(II) IN-HOUSE COUNSEL.—One
23 attorney that represents the reference
24 product sponsor who is an employee
25 of the reference product sponsor, pro-

1 vided that such attorney does not en-
2 gage, formally or informally, in patent
3 prosecution relevant or related to the
4 reference product.

5 “(iii) PATENT OWNER ACCESS.—A
6 representative of the owner of a patent ex-
7 clusively licensed to a reference product
8 sponsor with respect to the reference prod-
9 uct and who has retained a right to assert
10 the patent or participate in litigation con-
11 cerning the patent may be provided the
12 confidential information, provided that the
13 representative informs the reference prod-
14 uct sponsor and the subsection (k) appli-
15 cant of his or her agreement to be subject
16 to the confidentiality provisions set forth in
17 this paragraph, including those under
18 clause (ii).

19 “(C) LIMITATION ON DISCLOSURE.—No
20 person that receives confidential information
21 pursuant to subparagraph (B) shall disclose
22 any confidential information to any other per-
23 son or entity, including the reference product
24 sponsor employees, outside scientific consult-
25 ants, or other outside counsel retained by the

1 reference product sponsor, without the prior
2 written consent of the subsection (k) applicant,
3 which shall not be unreasonably withheld.

4 “(D) USE OF CONFIDENTIAL INFORMA-
5 TION.—Confidential information shall be used
6 for the sole and exclusive purpose of deter-
7 mining, with respect to each patent assigned to
8 or exclusively licensed by the reference product
9 sponsor, whether a claim of patent infringement
10 could reasonably be asserted if the subsection
11 (k) applicant engaged in the manufacture, use,
12 offering for sale, sale, or importation into the
13 United States of the biological product that is
14 the subject of the application under subsection
15 (k).

16 “(E) OWNERSHIP OF CONFIDENTIAL IN-
17 FORMATION.—The confidential information dis-
18 closed under this paragraph is, and shall re-
19 main, the property of the subsection (k) appli-
20 cant. By providing the confidential information
21 pursuant to this paragraph, the subsection (k)
22 applicant does not provide the reference product
23 sponsor or the outside counsel any interest in or
24 license to use the confidential information, for

1 purposes other than those specified in subpara-
2 graph (D).

3 “(F) EFFECT OF INFRINGEMENT AC-
4 TION.—In the event that the reference product
5 sponsor files a patent infringement suit, the use
6 of confidential information shall continue to be
7 governed by the terms of this paragraph until
8 such time as a court enters a protective order
9 regarding the information. Upon entry of such
10 order, the subsection (k) applicant may redesign-
11 nate confidential information in accordance
12 with the terms of that order. No confidential in-
13 formation shall be included in any publicly-
14 available complaint or other pleading. In the
15 event that the reference product sponsor does
16 not file an infringement action by the date spec-
17 ified in paragraph (6), the reference product
18 sponsor shall return or destroy all confidential
19 information received under this paragraph, pro-
20 vided that if the reference product sponsor opts
21 to destroy such information, it will confirm de-
22 struction in writing to the subsection (k) appli-
23 cant.

24 “(G) RULE OF CONSTRUCTION.—Nothing
25 in this paragraph shall be construed—

1 “(i) as an admission by the subsection
2 (k) applicant regarding the validity, en-
3 forceability, or infringement of any patent;
4 or

5 “(ii) as an agreement or admission by
6 the subsection (k) applicant with respect to
7 the competency, relevance, or materiality
8 of any confidential information.

9 “(H) EFFECT OF VIOLATION.—The disclo-
10 sure of any confidential information in violation
11 of this paragraph shall be deemed to cause the
12 subsection (k) applicant to suffer irreparable
13 harm for which there is no adequate legal rem-
14 edy and the court shall consider immediate in-
15 junctive relief to be an appropriate and nec-
16 essary remedy for any violation or threatened
17 violation of this paragraph.

18 “(2) SUBSECTION (k) APPLICATION INFORMA-
19 TION.—Not later than 20 days after the Secretary
20 notifies the subsection (k) applicant that the applica-
21 tion has been accepted for review, the subsection (k)
22 applicant—

23 “(A) shall provide to the reference product
24 sponsor a copy of the application submitted to
25 the Secretary under subsection (k), and such

1 other information that describes the process or
2 processes used to manufacture the biological
3 product that is the subject of such application;
4 and

5 “(B) may provide to the reference product
6 sponsor additional information requested by or
7 on behalf of the reference product sponsor.

8 “(3) LIST AND DESCRIPTION OF PATENTS.—

9 “(A) LIST BY REFERENCE PRODUCT SPON-
10 SOR.—Not later than 60 days after the receipt
11 of the application and information under para-
12 graph (2), the reference product sponsor shall
13 provide to the subsection (k) applicant—

14 “(i) a list of patents for which the ref-
15 erence product sponsor believes a claim of
16 patent infringement could reasonably be
17 asserted by the reference product sponsor,
18 or by a patent owner that has granted an
19 exclusive license to the reference product
20 sponsor with respect to the reference prod-
21 uct, if a person not licensed by the ref-
22 erence product sponsor engaged in the
23 making, using, offering to sell, selling, or
24 importing into the United States of the bi-

1 logical product that is the subject of the
2 subsection (k) application; and

3 “(ii) an identification of the patents
4 on such list that the reference product
5 sponsor would be prepared to license to the
6 subsection (k) applicant.

7 “(B) LIST AND DESCRIPTION BY SUB-
8 SECTION (k) APPLICANT.—Not later than 60
9 days after receipt of the list under subpara-
10 graph (A), the subsection (k) applicant—

11 “(i) may provide to the reference
12 product sponsor a list of patents to which
13 the subsection (k) applicant believes a
14 claim of patent infringement could reason-
15 ably be asserted by the reference product
16 sponsor if a person not licensed by the ref-
17 erence product sponsor engaged in the
18 making, using, offering to sell, selling, or
19 importing into the United States of the bi-
20 ological product that is the subject of the
21 subsection (k) application;

22 “(ii) shall provide to the reference
23 product sponsor, with respect to each pat-
24 ent listed by the reference product sponsor

1 under subparagraph (A) or listed by the
2 subsection (k) applicant under clause (i)—

3 “(I) a detailed statement that de-
4 scribes, on a claim by claim basis, the
5 factual and legal basis of the opinion
6 of the subsection (k) applicant that
7 such patent is invalid, unenforceable,
8 or will not be infringed by the com-
9 mercial marketing of the biological
10 product that is the subject of the sub-
11 section (k) application; or

12 “(II) a statement that the sub-
13 section (k) applicant does not intend
14 to begin commercial marketing of the
15 biological product before the date that
16 such patent expires; and

17 “(iii) shall provide to the reference
18 product sponsor a response regarding each
19 patent identified by the reference product
20 sponsor under subparagraph (A)(ii).

21 “(C) DESCRIPTION BY REFERENCE PROD-
22 UCT SPONSOR.—Not later than 60 days after
23 receipt of the list and statement under subpara-
24 graph (B), the reference product sponsor shall
25 provide to the subsection (k) applicant a de-

1 tailed statement that describes, with respect to
2 each patent described in subparagraph
3 (B)(ii)(I), on a claim by claim basis, the factual
4 and legal basis of the opinion of the reference
5 product sponsor that such patent will be in-
6 fringed by the commercial marketing of the bio-
7 logical product that is the subject of the sub-
8 section (k) application and a response to the
9 statement concerning validity and enforceability
10 provided under subparagraph (B)(ii)(I).

11 “(4) PATENT RESOLUTION NEGOTIATIONS.—

12 “(A) IN GENERAL.—After receipt by the
13 subsection (k) applicant of the statement under
14 paragraph (3)(C), the reference product spon-
15 sor and the subsection (k) applicant shall en-
16 gage in good faith negotiations to agree on
17 which, if any, patents listed under paragraph
18 (3) by the subsection (k) applicant or the ref-
19 erence product sponsor shall be the subject of
20 an action for patent infringement under para-
21 graph (6).

22 “(B) FAILURE TO REACH AGREEMENT.—

23 If, within 15 days of beginning negotiations
24 under subparagraph (A), the subsection (k) ap-
25 plicant and the reference product sponsor fail to

1 agree on a final and complete list of which, if
2 any, patents listed under paragraph (3) by the
3 subsection (k) applicant or the reference prod-
4 uct sponsor shall be the subject of an action for
5 patent infringement under paragraph (6), the
6 provisions of paragraph (5) shall apply to the
7 parties.

8 “(5) PATENT RESOLUTION IF NO AGREE-
9 MENT.—

10 “(A) NUMBER OF PATENTS.—The sub-
11 section (k) applicant shall notify the reference
12 product sponsor of the number of patents that
13 such applicant will provide to the reference
14 product sponsor under subparagraph (B)(i)(I).

15 “(B) EXCHANGE OF PATENT LISTS.—

16 “(i) IN GENERAL.—On a date agreed
17 to by the subsection (k) applicant and the
18 reference product sponsor, but in no case
19 later than 5 days after the subsection (k)
20 applicant notifies the reference product
21 sponsor under subparagraph (A), the sub-
22 section (k) applicant and the reference
23 product sponsor shall simultaneously ex-
24 change—

1 “(I) the list of patents that the
2 subsection (k) applicant believes
3 should be the subject of an action for
4 patent infringement under paragraph
5 (6); and

6 “(II) the list of patents, in ac-
7 cordance with clause (ii), that the ref-
8 erence product sponsor believes should
9 be the subject of an action for patent
10 infringement under paragraph (6).

11 “(ii) NUMBER OF PATENTS LISTED BY
12 REFERENCE PRODUCT SPONSOR.—

13 “(I) IN GENERAL.—Subject to
14 subclause (II), the number of patents
15 listed by the reference product spon-
16 sor under clause (i)(II) may not ex-
17 ceed the number of patents listed by
18 the subsection (k) applicant under
19 clause (i)(I).

20 “(II) EXCEPTION.—If a sub-
21 section (k) applicant does not list any
22 patent under clause (i)(I), the ref-
23 erence product sponsor may list 1 pat-
24 ent under clause (i)(II).

1 “(6) IMMEDIATE PATENT INFRINGEMENT AC-
2 TION.—

3 “(A) ACTION IF AGREEMENT ON PATENT
4 LIST.—If the subsection (k) applicant and the
5 reference product sponsor agree on patents as
6 described in paragraph (4), not later than 30
7 days after such agreement, the reference prod-
8 uct sponsor shall bring an action for patent in-
9 fringement with respect to each such patent.

10 “(B) ACTION IF NO AGREEMENT ON PAT-
11 ENT LIST.—If the provisions of paragraph (5)
12 apply to the parties as described in paragraph
13 (4)(B), not later than 30 days after the ex-
14 change of lists under paragraph (5)(B), the ref-
15 erence product sponsor shall bring an action for
16 patent infringement with respect to each patent
17 that is included on such lists.

18 “(C) NOTIFICATION AND PUBLICATION OF
19 COMPLAINT.—

20 “(i) NOTIFICATION TO SECRETARY.—
21 Not later than 30 days after a complaint
22 is served to a subsection (k) applicant in
23 an action for patent infringement described
24 under this paragraph, the subsection (k)

1 applicant shall provide the Secretary with
2 notice and a copy of such complaint.

3 “(ii) PUBLICATION BY SECRETARY.—

4 The Secretary shall publish in the Federal
5 Register notice of a complaint received
6 under clause (i).

7 “(7) NEWLY ISSUED OR LICENSED PATENTS.—

8 In the case of a patent that—

9 “(A) is issued to, or exclusively licensed by,
10 the reference product sponsor after the date
11 that the reference product sponsor provided the
12 list to the subsection (k) applicant under para-
13 graph (3)(A); and

14 “(B) the reference product sponsor reason-
15 ably believes that, due to the issuance of such
16 patent, a claim of patent infringement could
17 reasonably be asserted by the reference product
18 sponsor if a person not licensed by the ref-
19 erence product sponsor engaged in the making,
20 using, offering to sell, selling, or importing into
21 the United States of the biological product that
22 is the subject of the subsection (k) application,
23 not later than 30 days after such issuance or licens-
24 ing, the reference product sponsor shall provide to
25 the subsection (k) applicant a supplement to the list

1 provided by the reference product sponsor under
2 paragraph (3)(A) that includes such patent, not
3 later than 30 days after such supplement is pro-
4 vided, the subsection (k) applicant shall provide a
5 statement to the reference product sponsor in ac-
6 cordance with paragraph (3)(B), and such patent
7 shall be subject to paragraph (8).

8 “(8) NOTICE OF COMMERCIAL MARKETING AND
9 PRELIMINARY INJUNCTION.—

10 “(A) NOTICE OF COMMERCIAL MAR-
11 KETING.—The subsection (k) applicant shall
12 provide notice to the reference product sponsor
13 not later than 180 days before the date of the
14 first commercial marketing of the biological
15 product licensed under subsection (k).

16 “(B) PRELIMINARY INJUNCTION.—After
17 receiving the notice under subparagraph (A)
18 and before such date of the first commercial
19 marketing of such biological product, the ref-
20 erence product sponsor may seek a preliminary
21 injunction prohibiting the subsection (k) appli-
22 cant from engaging in the commercial manufac-
23 ture or sale of such biological product until the
24 court decides the issue of patent validity, en-

1 forcement, and infringement with respect to any
2 patent that is—

3 “(i) included in the list provided by
4 the reference product sponsor under para-
5 graph (3)(A) or in the list provided by the
6 subsection (k) applicant under paragraph
7 (3)(B); and

8 “(ii) not included, as applicable, on—

9 “(I) the list of patents described
10 in paragraph (4); or

11 “(II) the lists of patents de-
12 scribed in paragraph (5)(B).

13 “(C) REASONABLE COOPERATION.—If the
14 reference product sponsor has sought a prelimi-
15 nary injunction under subparagraph (B), the
16 reference product sponsor and the subsection
17 (k) applicant shall reasonably cooperate to ex-
18 pedite such further discovery as is needed in
19 connection with the preliminary injunction mo-
20 tion.

21 “(9) LIMITATION ON DECLARATORY JUDGMENT
22 ACTION.—

23 “(A) SUBSECTION (k) APPLICATION PRO-
24 VIDED.—If a subsection (k) applicant provides
25 the application and information required under

1 paragraph (2)(A), neither the reference product
2 sponsor nor the subsection (k) applicant may,
3 prior to the date notice is received under para-
4 graph (8)(A), bring any action under section
5 2201 of title 28, United States Code, for a dec-
6 laration of infringement, validity, or enforce-
7 ability of any patent that is described in clauses
8 (i) and (ii) of paragraph (8)(B).

9 “(B) SUBSEQUENT FAILURE TO ACT BY
10 SUBSECTION (k) APPLICANT.—If a subsection
11 (k) applicant fails to complete an action re-
12 quired of the subsection (k) applicant under
13 paragraph (3)(B)(ii), paragraph (5), paragraph
14 (6)(C)(i), paragraph (7), or paragraph (8)(A),
15 the reference product sponsor, but not the sub-
16 section (k) applicant, may bring an action
17 under section 2201 of title 28, United States
18 Code, for a declaration of infringement, validity,
19 or enforceability of any patent included in the
20 list described in paragraph (3)(A), including as
21 provided under paragraph (7).

22 “(C) SUBSECTION (k) APPLICATION NOT
23 PROVIDED.—If a subsection (k) applicant fails
24 to provide the application and information re-
25 quired under paragraph (2)(A), the reference

1 product sponsor, but not the subsection (k) ap-
2 plicant, may bring an action under section 2201
3 of title 28, United States Code, for a declara-
4 tion of infringement, validity, or enforceability
5 of any patent that claims the biological product
6 or a use of the biological product.”.

7 (b) DEFINITIONS.—Section 351(i) of the Public
8 Health Service Act (42 U.S.C. 262(i)) is amended—

9 (1) by striking “In this section, the term ‘bio-
10 logical product’ means” and inserting the following:

11 “In this section:

12 “(1) The term ‘biological product’ means”;

13 (2) in paragraph (1), as so designated, by in-
14 sserting “protein (except any chemically synthesized
15 polypeptide),” after “allergenic product,”; and

16 (3) by adding at the end the following:

17 “(2) The term ‘biosimilar’ or ‘biosimilarity’, in
18 reference to a biological product that is the subject
19 of an application under subsection (k), means—

20 “(A) that the biological product is highly
21 similar to the reference product notwith-
22 standing minor differences in clinically inactive
23 components; and

24 “(B) there are no clinically meaningful dif-
25 ferences between the biological product and the

1 reference product in terms of the safety, purity,
2 and potency of the product.

3 “(3) The term ‘interchangeable’ or ‘inter-
4 changeability’, in reference to a biological product
5 that is shown to meet the standards described in
6 subsection (k)(4), means that the biological product
7 may be substituted for the reference product without
8 the intervention of the health care provider who pre-
9 scribed the reference product.

10 “(4) The term ‘reference product’ means the
11 single biological product licensed under subsection
12 (a) against which a biological product is evaluated in
13 an application submitted under subsection (k).”.

14 (c) CONFORMING AMENDMENTS RELATING TO PAT-
15 ENTS.—

16 (1) PATENTS.—Section 271(e) of title 35,
17 United States Code, is amended—

18 (A) in paragraph (2)—

19 (i) in subparagraph (A), by striking
20 “or” at the end;

21 (ii) in subparagraph (B), by adding
22 “or” at the end; and

23 (iii) by inserting after subparagraph
24 (B) the following:

1 “(C)(i) with respect to a patent that is identi-
2 fied in the list of patents described in section
3 351(l)(3) of the Public Health Service Act (including
4 as provided under section 351(l)(7) of such Act), an
5 application seeking approval of a biological product,
6 or

7 “(ii) if the applicant for the application fails to
8 provide the application and information required
9 under section 351(l)(2)(A) of such Act, an applica-
10 tion seeking approval of a biological product for a
11 patent that could be identified pursuant to section
12 351(l)(3)(A)(i) of such Act,”; and

13 (iv) in the matter following subpara-
14 graph (C) (as added by clause (iii)), by
15 striking “or veterinary biological product”
16 and inserting “, veterinary biological prod-
17 uct, or biological product”;

18 (B) in paragraph (4)—

19 (i) in subparagraph (B), by—

20 (I) striking “or veterinary bio-
21 logical product” and inserting “, vet-
22 erinary biological product, or biologi-
23 cal product”; and

24 (II) striking “and” at the end;

25 (ii) in subparagraph (C), by—

1 (I) striking “or veterinary bio-
2 logical product” and inserting “, vet-
3 erinary biological product, or biologi-
4 cal product”; and

5 (II) striking the period and in-
6 serting “, and”;

7 (iii) by inserting after subparagraph
8 (C) the following:

9 “(D) the court shall order a permanent injunc-
10 tion prohibiting any infringement of the patent by
11 the biological product involved in the infringement
12 until a date which is not earlier than the date of the
13 expiration of the patent that has been infringed
14 under paragraph (2)(C), provided the patent is the
15 subject of a final court decision, as defined in sec-
16 tion 351(k)(6) of the Public Health Service Act, in
17 an action for infringement of the patent under sec-
18 tion 351(l)(6) of such Act, and the biological prod-
19 uct has not yet been approved because of section
20 351(k)(7) of such Act.”; and

21 (iv) in the matter following subpara-
22 graph (D) (as added by clause (iii)), by
23 striking “and (C)” and inserting “(C), and
24 (D)”;

25 (C) by adding at the end the following:

1 “(6)(A) Subparagraph (B) applies, in lieu of para-
2 graph (4), in the case of a patent—

3 “(i) that is identified, as applicable, in the list
4 of patents described in section 351(l)(4) of the Pub-
5 lic Health Service Act or the lists of patents de-
6 scribed in section 351(l)(5)(B) of such Act with re-
7 spect to a biological product; and

8 “(ii) for which an action for infringement of the
9 patent with respect to the biological product—

10 “(I) was brought after the expiration of
11 the 30-day period described in subparagraph
12 (A) or (B), as applicable, of section 351(l)(6) of
13 such Act; or

14 “(II) was brought before the expiration of
15 the 30-day period described in subclause (I),
16 but which was dismissed without prejudice or
17 was not prosecuted to judgment in good faith.

18 “(B) In an action for infringement of a patent de-
19 scribed in subparagraph (A), the sole and exclusive remedy
20 that may be granted by a court, upon a finding that the
21 making, using, offering to sell, selling, or importation into
22 the United States of the biological product that is the sub-
23 ject of the action infringed the patent, shall be a reason-
24 able royalty.

1 “(C) The owner of a patent that should have been
2 included in the list described in section 351(l)(3)(A) of
3 the Public Health Service Act, including as provided under
4 section 351(l)(7) of such Act for a biological product, but
5 was not timely included in such list, may not bring an
6 action under this section for infringement of the patent
7 with respect to the biological product.”.

8 (2) CONFORMING AMENDMENT UNDER TITLE
9 28.—Section 2201(b) of title 28, United States
10 Code, is amended by inserting before the period the
11 following: “, or section 351 of the Public Health
12 Service Act”.

13 (d) CONFORMING AMENDMENTS UNDER THE FED-
14 ERAL FOOD, DRUG, AND COSMETIC ACT.—

15 (1) CONTENT AND REVIEW OF APPLICA-
16 TIONS.—Section 505(b)(5)(B) of the Federal Food,
17 Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is
18 amended by inserting before the period at the end
19 of the first sentence the following: “or, with respect
20 to an applicant for approval of a biological product
21 under section 351(k) of the Public Health Service
22 Act, any necessary clinical study or studies”.

23 (2) NEW ACTIVE INGREDIENT.—Section 505B
24 of the Federal Food, Drug, and Cosmetic Act (21

1 U.S.C. 355c) is amended by adding at the end the
2 following:

3 “(n) NEW ACTIVE INGREDIENT.—

4 “(1) NON-INTERCHANGEABLE BIOSIMILAR BIO-
5 LOGICAL PRODUCT.—A biological product that is
6 biosimilar to a reference product under section 351
7 of the Public Health Service Act, and that the Sec-
8 retary has not determined to meet the standards de-
9 scribed in subsection (k)(4) of such section for inter-
10 changeability with the reference product, shall be
11 considered to have a new active ingredient under
12 this section.

13 “(2) INTERCHANGEABLE BIOSIMILAR BIOLOGI-
14 CAL PRODUCT.—A biological product that is inter-
15 changeable with a reference product under section
16 351 of the Public Health Service Act shall not be
17 considered to have a new active ingredient under
18 this section.”.

19 (e) PRODUCTS PREVIOUSLY APPROVED UNDER SEC-
20 TION 505.—

21 (1) REQUIREMENT TO FOLLOW SECTION 351.—

22 Except as provided in paragraph (2), an application
23 for a biological product shall be submitted under
24 section 351 of the Public Health Service Act (42
25 U.S.C. 262) (as amended by this Act).

1 (2) EXCEPTION.—An application for a biological
2 cal product may be submitted under section 505 of
3 the Federal Food, Drug, and Cosmetic Act (21
4 U.S.C. 355) if—

5 (A) such biological product is in a product
6 class for which a biological product in such
7 product class is the subject of an application
8 approved under such section 505 not later than
9 the date of enactment of this Act; and

10 (B) such application—

11 (i) has been submitted to the Sec-
12 retary of Health and Human Services (re-
13 ferred to in this subtitle as the “Sec-
14 retary”) before the date of enactment of
15 this Act; or

16 (ii) is submitted to the Secretary not
17 later than the date that is 10 years after
18 the date of enactment of this Act.

19 (3) LIMITATION.—Notwithstanding paragraph
20 (2), an application for a biological product may not
21 be submitted under section 505 of the Federal Food,
22 Drug, and Cosmetic Act (21 U.S.C. 355) if there is
23 another biological product approved under sub-
24 section (a) of section 351 of the Public Health Serv-
25 ice Act that could be a reference product with re-

1 spect to such application (within the meaning of
2 such section 351) if such application were submitted
3 under subsection (k) of such section 351.

4 (4) DEEMED APPROVED UNDER SECTION
5 351.—An approved application for a biological prod-
6 uct under section 505 of the Federal Food, Drug,
7 and Cosmetic Act (21 U.S.C. 355) shall be deemed
8 to be a license for the biological product under such
9 section 351 on the date that is 10 years after the
10 date of enactment of this Act.

11 (5) DEFINITIONS.—For purposes of this sub-
12 section, the term “biological product” has the mean-
13 ing given such term under section 351 of the Public
14 Health Service Act (42 U.S.C. 262) (as amended by
15 this Act).

16 (f) FOLLOW-ON BIOLOGICS USER FEES.—

17 (1) DEVELOPMENT OF USER FEES FOR BIO-
18 SIMILAR BIOLOGICAL PRODUCTS.—

19 (A) IN GENERAL.—Beginning not later
20 than October 1, 2010, the Secretary shall de-
21 velop recommendations to present to Congress
22 with respect to the goals, and plans for meeting
23 the goals, for the process for the review of bio-
24 similar biological product applications sub-
25 mitted under section 351(k) of the Public

1 Health Service Act (as added by this Act) for
2 the first 5 fiscal years after fiscal year 2012. In
3 developing such recommendations, the Sec-
4 retary shall consult with—

5 (i) the Committee on Health, Edu-
6 cation, Labor, and Pensions of the Senate;

7 (ii) the Committee on Energy and
8 Commerce of the House of Representa-
9 tives;

10 (iii) scientific and academic experts;

11 (iv) health care professionals;

12 (v) representatives of patient and con-
13 sumer advocacy groups; and

14 (vi) the regulated industry.

15 (B) PUBLIC REVIEW OF RECOMMENDA-
16 TIONS.—After negotiations with the regulated
17 industry, the Secretary shall—

18 (i) present the recommendations de-
19 veloped under subparagraph (A) to the
20 Congressional committees specified in such
21 subparagraph;

22 (ii) publish such recommendations in
23 the Federal Register;

1 (iii) provide for a period of 30 days
2 for the public to provide written comments
3 on such recommendations;

4 (iv) hold a meeting at which the pub-
5 lic may present its views on such rec-
6 ommendations; and

7 (v) after consideration of such public
8 views and comments, revise such rec-
9 ommendations as necessary.

10 (C) TRANSMITTAL OF RECOMMENDA-
11 TIONS.—Not later than January 15, 2012, the
12 Secretary shall transmit to Congress the revised
13 recommendations under subparagraph (B), a
14 summary of the views and comments received
15 under such subparagraph, and any changes
16 made to the recommendations in response to
17 such views and comments.

18 (2) ESTABLISHMENT OF USER FEE PRO-
19 GRAM.—It is the sense of the Senate that, based on
20 the recommendations transmitted to Congress by the
21 Secretary pursuant to paragraph (1)(C), Congress
22 should authorize a program, effective on October 1,
23 2012, for the collection of user fees relating to the
24 submission of biosimilar biological product applica-

1 tions under section 351(k) of the Public Health
2 Service Act (as added by this Act).

3 (3) TRANSITIONAL PROVISIONS FOR USER FEES
4 FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

5 (A) APPLICATION OF THE PRESCRIPTION
6 DRUG USER FEE PROVISIONS.—Section
7 735(1)(B) of the Federal Food, Drug, and Cos-
8 metic Act (21 U.S.C. 379g(1)(B)) is amended
9 by striking “section 351” and inserting “sub-
10 section (a) or (k) of section 351”.

11 (B) EVALUATION OF COSTS OF REVIEWING
12 BIOSIMILAR BIOLOGICAL PRODUCT APPLICA-
13 TIONS.—During the period beginning on the
14 date of enactment of this Act and ending on
15 October 1, 2010, the Secretary shall collect and
16 evaluate data regarding the costs of reviewing
17 applications for biological products submitted
18 under section 351(k) of the Public Health Serv-
19 ice Act (as added by this Act) during such pe-
20 riod.

21 (C) AUDIT.—

22 (i) IN GENERAL.—On the date that is
23 2 years after first receiving a user fee ap-
24 plicable to an application for a biological
25 product under section 351(k) of the Public

1 Health Service Act (as added by this Act),
2 and on a biennial basis thereafter until Oc-
3 tober 1, 2013, the Secretary shall perform
4 an audit of the costs of reviewing such ap-
5 plications under such section 351(k). Such
6 an audit shall compare—

7 (I) the costs of reviewing such
8 applications under such section
9 351(k) to the amount of the user fee
10 applicable to such applications; and

11 (II)(aa) such ratio determined
12 under subclause (I); to

13 (bb) the ratio of the costs of re-
14 viewing applications for biological
15 products under section 351(a) of such
16 Act (as amended by this Act) to the
17 amount of the user fee applicable to
18 such applications under such section
19 351(a).

20 (ii) ALTERATION OF USER FEE.—If
21 the audit performed under clause (i) indi-
22 cates that the ratios compared under sub-
23 clause (II) of such clause differ by more
24 than 5 percent, then the Secretary shall
25 alter the user fee applicable to applications

1 submitted under such section 351(k) to
2 more appropriately account for the costs of
3 reviewing such applications.

4 (iii) ACCOUNTING STANDARDS.—The
5 Secretary shall perform an audit under
6 clause (i) in conformance with the account-
7 ing principles, standards, and requirements
8 prescribed by the Comptroller General of
9 the United States under section 3511 of
10 title 31, United State Code, to ensure the
11 validity of any potential variability.

12 (4) AUTHORIZATION OF APPROPRIATIONS.—

13 There is authorized to be appropriated to carry out
14 this subsection such sums as may be necessary for
15 each of fiscal years 2010 through 2012.

16 (g) PEDIATRIC STUDIES OF BIOLOGICAL PROD-
17 UCTS.—

18 (1) IN GENERAL.—Section 351 of the Public
19 Health Service Act (42 U.S.C. 262) is amended by
20 adding at the end the following:

21 “(m) PEDIATRIC STUDIES.—

22 “(1) APPLICATION OF CERTAIN PROVISIONS.—

23 The provisions of subsections (a), (d), (e), (f), (i),
24 (j), (k), (l), (p), and (q) of section 505A of the Fed-
25 eral Food, Drug, and Cosmetic Act shall apply with

1 respect to the extension of a period under para-
2 graphs (2) and (3) to the same extent and in the
3 same manner as such provisions apply with respect
4 to the extension of a period under subsection (b) or
5 (c) of section 505A of the Federal Food, Drug, and
6 Cosmetic Act.

7 “(2) MARKET EXCLUSIVITY FOR NEW BIOLOGI-
8 CAL PRODUCTS.—If, prior to approval of an applica-
9 tion that is submitted under subsection (a), the Sec-
10 retary determines that information relating to the
11 use of a new biological product in the pediatric pop-
12 ulation may produce health benefits in that popu-
13 lation, the Secretary makes a written request for pe-
14 diatric studies (which shall include a timeframe for
15 completing such studies), the applicant agrees to the
16 request, such studies are completed using appro-
17 priate formulations for each age group for which the
18 study is requested within any such timeframe, and
19 the reports thereof are submitted and accepted in
20 accordance with section 505A(d)(3) of the Federal
21 Food, Drug, and Cosmetic Act—

22 “(A) the periods for such biological prod-
23 uct referred to in subsection (k)(7) are deemed
24 to be 4 years and 6 months rather than 4 years

1 and 12 years and 6 months rather than 12
2 years; and

3 “(B) if the biological product is designated
4 under section 526 for a rare disease or condi-
5 tion, the period for such biological product re-
6 ferred to in section 527(a) is deemed to be 7
7 years and 6 months rather than 7 years.

8 “(3) MARKET EXCLUSIVITY FOR ALREADY-MAR-
9 KETED BIOLOGICAL PRODUCTS.—If the Secretary
10 determines that information relating to the use of a
11 licensed biological product in the pediatric popu-
12 lation may produce health benefits in that popu-
13 lation and makes a written request to the holder of
14 an approved application under subsection (a) for pe-
15 diatric studies (which shall include a timeframe for
16 completing such studies), the holder agrees to the
17 request, such studies are completed using appro-
18 priate formulations for each age group for which the
19 study is requested within any such timeframe, and
20 the reports thereof are submitted and accepted in
21 accordance with section 505A(d)(3) of the Federal
22 Food, Drug, and Cosmetic Act—

23 “(A) the periods for such biological prod-
24 uct referred to in subsection (k)(7) are deemed
25 to be 4 years and 6 months rather than 4 years

1 and 12 years and 6 months rather than 12
2 years; and

3 “(B) if the biological product is designated
4 under section 526 for a rare disease or condi-
5 tion, the period for such biological product re-
6 ferred to in section 527(a) is deemed to be 7
7 years and 6 months rather than 7 years.

8 “(4) EXCEPTION.—The Secretary shall not ex-
9 tend a period referred to in paragraph (2)(A),
10 (2)(B), (3)(A), or (3)(B) if the determination under
11 section 505A(d)(3) is made later than 9 months
12 prior to the expiration of such period.”.

13 (2) STUDIES REGARDING PEDIATRIC RE-
14 SEARCH.—

15 (A) PROGRAM FOR PEDIATRIC STUDY OF
16 DRUGS.—Subsection (a)(1) of section 409I of
17 the Public Health Service Act (42 U.S.C.
18 284m) is amended by inserting “, biological
19 products,” after “including drugs”.

20 (B) INSTITUTE OF MEDICINE STUDY.—
21 Section 505A(p) of the Federal Food, Drug,
22 and Cosmetic Act (21 U.S.C. 355b(p)) is
23 amended by striking paragraphs (4) and (5)
24 and inserting the following:

1 “(4) review and assess the number and impor-
2 tance of biological products for children that are
3 being tested as a result of the amendments made by
4 the Biologics Price Competition and Innovation Act
5 of 2009 and the importance for children, health care
6 providers, parents, and others of labeling changes
7 made as a result of such testing;

8 “(5) review and assess the number, importance,
9 and prioritization of any biological products that are
10 not being tested for pediatric use; and

11 “(6) offer recommendations for ensuring pedi-
12 atric testing of biological products, including consid-
13 eration of any incentives, such as those provided
14 under this section or section 351(m) of the Public
15 Health Service Act.”.

16 (h) ORPHAN PRODUCTS.—If a reference product, as
17 defined in section 351 of the Public Health Service Act
18 (42 U.S.C. 262) (as amended by this Act) has been des-
19 ignated under section 526 of the Federal Food, Drug, and
20 Cosmetic Act (21 U.S.C. 360bb) for a rare disease or con-
21 dition, a biological product seeking approval for such dis-
22 ease or condition under subsection (k) of such section 351
23 as biosimilar to, or interchangeable with, such reference
24 product may be licensed by the Secretary only after the
25 expiration for such reference product of the later of—

1 (1) the 7-year period described in section
2 527(a) of the Federal Food, Drug, and Cosmetic Act
3 (21 U.S.C. 360cc(a)); and

4 (2) the 12-year period described in subsection
5 (k)(7) of such section 351.

6 **SEC. 7003. SAVINGS.**

7 (a) DETERMINATION.—The Secretary of the Treas-
8 ury, in consultation with the Secretary of Health and
9 Human Services, shall for each fiscal year determine the
10 amount of savings to the Federal Government as a result
11 of the enactment of this subtitle.

12 (b) USE.—Notwithstanding any other provision of
13 this subtitle (or an amendment made by this subtitle), the
14 savings to the Federal Government generated as a result
15 of the enactment of this subtitle shall be used for deficit
16 reduction.

17 **Subtitle B—More Affordable Medi-**
18 **cines for Children and Under-**
19 **served Communities**

20 **SEC. 7101. EXPANDED PARTICIPATION IN 340B PROGRAM.**

21 (a) EXPANSION OF COVERED ENTITIES RECEIVING
22 DISCOUNTED PRICES.—Section 340B(a)(4) of the Public
23 Health Service Act (42 U.S.C. 256b(a)(4)) is amended by
24 adding at the end the following:

1 “(M) A children’s hospital excluded from
2 the Medicare prospective payment system pur-
3 suant to section 1886(d)(1)(B)(iii) of the Social
4 Security Act, or a free-standing cancer hospital
5 excluded from the Medicare prospective pay-
6 ment system pursuant to section
7 1886(d)(1)(B)(v) of the Social Security Act,
8 that would meet the requirements of subpara-
9 graph (L), including the disproportionate share
10 adjustment percentage requirement under
11 clause (ii) of such subparagraph, if the hospital
12 were a subsection (d) hospital as defined by sec-
13 tion 1886(d)(1)(B) of the Social Security Act.

14 “(N) An entity that is a critical access hos-
15 pital (as determined under section 1820(c)(2)
16 of the Social Security Act), and that meets the
17 requirements of subparagraph (L)(i).

18 “(O) An entity that is a rural referral cen-
19 ter, as defined by section 1886(d)(5)(C)(i) of
20 the Social Security Act, or a sole community
21 hospital, as defined by section
22 1886(d)(5)(C)(iii) of such Act, and that both
23 meets the requirements of subparagraph (L)(i)
24 and has a disproportionate share adjustment
25 percentage equal to or greater than 8 percent.”.

1 (b) EXTENSION OF DISCOUNT TO INPATIENT
2 DRUGS.—Section 340B of the Public Health Service Act
3 (42 U.S.C. 256b) is amended—

4 (1) in paragraphs (2), (5), (7), and (9) of sub-
5 section (a), by striking “outpatient” each place it
6 appears; and

7 (2) in subsection (b)—

8 (A) by striking “OTHER DEFINITION” and
9 all that follows through “In this section” and
10 inserting the following: “OTHER DEFINI-
11 TIONS.—

12 “(1) IN GENERAL.—In this section”; and

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

15 “(2) COVERED DRUG.—In this section, the term
16 ‘covered drug’—

17 “(A) means a covered outpatient drug (as
18 defined in section 1927(k)(2) of the Social Se-
19 curity Act); and

20 “(B) includes, notwithstanding paragraph
21 (3)(A) of section 1927(k) of such Act, a drug
22 used in connection with an inpatient or out-
23 patient service provided by a hospital described
24 in subparagraph (L), (M), (N), or (O) of sub-

1 section (a)(4) that is enrolled to participate in
2 the drug discount program under this section.”.

3 (c) PROHIBITION ON GROUP PURCHASING ARRANGE-
4 MENTS.—Section 340B(a) of the Public Health Service
5 Act (42 U.S.C. 256b(a)) is amended—

6 (1) in paragraph (4)(L)—

7 (A) in clause (i), by adding “and” at the
8 end;

9 (B) in clause (ii), by striking “; and” and
10 inserting a period; and

11 (C) by striking clause (iii); and

12 (2) in paragraph (5), as amended by subsection
13 (b)—

14 (A) by redesignating subparagraphs (C)
15 and (D) as subparagraphs (D) and (E); respec-
16 tively; and

17 (B) by inserting after subparagraph (B),
18 the following:

19 “(C) PROHIBITION ON GROUP PURCHASING
20 ARRANGEMENTS.—

21 “(i) IN GENERAL.—A hospital de-
22 scribed in subparagraph (L), (M), (N), or
23 (O) of paragraph (4) shall not obtain cov-
24 ered outpatient drugs through a group
25 purchasing organization or other group

1 purchasing arrangement, except as per-
2 mitted or provided for pursuant to clauses
3 (ii) or (iii).

4 “(ii) INPATIENT DRUGS.—Clause (i)
5 shall not apply to drugs purchased for in-
6 patient use.

7 “(iii) EXCEPTIONS.—The Secretary
8 shall establish reasonable exceptions to
9 clause (i)—

10 “(I) with respect to a covered
11 outpatient drug that is unavailable to
12 be purchased through the program
13 under this section due to a drug
14 shortage problem, manufacturer non-
15 compliance, or any other circumstance
16 beyond the hospital’s control;

17 “(II) to facilitate generic substi-
18 tution when a generic covered out-
19 patient drug is available at a lower
20 price; or

21 “(III) to reduce in other ways
22 the administrative burdens of man-
23 aging both inventories of drugs sub-
24 ject to this section and inventories of
25 drugs that are not subject to this sec-

1 tion, so long as the exceptions do not
2 create a duplicate discount problem in
3 violation of subparagraph (A) or a di-
4 version problem in violation of sub-
5 paragraph (B).

6 “(iv) PURCHASING ARRANGEMENTS
7 FOR INPATIENT DRUGS.—The Secretary
8 shall ensure that a hospital described in
9 subparagraph (L), (M), (N), or (O) of sub-
10 section (a)(4) that is enrolled to partici-
11 pate in the drug discount program under
12 this section shall have multiple options for
13 purchasing covered drugs for inpatients,
14 including by utilizing a group purchasing
15 organization or other group purchasing ar-
16 rangement, establishing and utilizing its
17 own group purchasing program, pur-
18 chasing directly from a manufacturer, and
19 any other purchasing arrangements that
20 the Secretary determines is appropriate to
21 ensure access to drug discount pricing
22 under this section for inpatient drugs tak-
23 ing into account the particular needs of
24 small and rural hospitals.”.

1 (d) MEDICAID CREDITS ON INPATIENT DRUGS.—
2 Section 340B of the Public Health Service Act (42 U.S.C.
3 256b) is amended by striking subsection (c) and inserting
4 the following:

5 “(c) MEDICAID CREDIT.—Not later than 90 days
6 after the date of filing of the hospital’s most recently filed
7 Medicare cost report, the hospital shall issue a credit as
8 determined by the Secretary to the State Medicaid pro-
9 gram for inpatient covered drugs provided to Medicaid re-
10 cipients.”.

11 (e) EFFECTIVE DATES.—

12 (1) IN GENERAL.—The amendments made by
13 this section and section 7102 shall take effect on
14 January 1, 2010, and shall apply to drugs pur-
15 chased on or after January 1, 2010.

16 (2) EFFECTIVENESS.—The amendments made
17 by this section and section 7102 shall be effective
18 and shall be taken into account in determining
19 whether a manufacturer is deemed to meet the re-
20 quirements of section 340B(a) of the Public Health
21 Service Act (42 U.S.C. 256b(a)), notwithstanding
22 any other provision of law.

1 **SEC. 7102. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.**

2 (a) INTEGRITY IMPROVEMENTS.—Subsection (d) of
3 section 340B of the Public Health Service Act (42 U.S.C.
4 256b) is amended to read as follows:

5 “(d) IMPROVEMENTS IN PROGRAM INTEGRITY.—

6 “(1) MANUFACTURER COMPLIANCE.—

7 “(A) IN GENERAL.—From amounts appro-
8 priated under paragraph (4), the Secretary
9 shall provide for improvements in compliance by
10 manufacturers with the requirements of this
11 section in order to prevent overcharges and
12 other violations of the discounted pricing re-
13 quirements specified in this section.

14 “(B) IMPROVEMENTS.—The improvements
15 described in subparagraph (A) shall include the
16 following:

17 “(i) The development of a system to
18 enable the Secretary to verify the accuracy
19 of ceiling prices calculated by manufactur-
20 ers under subsection (a)(1) and charged to
21 covered entities, which shall include the
22 following:

23 “(I) Developing and publishing
24 through an appropriate policy or regu-
25 latory issuance, precisely defined
26 standards and methodology for the

1 calculation of ceiling prices under
2 such subsection.

3 “(II) Comparing regularly the
4 ceiling prices calculated by the Sec-
5 retary with the quarterly pricing data
6 that is reported by manufacturers to
7 the Secretary.

8 “(III) Performing spot checks of
9 sales transactions by covered entities.

10 “(IV) Inquiring into the cause of
11 any pricing discrepancies that may be
12 identified and either taking, or requir-
13 ing manufacturers to take, such cor-
14 rective action as is appropriate in re-
15 sponse to such price discrepancies.

16 “(ii) The establishment of procedures
17 for manufacturers to issue refunds to cov-
18 ered entities in the event that there is an
19 overcharge by the manufacturers, including
20 the following:

21 “(I) Providing the Secretary with
22 an explanation of why and how the
23 overcharge occurred, how the refunds
24 will be calculated, and to whom the
25 refunds will be issued.

1 “(II) Oversight by the Secretary
2 to ensure that the refunds are issued
3 accurately and within a reasonable pe-
4 riod of time, both in routine instances
5 of retroactive adjustment to relevant
6 pricing data and exceptional cir-
7 cumstances such as erroneous or in-
8 tentional overcharging for covered
9 drugs.

10 “(iii) The provision of access through
11 the Internet website of the Department of
12 Health and Human Services to the applica-
13 ble ceiling prices for covered drugs as cal-
14 culated and verified by the Secretary in ac-
15 cordance with this section, in a manner
16 (such as through the use of password pro-
17 tection) that limits such access to covered
18 entities and adequately assures security
19 and protection of privileged pricing data
20 from unauthorized re-disclosure.

21 “(iv) The development of a mecha-
22 nism by which—

23 “(I) rebates and other discounts
24 provided by manufacturers to other
25 purchasers subsequent to the sale of

1 covered drugs to covered entities are
2 reported to the Secretary; and

3 “(II) appropriate credits and re-
4 funds are issued to covered entities if
5 such discounts or rebates have the ef-
6 fect of lowering the applicable ceiling
7 price for the relevant quarter for the
8 drugs involved.

9 “(v) Selective auditing of manufactur-
10 ers and wholesalers to ensure the integrity
11 of the drug discount program under this
12 section.

13 “(vi) The imposition of sanctions in
14 the form of civil monetary penalties,
15 which—

16 “(I) shall be assessed according
17 to standards established in regulations
18 to be promulgated by the Secretary
19 not later than 180 days after the date
20 of enactment of the Patient Protec-
21 tion and Affordable Care Act;

22 “(II) shall not exceed \$5,000 for
23 each instance of overcharging a cov-
24 ered entity that may have occurred;
25 and

1 “(III) shall apply to any manu-
2 facturer with an agreement under this
3 section that knowingly and inten-
4 tionally charges a covered entity a
5 price for purchase of a drug that ex-
6 ceeds the maximum applicable price
7 under subsection (a)(1).

8 “(2) COVERED ENTITY COMPLIANCE.—

9 “(A) IN GENERAL.—From amounts appro-
10 priated under paragraph (4), the Secretary
11 shall provide for improvements in compliance by
12 covered entities with the requirements of this
13 section in order to prevent diversion and viola-
14 tions of the duplicate discount provision and
15 other requirements specified under subsection
16 (a)(5).

17 “(B) IMPROVEMENTS.—The improvements
18 described in subparagraph (A) shall include the
19 following:

20 “(i) The development of procedures to
21 enable and require covered entities to regu-
22 larly update (at least annually) the infor-
23 mation on the Internet website of the De-
24 partment of Health and Human Services
25 relating to this section.

1 “(ii) The development of a system for
2 the Secretary to verify the accuracy of in-
3 formation regarding covered entities that is
4 listed on the website described in clause
5 (i).

6 “(iii) The development of more de-
7 tailed guidance describing methodologies
8 and options available to covered entities for
9 billing covered drugs to State Medicaid
10 agencies in a manner that avoids duplicate
11 discounts pursuant to subsection (a)(5)(A).

12 “(iv) The establishment of a single,
13 universal, and standardized identification
14 system by which each covered entity site
15 can be identified by manufacturers, dis-
16 tributors, covered entities, and the Sec-
17 retary for purposes of facilitating the or-
18 dering, purchasing, and delivery of covered
19 drugs under this section, including the
20 processing of chargebacks for such drugs.

21 “(v) The imposition of sanctions, in
22 appropriate cases as determined by the
23 Secretary, additional to those to which cov-
24 ered entities are subject under subsection

1 (a)(5)(E), through one or more of the fol-
2 lowing actions:

3 “(I) Where a covered entity
4 knowingly and intentionally violates
5 subsection (a)(5)(B), the covered enti-
6 ty shall be required to pay a monetary
7 penalty to a manufacturer or manu-
8 facturers in the form of interest on
9 sums for which the covered entity is
10 found liable under subsection
11 (a)(5)(E), such interest to be com-
12 pounded monthly and equal to the
13 current short term interest rate as de-
14 termined by the Federal Reserve for
15 the time period for which the covered
16 entity is liable.

17 “(II) Where the Secretary deter-
18 mines a violation of subsection
19 (a)(5)(B) was systematic and egre-
20 gious as well as knowing and inten-
21 tional, removing the covered entity
22 from the drug discount program
23 under this section and disqualifying
24 the entity from re-entry into such pro-

1 gram for a reasonable period of time
2 to be determined by the Secretary.

3 “(III) Referring matters to ap-
4 propriate Federal authorities within
5 the Food and Drug Administration,
6 the Office of Inspector General of De-
7 partment of Health and Human Serv-
8 ices, or other Federal agencies for
9 consideration of appropriate action
10 under other Federal statutes, such as
11 the Prescription Drug Marketing Act
12 (21 U.S.C. 353).

13 “(3) ADMINISTRATIVE DISPUTE RESOLUTION
14 PROCESS.—

15 “(A) IN GENERAL.—Not later than 180
16 days after the date of enactment of the Patient
17 Protection and Affordable Care Act, the Sec-
18 retary shall promulgate regulations to establish
19 and implement an administrative process for
20 the resolution of claims by covered entities that
21 they have been overcharged for drugs purchased
22 under this section, and claims by manufactur-
23 ers, after the conduct of audits as authorized by
24 subsection (a)(5)(D), of violations of sub-
25 sections (a)(5)(A) or (a)(5)(B), including ap-

1 appropriate procedures for the provision of rem-
2 edies and enforcement of determinations made
3 pursuant to such process through mechanisms
4 and sanctions described in paragraphs (1)(B)
5 and (2)(B).

6 “(B) DEADLINES AND PROCEDURES.—
7 Regulations promulgated by the Secretary
8 under subparagraph (A) shall—

9 “(i) designate or establish a decision-
10 making official or decision-making body
11 within the Department of Health and
12 Human Services to be responsible for re-
13 viewing and finally resolving claims by cov-
14 ered entities that they have been charged
15 prices for covered drugs in excess of the
16 ceiling price described in subsection (a)(1),
17 and claims by manufacturers that viola-
18 tions of subsection (a)(5)(A) or (a)(5)(B)
19 have occurred;

20 “(ii) establish such deadlines and pro-
21 cedures as may be necessary to ensure that
22 claims shall be resolved fairly, efficiently,
23 and expeditiously;

24 “(iii) establish procedures by which a
25 covered entity may discover and obtain

1 such information and documents from
2 manufacturers and third parties as may be
3 relevant to demonstrate the merits of a
4 claim that charges for a manufacturer's
5 product have exceeded the applicable ceil-
6 ing price under this section, and may sub-
7 mit such documents and information to the
8 administrative official or body responsible
9 for adjudicating such claim;

10 “(iv) require that a manufacturer con-
11 duct an audit of a covered entity pursuant
12 to subsection (a)(5)(D) as a prerequisite to
13 initiating administrative dispute resolution
14 proceedings against a covered entity;

15 “(v) permit the official or body des-
16 ignated under clause (i), at the request of
17 a manufacturer or manufacturers, to con-
18 solidate claims brought by more than one
19 manufacturer against the same covered en-
20 tity where, in the judgment of such official
21 or body, consolidation is appropriate and
22 consistent with the goals of fairness and
23 economy of resources; and

24 “(vi) include provisions and proce-
25 dures to permit multiple covered entities to

1 jointly assert claims of overcharges by the
2 same manufacturer for the same drug or
3 drugs in one administrative proceeding,
4 and permit such claims to be asserted on
5 behalf of covered entities by associations or
6 organizations representing the interests of
7 such covered entities and of which the cov-
8 ered entities are members.

9 “(C) FINALITY OF ADMINISTRATIVE RESO-
10 LUTION.—The administrative resolution of a
11 claim or claims under the regulations promul-
12 gated under subparagraph (A) shall be a final
13 agency decision and shall be binding upon the
14 parties involved, unless invalidated by an order
15 of a court of competent jurisdiction.

16 “(4) AUTHORIZATION OF APPROPRIATIONS.—
17 There are authorized to be appropriated to carry out
18 this subsection, such sums as may be necessary for
19 fiscal year 2010 and each succeeding fiscal year.”.

20 (b) CONFORMING AMENDMENTS.—Section 340B(a)
21 of the Public Health Service Act (42 U.S.C. 256b(a)) is
22 amended—

23 (1) in subsection (a)(1), by adding at the end
24 the following: “Each such agreement shall require
25 that the manufacturer furnish the Secretary with re-

1 ports, on a quarterly basis, of the price for each cov-
2 ered drug subject to the agreement that, according
3 to the manufacturer, represents the maximum price
4 that covered entities may permissibly be required to
5 pay for the drug (referred to in this section as the
6 ‘ceiling price’), and shall require that the manufac-
7 turer offer each covered entity covered drugs for
8 purchase at or below the applicable ceiling price if
9 such drug is made available to any other purchaser
10 at any price.”; and

11 (2) in the first sentence of subsection (a)(5)(E),
12 as redesignated by section 7101(c), by inserting
13 “after audit as described in subparagraph (D) and”
14 after “finds,”.

15 **SEC. 7103. GAO STUDY TO MAKE RECOMMENDATIONS ON**
16 **IMPROVING THE 340B PROGRAM.**

17 (a) REPORT.—Not later than 18 months after the
18 date of enactment of this Act, the Comptroller General
19 of the United States shall submit to Congress a report
20 that examines whether those individuals served by the cov-
21 ered entities under the program under section 340B of
22 the Public Health Service Act (42 U.S.C. 256b) (referred
23 to in this section as the “340B program”) are receiving
24 optimal health care services.

1 (b) RECOMMENDATIONS.—The report under sub-
 2 section (a) shall include recommendations on the fol-
 3 lowing:

4 (1) Whether the 340B program should be ex-
 5 panded since it is anticipated that the 47,000,000
 6 individuals who are uninsured as of the date of en-
 7 actment of this Act will have health care coverage
 8 once this Act is implemented.

9 (2) Whether mandatory sales of certain prod-
 10 ucts by the 340B program could hinder patients ac-
 11 cess to those therapies through any provider.

12 (3) Whether income from the 340B program is
 13 being used by the covered entities under the pro-
 14 gram to further the program objectives.

15 **TITLE VIII—CLASS ACT**

16 **SEC. 8001. SHORT TITLE OF TITLE.**

17 This title may be cited as the “Community Living
 18 Assistance Services and Supports Act” or the “CLASS
 19 Act”.

20 **SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY IN-** 21 **SURANCE PROGRAM FOR PURCHASING COM-** 22 **MUNITY LIVING ASSISTANCE SERVICES AND** 23 **SUPPORT.**

24 (a) ESTABLISHMENT OF CLASS PROGRAM.—

1 (1) IN GENERAL.—The Public Health Service
2 Act (42 U.S.C. 201 et seq.), as amended by section
3 4302(a), is amended by adding at the end the fol-
4 lowing:

5 **“TITLE XXXII—COMMUNITY LIV-**
6 **ING ASSISTANCE SERVICES**
7 **AND SUPPORTS**

8 **“SEC. 3201. PURPOSE.**

9 “The purpose of this title is to establish a national
10 voluntary insurance program for purchasing community
11 living assistance services and supports in order to—

12 “(1) provide individuals with functional limita-
13 tions with tools that will allow them to maintain
14 their personal and financial independence and live in
15 the community through a new financing strategy for
16 community living assistance services and supports;

17 “(2) establish an infrastructure that will help
18 address the Nation’s community living assistance
19 services and supports needs;

20 “(3) alleviate burdens on family caregivers; and

21 “(4) address institutional bias by providing a fi-
22 nancing mechanism that supports personal choice
23 and independence to live in the community.

24 **“SEC. 3202. DEFINITIONS.**

25 “In this title:

1 “(1) ACTIVE ENROLLEE.—The term ‘active en-
2 rollee’ means an individual who is enrolled in the
3 CLASS program in accordance with section 3204
4 and who has paid any premiums due to maintain
5 such enrollment.

6 “(2) ACTIVELY EMPLOYED.—The term ‘actively
7 employed’ means an individual who—

8 “(A) is reporting for work at the individ-
9 ual’s usual place of employment or at another
10 location to which the individual is required to
11 travel because of the individual’s employment
12 (or in the case of an individual who is a mem-
13 ber of the uniformed services, is on active duty
14 and is physically able to perform the duties of
15 the individual’s position); and

16 “(B) is able to perform all the usual and
17 customary duties of the individual’s employment
18 on the individual’s regular work schedule.

19 “(3) ACTIVITIES OF DAILY LIVING.—The term
20 ‘activities of daily living’ means each of the following
21 activities specified in section 7702B(c)(2)(B) of the
22 Internal Revenue Code of 1986:

23 “(A) Eating.

24 “(B) Toileting.

25 “(C) Transferring.

1 “(D) Bathing.

2 “(E) Dressing.

3 “(F) Contenance.

4 “(4) CLASS PROGRAM.—The term ‘CLASS
5 program’ means the program established under this
6 title.

7 “(5) ELIGIBILITY ASSESSMENT SYSTEM.—The
8 term ‘Eligibility Assessment System’ means the enti-
9 ty established by the Secretary under section
10 3205(a)(2) to make functional eligibility determina-
11 tions for the CLASS program.

12 “(6) ELIGIBLE BENEFICIARY.—

13 “(A) IN GENERAL.—The term ‘eligible
14 beneficiary’ means any individual who is an ac-
15 tive enrollee in the CLASS program and, as of
16 the date described in subparagraph (B)—

17 “(i) has paid premiums for enrollment
18 in such program for at least 60 months;

19 “(ii) has earned, with respect to at
20 least 3 calendar years that occur during
21 the first 60 months for which the indi-
22 vidual has paid premiums for enrollment in
23 the program, at least an amount equal to
24 the amount of wages and self-employment
25 income which an individual must have in

1 order to be credited with a quarter of cov-
2 erage under section 213(d) of the Social
3 Security Act for the year; and

4 “(iii) has paid premiums for enroll-
5 ment in such program for at least 24 con-
6 secutive months, if a lapse in premium
7 payments of more than 3 months has oc-
8 curred during the period that begins on the
9 date of the individual’s enrollment and
10 ends on the date of such determination.

11 “(B) DATE DESCRIBED.—For purposes of
12 subparagraph (A), the date described in this
13 subparagraph is the date on which the indi-
14 vidual is determined to have a functional limita-
15 tion described in section 3203(a)(1)(C) that is
16 expected to last for a continuous period of more
17 than 90 days.

18 “(C) REGULATIONS.—The Secretary shall
19 promulgate regulations specifying exceptions to
20 the minimum earnings requirements under sub-
21 paragraph (A)(ii) for purposes of being consid-
22 ered an eligible beneficiary for certain popu-
23 lations.

24 “(7) HOSPITAL; NURSING FACILITY; INTER-
25 MEDIATE CARE FACILITY FOR THE MENTALLY RE-

1 TARDED; INSTITUTION FOR MENTAL DISEASES.—
2 The terms ‘hospital’, ‘nursing facility’, ‘intermediate
3 care facility for the mentally retarded’, and ‘institu-
4 tion for mental diseases’ have the meanings given
5 such terms for purposes of Medicaid.

6 “(8) CLASS INDEPENDENCE ADVISORY COUN-
7 CIL.—The term ‘CLASS Independence Advisory
8 Council’ or ‘Council’ means the Advisory Council es-
9 tablished under section 3207 to advise the Secretary.

10 “(9) CLASS INDEPENDENCE BENEFIT PLAN.—
11 The term ‘CLASS Independence Benefit Plan’
12 means the benefit plan developed and designated by
13 the Secretary in accordance with section 3203.

14 “(10) CLASS INDEPENDENCE FUND.—The
15 term ‘CLASS Independence Fund’ or ‘Fund’ means
16 the fund established under section 3206.

17 “(11) MEDICAID.—The term ‘Medicaid’ means
18 the program established under title XIX of the So-
19 cial Security Act (42 U.S.C. 1396 et seq.).

20 “(12) POVERTY LINE.—The term ‘poverty line’
21 has the meaning given that term in section
22 2110(e)(5) of the Social Security Act (42 U.S.C.
23 1397jj(c)(5)).

24 “(13) PROTECTION AND ADVOCACY SYSTEM.—
25 The term ‘Protection and Advocacy System’ means

1 the system for each State established under section
2 143 of the Developmental Disabilities Assistance
3 and Bill of Rights Act of 2000 (42 U.S.C. 15043).

4 **“SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN.**

5 “(a) PROCESS FOR DEVELOPMENT.—

6 “(1) IN GENERAL.—The Secretary, in consulta-
7 tion with appropriate actuaries and other experts,
8 shall develop at least 3 actuarially sound benefit
9 plans as alternatives for consideration for designa-
10 tion by the Secretary as the CLASS Independence
11 Benefit Plan under which eligible beneficiaries shall
12 receive benefits under this title. Each of the plan al-
13 ternatives developed shall be designed to provide eli-
14 gible beneficiaries with the benefits described in sec-
15 tion 3205 consistent with the following require-
16 ments:

17 “(A) PREMIUMS.—

18 “(i) IN GENERAL.—Beginning with
19 the first year of the CLASS program, and
20 for each year thereafter, subject to clauses
21 (ii) and (iii), the Secretary shall establish
22 all premiums to be paid by enrollees for
23 the year based on an actuarial analysis of
24 the 75-year costs of the program that en-

1 sures solvency throughout such 75-year pe-
2 riod.

3 “(ii) NOMINAL PREMIUM FOR POOR-
4 EST INDIVIDUALS AND FULL-TIME STU-
5 DENTS.—

6 “(I) IN GENERAL.—The monthly
7 premium for enrollment in the
8 CLASS program shall not exceed the
9 applicable dollar amount per month
10 determined under subclause (II) for—

11 “(aa) any individual whose
12 income does not exceed the pov-
13 erty line; and

14 “(bb) any individual who
15 has not attained age 22, and is
16 actively employed during any pe-
17 riod in which the individual is a
18 full-time student (as determined
19 by the Secretary).

20 “(II) APPLICABLE DOLLAR
21 AMOUNT.—The applicable dollar
22 amount described in this subclause is
23 the amount equal to \$5, increased by
24 the percentage increase in the con-
25 sumer price index for all urban con-

1 sumers (U.S. city average) for each
2 year occurring after 2009 and before
3 such year.

4 “(iii) CLASS INDEPENDENCE FUND
5 RESERVES.—At such time as the CLASS
6 program has been in operation for 10
7 years, the Secretary shall establish all pre-
8 miums to be paid by enrollees for the year
9 based on an actuarial analysis that accu-
10 mulated reserves in the CLASS Independ-
11 ence Fund would not decrease in that year.
12 At such time as the Secretary determines
13 the CLASS program demonstrates a sus-
14 tained ability to finance expected yearly ex-
15 penses with expected yearly premiums and
16 interest credited to the CLASS Independ-
17 ence Fund, the Secretary may decrease the
18 required amount of CLASS Independence
19 Fund reserves.

20 “(B) VESTING PERIOD.—A 5-year vesting
21 period for eligibility for benefits.

22 “(C) BENEFIT TRIGGERS.—A benefit trig-
23 ger for provision of benefits that requires a de-
24 termination that an individual has a functional
25 limitation, as certified by a licensed health care

1 practitioner, described in any of the following
2 clauses that is expected to last for a continuous
3 period of more than 90 days:

4 “(i) The individual is determined to
5 be unable to perform at least the minimum
6 number (which may be 2 or 3) of activities
7 of daily living as are required under the
8 plan for the provision of benefits without
9 substantial assistance (as defined by the
10 Secretary) from another individual.

11 “(ii) The individual requires substan-
12 tial supervision to protect the individual
13 from threats to health and safety due to
14 substantial cognitive impairment.

15 “(iii) The individual has a level of
16 functional limitation similar (as determined
17 under regulations prescribed by the Sec-
18 retary) to the level of functional limitation
19 described in clause (i) or (ii).

20 “(D) CASH BENEFIT.—Payment of a cash
21 benefit that satisfies the following requirements:

22 “(i) MINIMUM REQUIRED AMOUNT.—
23 The benefit amount provides an eligible
24 beneficiary with not less than an average
25 of \$50 per day (as determined based on

1 the reasonably expected distribution of
2 beneficiaries receiving benefits at various
3 benefit levels).

4 “(ii) AMOUNT SCALED TO FUNC-
5 TIONAL ABILITY.—The benefit amount is
6 varied based on a scale of functional abil-
7 ity, with not less than 2, and not more
8 than 6, benefit level amounts.

9 “(iii) DAILY OR WEEKLY.—The ben-
10 efit is paid on a daily or weekly basis.

11 “(iv) NO LIFETIME OR AGGREGATE
12 LIMIT.—The benefit is not subject to any
13 lifetime or aggregate limit.

14 “(E) COORDINATION WITH SUPPLE-
15 MENTAL COVERAGE OBTAINED THROUGH THE
16 EXCHANGE.—The benefits allow for coordina-
17 tion with any supplemental coverage purchased
18 through an Exchange established under section
19 1311 of the Patient Protection and Affordable
20 Care Act.

21 “(2) REVIEW AND RECOMMENDATION BY THE
22 CLASS INDEPENDENCE ADVISORY COUNCIL.—The
23 CLASS Independence Advisory Council shall—

24 “(A) evaluate the alternative benefit plans
25 developed under paragraph (1); and

1 “(B) recommend for designation as the
2 CLASS Independence Benefit Plan for offering
3 to the public the plan that the Council deter-
4 mines best balances price and benefits to meet
5 enrollees’ needs in an actuarially sound manner,
6 while optimizing the probability of the long-
7 term sustainability of the CLASS program.

8 “(3) DESIGNATION BY THE SECRETARY.—Not
9 later than October 1, 2012, the Secretary, taking
10 into consideration the recommendation of the
11 CLASS Independence Advisory Council under para-
12 graph (2)(B), shall designate a benefit plan as the
13 CLASS Independence Benefit Plan. The Secretary
14 shall publish such designation, along with details of
15 the plan and the reasons for the selection by the
16 Secretary, in a final rule that allows for a period of
17 public comment.

18 “(b) ADDITIONAL PREMIUM REQUIREMENTS.—

19 “(1) ADJUSTMENT OF PREMIUMS.—

20 “(A) IN GENERAL.—Except as provided in
21 subparagraphs (B), (C), (D), and (E), the
22 amount of the monthly premium determined for
23 an individual upon such individual’s enrollment
24 in the CLASS program shall remain the same

1 for as long as the individual is an active en-
2 rollee in the program.

3 “(B) RECALCULATED PREMIUM IF RE-
4 QUIRED FOR PROGRAM SOLVENCY.—

5 “(i) IN GENERAL.—Subject to clause
6 (ii), if the Secretary determines, based on
7 the most recent report of the Board of
8 Trustees of the CLASS Independence
9 Fund, the advice of the CLASS Independ-
10 ence Advisory Council, and the annual re-
11 port of the Inspector General of the De-
12 partment of Health and Human Services,
13 and waste, fraud, and abuse, or such other
14 information as the Secretary determines
15 appropriate, that the monthly premiums
16 and income to the CLASS Independence
17 Fund for a year are projected to be insuffi-
18 cient with respect to the 20-year period
19 that begins with that year, the Secretary
20 shall adjust the monthly premiums for in-
21 dividuals enrolled in the CLASS program
22 as necessary (but maintaining a nominal
23 premium for enrollees whose income is
24 below the poverty line or who are full-time
25 students actively employed).

1 “(ii) EXEMPTION FROM INCREASE.—
2 Any increase in a monthly premium im-
3 posed as result of a determination de-
4 scribed in clause (i) shall not apply with
5 respect to the monthly premium of any ac-
6 tive enrollee who—

7 “(I) has attained age 65;

8 “(II) has paid premiums for en-
9 rollment in the program for at least
10 20 years; and

11 “(III) is not actively employed.

12 “(C) RECALCULATED PREMIUM IF RE-
13 ENROLLMENT AFTER MORE THAN A 3-MONTH
14 LAPSE.—

15 “(i) IN GENERAL.—The reenrollment
16 of an individual after a 90-day period dur-
17 ing which the individual failed to pay the
18 monthly premium required to maintain the
19 individual’s enrollment in the CLASS pro-
20 gram shall be treated as an initial enroll-
21 ment for purposes of age-adjusting the
22 premium for enrollment in the program.

23 “(ii) CREDIT FOR PRIOR MONTHS IF
24 REENROLLED WITHIN 5 YEARS.—An indi-
25 vidual who reenrolls in the CLASS pro-

1 gram after such a 90-day period and be-
2 fore the end of the 5-year period that be-
3 gins with the first month for which the in-
4 dividual failed to pay the monthly premium
5 required to maintain the individual's en-
6 rollment in the program shall be—

7 “(I) credited with any months of
8 paid premiums that accrued prior to
9 the individual's lapse in enrollment;
10 and

11 “(II) notwithstanding the total
12 amount of any such credited months,
13 required to satisfy section
14 3202(6)(A)(ii) before being eligible to
15 receive benefits.

16 “(D) NO LONGER STATUS AS A FULL-TIME
17 STUDENT.—An individual subject to a nominal
18 premium on the basis of being described in sub-
19 section (a)(1)(A)(ii)(I)(bb) who ceases to be de-
20 scribed in that subsection, beginning with the
21 first month following the month in which the
22 individual ceases to be so described, shall be
23 subject to the same monthly premium as the
24 monthly premium that applies to an individual
25 of the same age who first enrolls in the pro-

1 gram under the most similar circumstances as
2 the individual (such as the first year of eligi-
3 bility for enrollment in the program or in a sub-
4 sequent year).

5 “(E) PENALTY FOR REENOLLMENT AFTER
6 5-YEAR LAPSE.—In the case of an individual
7 who reenrolls in the CLASS program after the
8 end of the 5-year period described in subpara-
9 graph (C)(ii), the monthly premium required
10 for the individual shall be the age-adjusted pre-
11 mium that would be applicable to an initially
12 enrolling individual who is the same age as the
13 reenrolling individual, increased by the greater
14 of—

15 “(i) an amount that the Secretary de-
16 termines is actuarially sound for each
17 month that occurs during the period that
18 begins with the first month for which the
19 individual failed to pay the monthly pre-
20 mium required to maintain the individual’s
21 enrollment in the CLASS program and
22 ends with the month preceding the month
23 in which the reenollment is effective; or

1 “(ii) 1 percent of the applicable age-
2 adjusted premium for each such month oc-
3 curring in such period.

4 “(2) ADMINISTRATIVE EXPENSES.—In deter-
5 mining the monthly premiums for the CLASS pro-
6 gram the Secretary may factor in costs for admin-
7 istering the program, not to exceed for any year in
8 which the program is in effect under this title, an
9 amount equal to 3 percent of all premiums paid dur-
10 ing the year.

11 “(3) NO UNDERWRITING REQUIREMENTS.—No
12 underwriting (other than on the basis of age in ac-
13 cordance with subparagraphs (D) and (E) of para-
14 graph (1)) shall be used to—

15 “(A) determine the monthly premium for
16 enrollment in the CLASS program; or

17 “(B) prevent an individual from enrolling
18 in the program.

19 “(c) SELF-ATTESTATION AND VERIFICATION OF IN-
20 COME.—The Secretary shall establish procedures to—

21 “(1) permit an individual who is eligible for the
22 nominal premium required under subsection
23 (a)(1)(A)(ii), as part of their automatic enrollment
24 in the CLASS program, to self-attest that their in-
25 come does not exceed the poverty line or that their

1 status as a full-time student who is actively em-
2 ployed;

3 “(2) verify, using procedures similar to the pro-
4 cedures used by the Commissioner of Social Security
5 under section 1631(e)(1)(B)(ii) of the Social Secu-
6 rity Act and consistent with the requirements appli-
7 cable to the conveyance of data and information
8 under section 1942 of such Act, the validity of such
9 self-attestation; and

10 “(3) require an individual to confirm, on at
11 least an annual basis, that their income does not ex-
12 ceed the poverty line or that they continue to main-
13 tain such status.

14 **“SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIRE-**
15 **MENTS.**

16 “(a) **AUTOMATIC ENROLLMENT.**—

17 “(1) **IN GENERAL.**—Subject to paragraph (2),
18 the Secretary, in coordination with the Secretary of
19 the Treasury, shall establish procedures under which
20 each individual described in subsection (c) may be
21 automatically enrolled in the CLASS program by an
22 employer of such individual in the same manner as
23 an employer may elect to automatically enroll em-
24 ployees in a plan under section 401(k), 403(b), or
25 457 of the Internal Revenue Code of 1986.

1 “(2) ALTERNATIVE ENROLLMENT PROCE-
2 DURES.—The procedures established under para-
3 graph (1) shall provide for an alternative enrollment
4 process for an individual described in subsection (c)
5 in the case of such an individual—

6 “(A) who is self-employed;

7 “(B) who has more than 1 employer; or

8 “(C) whose employer does not elect to par-
9 ticipate in the automatic enrollment process es-
10 tablished by the Secretary.

11 “(3) ADMINISTRATION.—

12 “(A) IN GENERAL.—The Secretary and the
13 Secretary of the Treasury shall, by regulation,
14 establish procedures to ensure that an indi-
15 vidual is not automatically enrolled in the
16 CLASS program by more than 1 employer.

17 “(B) FORM.—Enrollment in the CLASS
18 program shall be made in such manner as the
19 Secretary may prescribe in order to ensure ease
20 of administration.

21 “(b) ELECTION TO OPT-OUT.—An individual de-
22 scribed in subsection (c) may elect to waive enrollment in
23 the CLASS program at any time in such form and manner
24 as the Secretary and the Secretary of the Treasury shall
25 prescribe.

1 “(c) INDIVIDUAL DESCRIBED.—For purposes of en-
2 rolling in the CLASS program, an individual described in
3 this paragraph is an individual—

4 “(1) who has attained age 18;

5 “(2) who—

6 “(A) receives wages on which there is im-
7 posed a tax under section 3201(a) of the Inter-
8 nal Revenue Code of 1986; or

9 “(B) derives self-employment income on
10 which there is imposed a tax under section
11 1401(a) of the Internal Revenue Code of 1986;

12 “(3) who is actively employed; and

13 “(4) who is not—

14 “(A) a patient in a hospital or nursing fa-
15 cility, an intermediate care facility for the men-
16 tally retarded, or an institution for mental dis-
17 eases and receiving medical assistance under
18 Medicaid; or

19 “(B) confined in a jail, prison, other penal
20 institution or correctional facility, or by court
21 order pursuant to conviction of a criminal of-
22 fense or in connection with a verdict or finding
23 described in section 202(x)(1)(A)(ii) of the So-
24 cial Security Act (42 U.S.C. 402(x)(1)(A)(ii)).

1 “(d) RULE OF CONSTRUCTION.—Nothing in this title
2 shall be construed as requiring an active enrollee to con-
3 tinue to satisfy subparagraph (B) or (C) of subsection
4 (c)(1) in order to maintain enrollment in the CLASS pro-
5 gram.

6 “(e) PAYMENT.—

7 “(1) PAYROLL DEDUCTION.—An amount equal
8 to the monthly premium for the enrollment in the
9 CLASS program of an individual shall be deducted
10 from the wages or self-employment income of such
11 individual in accordance with such procedures as the
12 Secretary, in coordination with the Secretary of the
13 Treasury, shall establish for employers who elect to
14 deduct and withhold such premiums on behalf of en-
15 rolled employees.

16 “(2) ALTERNATIVE PAYMENT MECHANISM.—
17 The Secretary, in coordination with the Secretary of
18 the Treasury, shall establish alternative procedures
19 for the payment of monthly premiums by an indi-
20 vidual enrolled in the CLASS program—

21 “(A) who does not have an employer who
22 elects to deduct and withhold premiums in ac-
23 cordance with subparagraph (A); or

24 “(B) who does not earn wages or derive
25 self-employment income.

1 “(f) TRANSFER OF PREMIUMS COLLECTED.—

2 “(1) IN GENERAL.—During each calendar year
3 the Secretary of the Treasury shall deposit into the
4 CLASS Independence Fund a total amount equal, in
5 the aggregate, to 100 percent of the premiums col-
6 lected during that year.

7 “(2) TRANSFERS BASED ON ESTIMATES.—The
8 amount deposited pursuant to paragraph (1) shall be
9 transferred in at least monthly payments to the
10 CLASS Independence Fund on the basis of esti-
11 mates by the Secretary and certified to the Sec-
12 retary of the Treasury of the amounts collected in
13 accordance with subparagraphs (A) and (B) of para-
14 graph (5). Proper adjustments shall be made in
15 amounts subsequently transferred to the Fund to
16 the extent prior estimates were in excess of, or were
17 less than, actual amounts collected.

18 “(g) OTHER ENROLLMENT AND DISENROLLMENT
19 OPPORTUNITIES.—The Secretary, in coordination with
20 the Secretary of the Treasury, shall establish procedures
21 under which—

22 “(1) an individual who, in the year of the indi-
23 vidual’s initial eligibility to enroll in the CLASS pro-
24 gram, has elected to waive enrollment in the pro-
25 gram, is eligible to elect to enroll in the program, in

1 such form and manner as the Secretaries shall es-
 2 tablish, only during an open enrollment period estab-
 3 lished by the Secretaries that is specific to the indi-
 4 vidual and that may not occur more frequently than
 5 biennially after the date on which the individual first
 6 elected to waive enrollment in the program; and

7 “(2) an individual shall only be permitted to
 8 disenroll from the program (other than for non-
 9 payment of premiums) during an annual
 10 disenrollment period established by the Secretaries
 11 and in such form and manner as the Secretaries
 12 shall establish.

13 **“SEC. 3205. BENEFITS.**

14 “(a) DETERMINATION OF ELIGIBILITY.—

15 “(1) APPLICATION FOR RECEIPT OF BENE-
 16 FITS.—The Secretary shall establish procedures
 17 under which an active enrollee shall apply for receipt
 18 of benefits under the CLASS Independence Benefit
 19 Plan.

20 “(2) ELIGIBILITY ASSESSMENTS.—

21 “(A) IN GENERAL.—Not later than Janu-
 22 ary 1, 2012, the Secretary shall—

23 “(i) establish an Eligibility Assess-
 24 ment System (other than a service with
 25 which the Commissioner of Social Security

1 has entered into an agreement, with re-
2 spect to any State, to make disability de-
3 terminations for purposes of title II or
4 XVI of the Social Security Act) to provide
5 for eligibility assessments of active enroll-
6 ees who apply for receipt of benefits;

7 “(ii) enter into an agreement with the
8 Protection and Advocacy System for each
9 State to provide advocacy services in ac-
10 cordance with subsection (d); and

11 “(iii) enter into an agreement with
12 public and private entities to provide ad-
13 vice and assistance counseling in accord-
14 ance with subsection (e).

15 “(B) REGULATIONS.—The Secretary shall
16 promulgate regulations to develop an expedited
17 nationally equitable eligibility determination
18 process, as certified by a licensed health care
19 practitioner, an appeals process, and a redeter-
20 mination process, as certified by a licensed
21 health care practitioner, including whether an
22 active enrollee is eligible for a cash benefit
23 under the program and if so, the amount of the
24 cash benefit (in accordance the sliding scale es-
25 tablished under the plan).

1 “(C) PRESUMPTIVE ELIGIBILITY FOR CER-
2 TAIN INSTITUTIONALIZED ENROLLEES PLAN-
3 NING TO DISCHARGE.—An active enrollee shall
4 be deemed presumptively eligible if the en-
5 rollee—

6 “(i) has applied for, and attests is eli-
7 gible for, the maximum cash benefit avail-
8 able under the sliding scale established
9 under the CLASS Independence Benefit
10 Plan;

11 “(ii) is a patient in a hospital (but
12 only if the hospitalization is for long-term
13 care), nursing facility, intermediate care
14 facility for the mentally retarded, or an in-
15 stitution for mental diseases; and

16 “(iii) is in the process of, or about to
17 begin the process of, planning to discharge
18 from the hospital, facility, or institution, or
19 within 60 days from the date of discharge
20 from the hospital, facility, or institution.

21 “(D) APPEALS.—The Secretary shall es-
22 tablish procedures under which an applicant for
23 benefits under the CLASS Independence Ben-
24 efit Plan shall be guaranteed the right to ap-
25 peal an adverse determination.

1 “(b) BENEFITS.—An eligible beneficiary shall receive
2 the following benefits under the CLASS Independence
3 Benefit Plan:

4 “(1) CASH BENEFIT.—A cash benefit estab-
5 lished by the Secretary in accordance with the re-
6 quirements of section 3203(a)(1)(D) that—

7 “(A) the first year in which beneficiaries
8 receive the benefits under the plan, is not less
9 than the average dollar amount specified in
10 clause (i) of such section; and

11 “(B) for any subsequent year, is not less
12 than the average per day dollar limit applicable
13 under this subparagraph for the preceding year,
14 increased by the percentage increase in the con-
15 sumer price index for all urban consumers
16 (U.S. city average) over the previous year.

17 “(2) ADVOCACY SERVICES.—Advocacy services
18 in accordance with subsection (d).

19 “(3) ADVICE AND ASSISTANCE COUNSELING.—
20 Advice and assistance counseling in accordance with
21 subsection (e).

22 “(4) ADMINISTRATIVE EXPENSES.—Advocacy
23 services and advise and assistance counseling serv-
24 ices under paragraphs (2) and (3) of this subsection

1 shall be included as administrative expenses under
2 section 3203(b)(3).

3 “(c) PAYMENT OF BENEFITS.—

4 “(1) LIFE INDEPENDENCE ACCOUNT.—

5 “(A) IN GENERAL.—The Secretary shall
6 establish procedures for administering the pro-
7 vision of benefits to eligible beneficiaries under
8 the CLASS Independence Benefit Plan, includ-
9 ing the payment of the cash benefit for the ben-
10 efiary into a Life Independence Account es-
11 tablished by the Secretary on behalf of each eli-
12 gible beneficiary.

13 “(B) USE OF CASH BENEFITS.—Cash ben-
14 efits paid into a Life Independence Account of
15 an eligible beneficiary shall be used to purchase
16 nonmedical services and supports that the bene-
17 fiary needs to maintain his or her independ-
18 ence at home or in another residential setting
19 of their choice in the community, including (but
20 not limited to) home modifications, assistive
21 technology, accessible transportation, home-
22 maker services, respite care, personal assistance
23 services, home care aides, and nursing support.
24 Nothing in the preceding sentence shall prevent
25 an eligible beneficiary from using cash benefits

1 paid into a Life Independence Account for ob-
2 taining assistance with decision making con-
3 cerning medical care, including the right to ac-
4 cept or refuse medical or surgical treatment
5 and the right to formulate advance directives or
6 other written instructions recognized under
7 State law, such as a living will or durable power
8 of attorney for health care, in the case that an
9 injury or illness causes the individual to be un-
10 able to make health care decisions.

11 “(C) ELECTRONIC MANAGEMENT OF
12 FUNDS.—The Secretary shall establish proce-
13 dures for—

14 “(i) crediting an account established
15 on behalf of a beneficiary with the bene-
16 ficiary’s cash daily benefit;

17 “(ii) allowing the beneficiary to access
18 such account through debit cards; and

19 “(iii) accounting for withdrawals by
20 the beneficiary from such account.

21 “(D) PRIMARY PAYOR RULES FOR BENE-
22 FICIARIES WHO ARE ENROLLED IN MEDICAID.—
23 In the case of an eligible beneficiary who is en-
24 rolled in Medicaid, the following payment rules
25 shall apply:

1 “(i) INSTITUTIONALIZED BENE-
2 FICIARY.—If the beneficiary is a patient in
3 a hospital, nursing facility, intermediate
4 care facility for the mentally retarded, or
5 an institution for mental diseases, the ben-
6 eficiary shall retain an amount equal to 5
7 percent of the beneficiary’s daily or weekly
8 cash benefit (as applicable) (which shall be
9 in addition to the amount of the bene-
10 ficiary’s personal needs allowance provided
11 under Medicaid), and the remainder of
12 such benefit shall be applied toward the fa-
13 cility’s cost of providing the beneficiary’s
14 care, and Medicaid shall provide secondary
15 coverage for such care.

16 “(ii) BENEFICIARIES RECEIVING
17 HOME AND COMMUNITY-BASED SERV-
18 ICES.—

19 “(I) 50 PERCENT OF BENEFIT
20 RETAINED BY BENEFICIARY.—Subject
21 to subclause (II), if a beneficiary is
22 receiving medical assistance under
23 Medicaid for home and community
24 based services, the beneficiary shall
25 retain an amount equal to 50 percent

1 of the beneficiary's daily or weekly
2 cash benefit (as applicable), and the
3 remainder of the daily or weekly cash
4 benefit shall be applied toward the
5 cost to the State of providing such as-
6 sistance (and shall not be used to
7 claim Federal matching funds under
8 Medicaid), and Medicaid shall provide
9 secondary coverage for the remainder
10 of any costs incurred in providing
11 such assistance.

12 “(II) REQUIREMENT FOR STATE
13 OFFSET.—A State shall be paid the
14 remainder of a beneficiary's daily or
15 weekly cash benefit under subclause
16 (I) only if the State home and com-
17 munity-based waiver under section
18 1115 of the Social Security Act (42
19 U.S.C. 1315) or subsection (c) or (d)
20 of section 1915 of such Act (42
21 U.S.C. 1396n), or the State plan
22 amendment under subsection (i) of
23 such section does not include a waiver
24 of the requirements of section
25 1902(a)(1) of the Social Security Act

1 (relating to statewideness) or of sec-
2 tion 1902(a)(10)(B) of such Act (re-
3 lating to comparability) and the State
4 offers at a minimum case manage-
5 ment services, personal care services,
6 habilitation services, and respite care
7 under such a waiver or State plan
8 amendment.

9 “(III) DEFINITION OF HOME AND
10 COMMUNITY-BASED SERVICES.—In
11 this clause, the term ‘home and com-
12 munity-based services’ means any
13 services which may be offered under a
14 home and community-based waiver
15 authorized for a State under section
16 1115 of the Social Security Act (42
17 U.S.C. 1315) or subsection (e) or (d)
18 of section 1915 of such Act (42
19 U.S.C. 1396n) or under a State plan
20 amendment under subsection (i) of
21 such section.

22 “(iii) BENEFICIARIES ENROLLED IN
23 PROGRAMS OF ALL-INCLUSIVE CARE FOR
24 THE ELDERLY (PACE).—

1 “(I) IN GENERAL.—Subject to
2 subclause (II), if a beneficiary is re-
3 ceiving medical assistance under Med-
4 icaid for PACE program services
5 under section 1934 of the Social Secu-
6 rity Act (42 U.S.C. 1396u-4), the
7 beneficiary shall retain an amount
8 equal to 50 percent of the bene-
9 ficiary’s daily or weekly cash benefit
10 (as applicable), and the remainder of
11 the daily or weekly cash benefit shall
12 be applied toward the cost to the
13 State of providing such assistance
14 (and shall not be used to claim Fed-
15 eral matching funds under Medicaid),
16 and Medicaid shall provide secondary
17 coverage for the remainder of any
18 costs incurred in providing such as-
19 sistance.

20 “(II) INSTITUTIONALIZED RE-
21 CIPIENTS OF PACE PROGRAM SERV-
22 ICES.—If a beneficiary receiving as-
23 sistance under Medicaid for PACE
24 program services is a patient in a hos-
25 pital, nursing facility, intermediate

1 care facility for the mentally retarded,
2 or an institution for mental diseases,
3 the beneficiary shall be treated as in
4 institutionalized beneficiary under
5 clause (i).

6 “(2) AUTHORIZED REPRESENTATIVES.—

7 “(A) IN GENERAL.—The Secretary shall
8 establish procedures to allow access to a bene-
9 ficiary’s cash benefits by an authorized rep-
10 resentative of the eligible beneficiary on whose
11 behalf such benefits are paid.

12 “(B) QUALITY ASSURANCE AND PROTEC-
13 TION AGAINST FRAUD AND ABUSE.—The proce-
14 dures established under subparagraph (A) shall
15 ensure that authorized representatives of eligi-
16 ble beneficiaries comply with standards of con-
17 duct established by the Secretary, including
18 standards requiring that such representatives
19 provide quality services on behalf of such bene-
20 ficiaries, do not have conflicts of interest, and
21 do not misuse benefits paid on behalf of such
22 beneficiaries or otherwise engage in fraud or
23 abuse.

24 “(3) COMMENCEMENT OF BENEFITS.—Benefits
25 shall be paid to, or on behalf of, an eligible bene-

1 ficiary beginning with the first month in which an
2 application for such benefits is approved.

3 “(4) ROLLOVER OPTION FOR LUMP-SUM PAY-
4 MENT.—An eligible beneficiary may elect to—

5 “(A) defer payment of their daily or weekly
6 benefit and to rollover any such deferred bene-
7 fits from month-to-month, but not from year-to-
8 year; and

9 “(B) receive a lump-sum payment of such
10 deferred benefits in an amount that may not
11 exceed the lesser of—

12 “(i) the total amount of the accrued
13 deferred benefits; or

14 “(ii) the applicable annual benefit.

15 “(5) PERIOD FOR DETERMINATION OF ANNUAL
16 BENEFITS.—

17 “(A) IN GENERAL.—The applicable period
18 for determining with respect to an eligible bene-
19 ficiary the applicable annual benefit and the
20 amount of any accrued deferred benefits is the
21 12-month period that commences with the first
22 month in which the beneficiary began to receive
23 such benefits, and each 12-month period there-
24 after.

1 “(B) INCLUSION OF INCREASED BENE-
2 FITS.—The Secretary shall establish procedures
3 under which cash benefits paid to an eligible
4 beneficiary that increase or decrease as a result
5 of a change in the functional status of the bene-
6 ficiary before the end of a 12-month benefit pe-
7 riod shall be included in the determination of
8 the applicable annual benefit paid to the eligible
9 beneficiary.

10 “(C) RECOUPMENT OF UNPAID, ACCRUED
11 BENEFITS.—

12 “(i) IN GENERAL.—The Secretary, in
13 coordination with the Secretary of the
14 Treasury, shall recoup any accrued bene-
15 fits in the event of—

16 “(I) the death of a beneficiary; or

17 “(II) the failure of a beneficiary
18 to elect under paragraph (4)(B) to re-
19 ceive such benefits as a lump-sum
20 payment before the end of the 12-
21 month period in which such benefits
22 accrued.

23 “(ii) PAYMENT INTO CLASS INDE-
24 PENDENCE FUND.—Any benefits recouped
25 in accordance with clause (i) shall be paid

1 into the CLASS Independence Fund and
2 used in accordance with section 3206.

3 “(6) REQUIREMENT TO RECERTIFY ELIGIBILITY
4 FOR RECEIPT OF BENEFITS.—An eligible beneficiary
5 shall periodically, as determined by the Secretary—

6 “(A) recertify by submission of medical
7 evidence the beneficiary’s continued eligibility
8 for receipt of benefits; and

9 “(B) submit records of expenditures attrib-
10 utable to the aggregate cash benefit received by
11 the beneficiary during the preceding year.

12 “(7) SUPPLEMENT, NOT SUPPLANT OTHER
13 HEALTH CARE BENEFITS.—Subject to the Medicaid
14 payment rules under paragraph (1)(D), benefits re-
15 ceived by an eligible beneficiary shall supplement,
16 but not supplant, other health care benefits for
17 which the beneficiary is eligible under Medicaid or
18 any other Federally funded program that provides
19 health care benefits or assistance.

20 “(d) ADVOCACY SERVICES.—An agreement entered
21 into under subsection (a)(2)(A)(ii) shall require the Pro-
22 tection and Advocacy System for the State to—

23 “(1) assign, as needed, an advocacy counselor
24 to each eligible beneficiary that is covered by such

1 agreement and who shall provide an eligible bene-
2 ficiary with—

3 “(A) information regarding how to access
4 the appeals process established for the program;

5 “(B) assistance with respect to the annual
6 recertification and notification required under
7 subsection (c)(6); and

8 “(C) such other assistance with obtaining
9 services as the Secretary, by regulation, shall
10 require; and

11 “(2) ensure that the System and such coun-
12 selors comply with the requirements of subsection
13 (h).

14 “(e) ADVICE AND ASSISTANCE COUNSELING.—An
15 agreement entered into under subsection (a)(2)(A)(iii)
16 shall require the entity to assign, as requested by an eligi-
17 ble beneficiary that is covered by such agreement, an ad-
18 vice and assistance counselor who shall provide an eligible
19 beneficiary with information regarding—

20 “(1) accessing and coordinating long-term serv-
21 ices and supports in the most integrated setting;

22 “(2) possible eligibility for other benefits and
23 services;

24 “(3) development of a service and support plan;

1 “(4) information about programs established
2 under the Assistive Technology Act of 1998 and the
3 services offered under such programs;

4 “(5) available assistance with decision making
5 concerning medical care, including the right to ac-
6 cept or refuse medical or surgical treatment and the
7 right to formulate advance directives or other writ-
8 ten instructions recognized under State law, such as
9 a living will or durable power of attorney for health
10 care, in the case that an injury or illness causes the
11 individual to be unable to make health care deci-
12 sions; and

13 “(6) such other services as the Secretary, by
14 regulation, may require.

15 “(f) NO EFFECT ON ELIGIBILITY FOR OTHER BENE-
16 FITS.—Benefits paid to an eligible beneficiary under the
17 CLASS program shall be disregarded for purposes of de-
18 termining or continuing the beneficiary’s eligibility for re-
19 ceipt of benefits under any other Federal, State, or locally
20 funded assistance program, including benefits paid under
21 titles II, XVI, XVIII, XIX, or XXI of the Social Security
22 Act (42 U.S.C. 401 et seq., 1381 et seq., 1395 et seq.,
23 1396 et seq., 1397aa et seq.), under the laws administered
24 by the Secretary of Veterans Affairs, under low-income
25 housing assistance programs, or under the supplemental

1 nutrition assistance program established under the Food
2 and Nutrition Act of 2008 (7 U.S.C. 2011 et seq.).

3 “(g) RULE OF CONSTRUCTION.—Nothing in this title
4 shall be construed as prohibiting benefits paid under the
5 CLASS Independence Benefit Plan from being used to
6 compensate a family caregiver for providing community
7 living assistance services and supports to an eligible bene-
8 ficiary.

9 “(h) PROTECTION AGAINST CONFLICT OF INTER-
10 ESTS.—The Secretary shall establish procedures to ensure
11 that the Eligibility Assessment System, the Protection and
12 Advocacy System for a State, advocacy counselors for eli-
13 gible beneficiaries, and any other entities that provide
14 services to active enrollees and eligible beneficiaries under
15 the CLASS program comply with the following:

16 “(1) If the entity provides counseling or plan-
17 ning services, such services are provided in a manner
18 that fosters the best interests of the active enrollee
19 or beneficiary.

20 “(2) The entity has established operating proce-
21 dures that are designed to avoid or minimize con-
22 flicts of interest between the entity and an active en-
23 rollee or beneficiary.

24 “(3) The entity provides information about all
25 services and options available to the active enrollee

1 or beneficiary, to the best of its knowledge, including
2 services available through other entities or providers.

3 “(4) The entity assists the active enrollee or
4 beneficiary to access desired services, regardless of
5 the provider.

6 “(5) The entity reports the number of active
7 enrollees and beneficiaries provided with assistance
8 by age, disability, and whether such enrollees and
9 beneficiaries received services from the entity or an-
10 other entity.

11 “(6) If the entity provides counseling or plan-
12 ning services, the entity ensures that an active en-
13 rollee or beneficiary is informed of any financial in-
14 terest that the entity has in a service provider.

15 “(7) The entity provides an active enrollee or
16 beneficiary with a list of available service providers
17 that can meet the needs of the active enrollee or
18 beneficiary.

19 **“SEC. 3206. CLASS INDEPENDENCE FUND.**

20 “(a) ESTABLISHMENT OF CLASS INDEPENDENCE
21 FUND.—There is established in the Treasury of the
22 United States a trust fund to be known as the ‘CLASS
23 Independence Fund’. The Secretary of the Treasury shall
24 serve as Managing Trustee of such Fund. The Fund shall
25 consist of all amounts derived from payments into the

1 Fund under sections 3204(f) and 3205(c)(5)(C)(ii), and
2 remaining after investment of such amounts under sub-
3 section (b), including additional amounts derived as in-
4 come from such investments. The amounts held in the
5 Fund are appropriated and shall remain available without
6 fiscal year limitation—

7 “(1) to be held for investment on behalf of indi-
8 viduals enrolled in the CLASS program;

9 “(2) to pay the administrative expenses related
10 to the Fund and to investment under subsection (b);
11 and

12 “(3) to pay cash benefits to eligible bene-
13 ficiaries under the CLASS Independence Benefit
14 Plan.

15 “(b) INVESTMENT OF FUND BALANCE.—The Sec-
16 retary of the Treasury shall invest and manage the
17 CLASS Independence Fund in the same manner, and to
18 the same extent, as the Federal Supplementary Medical
19 Insurance Trust Fund may be invested and managed
20 under subsections (c), (d), and (e) of section 1841(d) of
21 the Social Security Act (42 U.S.C. 1395t).

22 “(c) BOARD OF TRUSTEES.—

23 “(1) IN GENERAL.—With respect to the CLASS
24 Independence Fund, there is hereby created a body
25 to be known as the Board of Trustees of the CLASS

1 Independence Fund (hereinafter in this section re-
2 ferred to as the 'Board of Trustees') composed of
3 the Secretary of the Treasury, the Secretary of
4 Labor, and the Secretary of Health and Human
5 Services, all ex officio, and of two members of the
6 public (both of whom may not be from the same po-
7 litical party), who shall be nominated by the Presi-
8 dent for a term of 4 years and subject to confirma-
9 tion by the Senate. A member of the Board of
10 Trustees serving as a member of the public and
11 nominated and confirmed to fill a vacancy occurring
12 during a term shall be nominated and confirmed
13 only for the remainder of such term. An individual
14 nominated and confirmed as a member of the public
15 may serve in such position after the expiration of
16 such member's term until the earlier of the time at
17 which the member's successor takes office or the
18 time at which a report of the Board is first issued
19 under paragraph (2) after the expiration of the
20 member's term. The Secretary of the Treasury shall
21 be the Managing Trustee of the Board of Trustees.
22 The Board of Trustees shall meet not less frequently
23 than once each calendar year. A person serving on
24 the Board of Trustees shall not be considered to be
25 a fiduciary and shall not be personally liable for ac-

1 tions taken in such capacity with respect to the
2 Trust Fund.

3 “(2) DUTIES.—

4 “(A) IN GENERAL.—It shall be the duty of
5 the Board of Trustees to do the following:

6 “(i) Hold the CLASS Independence
7 Fund.

8 “(ii) Report to the Congress not later
9 than the first day of April of each year on
10 the operation and status of the CLASS
11 Independence Fund during the preceding
12 fiscal year and on its expected operation
13 and status during the current fiscal year
14 and the next 2 fiscal years.

15 “(iii) Report immediately to the Con-
16 gress whenever the Board is of the opinion
17 that the amount of the CLASS Independ-
18 ence Fund is not actuarially sound in re-
19 gards to the projection under section
20 3203(b)(1)(B)(i).

21 “(iv) Review the general policies fol-
22 lowed in managing the CLASS Independ-
23 ence Fund, and recommend changes in
24 such policies, including necessary changes
25 in the provisions of law which govern the

1 way in which the CLASS Independence
2 Fund is to be managed.

3 “(B) REPORT.—The report provided for in
4 subparagraph (A)(ii) shall—

5 “(i) include—

6 “(I) a statement of the assets of,
7 and the disbursements made from, the
8 CLASS Independence Fund during
9 the preceding fiscal year;

10 “(II) an estimate of the expected
11 income to, and disbursements to be
12 made from, the CLASS Independence
13 Fund during the current fiscal year
14 and each of the next 2 fiscal years;

15 “(III) a statement of the actu-
16 arial status of the CLASS Independ-
17 ence Fund for the current fiscal year,
18 each of the next 2 fiscal years, and as
19 projected over the 75-year period be-
20 ginning with the current fiscal year;
21 and

22 “(IV) an actuarial opinion by the
23 Chief Actuary of the Centers for
24 Medicare & Medicaid Services certi-
25 fying that the techniques and meth-

1 odologies used are generally accepted
2 within the actuarial profession and
3 that the assumptions and cost esti-
4 mates used are reasonable; and

5 “(ii) be printed as a House document
6 of the session of the Congress to which the
7 report is made.

8 “(C) RECOMMENDATIONS.—If the Board
9 of Trustees determines that enrollment trends
10 and expected future benefit claims on the
11 CLASS Independence Fund are not actuarially
12 sound in regards to the projection under section
13 3203(b)(1)(B)(i) and are unlikely to be resolved
14 with reasonable premium increases or through
15 other means, the Board of Trustees shall in-
16 clude in the report provided for in subpara-
17 graph (A)(ii) recommendations for such legisla-
18 tive action as the Board of Trustees determine
19 to be appropriate, including whether to adjust
20 monthly premiums or impose a temporary mor-
21 atorium on new enrollments.

22 **“SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.**

23 “(a) ESTABLISHMENT.—There is hereby created an
24 Advisory Committee to be known as the ‘CLASS Inde-
25 pendence Advisory Council’.

1 “(b) MEMBERSHIP.—

2 “(1) IN GENERAL.—The CLASS Independence
3 Advisory Council shall be composed of not more
4 than 15 individuals, not otherwise in the employ of
5 the United States—

6 “(A) who shall be appointed by the Presi-
7 dent without regard to the civil service laws and
8 regulations; and

9 “(B) a majority of whom shall be rep-
10 resentatives of individuals who participate or
11 are likely to participate in the CLASS program,
12 and shall include representatives of older and
13 younger workers, individuals with disabilities,
14 family caregivers of individuals who require
15 services and supports to maintain their inde-
16 pendence at home or in another residential set-
17 ting of their choice in the community, individ-
18 uals with expertise in long-term care or dis-
19 ability insurance, actuarial science, economics,
20 and other relevant disciplines, as determined by
21 the Secretary.

22 “(2) TERMS.—

23 “(A) IN GENERAL.—The members of the
24 CLASS Independence Advisory Council shall
25 serve overlapping terms of 3 years (unless ap-

1 pointed to fill a vacancy occurring prior to the
2 expiration of a term, in which case the indi-
3 vidual shall serve for the remainder of the
4 term).

5 “(B) LIMITATION.—A member shall not be
6 eligible to serve for more than 2 consecutive
7 terms.

8 “(3) CHAIR.—The President shall, from time to
9 time, appoint one of the members of the CLASS
10 Independence Advisory Council to serve as the
11 Chair.

12 “(c) DUTIES.—The CLASS Independence Advisory
13 Council shall advise the Secretary on matters of general
14 policy in the administration of the CLASS program estab-
15 lished under this title and in the formulation of regula-
16 tions under this title including with respect to—

17 “(1) the development of the CLASS Independ-
18 ence Benefit Plan under section 3203;

19 “(2) the determination of monthly premiums
20 under such plan; and

21 “(3) the financial solvency of the program.

22 “(d) APPLICATION OF FACA.—The Federal Advisory
23 Committee Act (5 U.S.C. App.), other than section 14 of
24 that Act, shall apply to the CLASS Independence Advisory
25 Council.

1 “(e) AUTHORIZATION OF APPROPRIATIONS.—

2 “(1) IN GENERAL.—There are authorized to be
3 appropriated to the CLASS Independence Advisory
4 Council to carry out its duties under this section,
5 such sums as may be necessary for fiscal year 2011
6 and for each fiscal year thereafter.

7 “(2) AVAILABILITY.—Any sums appropriated
8 under the authorization contained in this section
9 shall remain available, without fiscal year limitation,
10 until expended.

11 **“SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGU-**
12 **LATIONS; ANNUAL REPORT.**

13 “(a) SOLVENCY.—The Secretary shall regularly con-
14 sult with the Board of Trustees of the CLASS Independ-
15 ence Fund and the CLASS Independence Advisory Coun-
16 cil, for purposes of ensuring that enrollees premiums are
17 adequate to ensure the financial solvency of the CLASS
18 program, both with respect to fiscal years occurring in the
19 near-term and fiscal years occurring over 20- and 75- year
20 periods, taking into account the projections required for
21 such periods under subsections (a)(1)(A)(i) and
22 (b)(1)(B)(i) of section 3202.

23 “(b) NO TAXPAYER FUNDS USED TO PAY BENE-
24 FITS.—No taxpayer funds shall be used for payment of
25 benefits under a CLASS Independent Benefit Plan. For

1 purposes of this subsection, the term ‘taxpayer funds’
2 means any Federal funds from a source other than pre-
3 miums deposited by CLASS program participants in the
4 CLASS Independence Fund and any associated interest
5 earnings.

6 “(c) REGULATIONS.—The Secretary shall promulgate
7 such regulations as are necessary to carry out the CLASS
8 program in accordance with this title. Such regulations
9 shall include provisions to prevent fraud and abuse under
10 the program.

11 “(d) ANNUAL REPORT.—Beginning January 1, 2014,
12 the Secretary shall submit an annual report to Congress
13 on the CLASS program. Each report shall include the fol-
14 lowing:

15 “(1) The total number of enrollees in the pro-
16 gram.

17 “(2) The total number of eligible beneficiaries
18 during the fiscal year.

19 “(3) The total amount of cash benefits provided
20 during the fiscal year.

21 “(4) A description of instances of fraud or
22 abuse identified during the fiscal year.

23 “(5) Recommendations for such administrative
24 or legislative action as the Secretary determines is
25 necessary to improve the program, ensure the sol-

1 vency of the program, or to prevent the occurrence
2 of fraud or abuse.

3 **“SEC. 3209. INSPECTOR GENERAL’S REPORT.**

4 “The Inspector General of the Department of Health
5 and Human Services shall submit an annual report to the
6 Secretary and Congress relating to the overall progress of
7 the CLASS program and of the existence of waste, fraud,
8 and abuse in the CLASS program. Each such report shall
9 include findings in the following areas:

10 “(1) The eligibility determination process.

11 “(2) The provision of cash benefits.

12 “(3) Quality assurance and protection against
13 waste, fraud, and abuse.

14 “(4) Recouping of unpaid and accrued benefits.

15 **“SEC. 3210. TAX TREATMENT OF PROGRAM.**

16 “The CLASS program shall be treated for purposes
17 of the Internal Revenue Code of 1986 in the same manner
18 as a qualified long-term care insurance contract for quali-
19 fied long-term care services.”.

20 (2) CONFORMING AMENDMENTS TO MED-
21 ICAID.—Section 1902(a) of the Social Security Act
22 (42 U.S.C. 1396a(a)), as amended by section 6505,
23 is amended by inserting after paragraph (80) the
24 following:

1 “(81) provide that the State will comply with
2 such regulations regarding the application of pri-
3 mary and secondary payor rules with respect to indi-
4 viduals who are eligible for medical assistance under
5 this title and are eligible beneficiaries under the
6 CLASS program established under title XXXII of
7 the Public Health Service Act as the Secretary shall
8 establish; and”.

9 (b) ASSURANCE OF ADEQUATE INFRASTRUCTURE
10 FOR THE PROVISION OF PERSONAL CARE ATTENDANT
11 WORKERS.—Section 1902(a) of the Social Security Act
12 (42 U.S.C. 1396a(a)), as amended by subsection (a)(2),
13 is amended by inserting after paragraph (81) the fol-
14 lowing:

15 “(82) provide that, not later than 2 years after
16 the date of enactment of the Community Living As-
17 sistance Services and Supports Act, each State
18 shall—

19 “(A) assess the extent to which entities
20 such as providers of home care, home health
21 services, home and community service providers,
22 public authorities created to provide personal
23 care services to individuals eligible for medical
24 assistance under the State plan, and nonprofit
25 organizations, are serving or have the capacity

1 to serve as fiscal agents for, employers of, and
2 providers of employment-related benefits for,
3 personal care attendant workers who provide
4 personal care services to individuals receiving
5 benefits under the CLASS program established
6 under title XXXII of the Public Health Service
7 Act, including in rural and underserved areas;

8 “(B) designate or create such entities to
9 serve as fiscal agents for, employers of, and
10 providers of employment-related benefits for,
11 such workers to ensure an adequate supply of
12 the workers for individuals receiving benefits
13 under the CLASS program, including in rural
14 and underserved areas; and

15 “(C) ensure that the designation or cre-
16 ation of such entities will not negatively alter or
17 impede existing programs, models, methods, or
18 administration of service delivery that provide
19 for consumer controlled or self-directed home
20 and community services and further ensure that
21 such entities will not impede the ability of indi-
22 viduals to direct and control their home and
23 community services, including the ability to se-
24 lect, manage, dismiss, co-employ, or employ
25 such workers or inhibit such individuals from

1 relying on family members for the provision of
2 personal care services.”.

3 (c) PERSONAL CARE ATTENDANTS WORKFORCE AD-
4 VISORY PANEL.—

5 (1) ESTABLISHMENT.—Not later than 90 days
6 after the date of enactment of this Act, the Sec-
7 retary of Health and Human Services shall establish
8 a Personal Care Attendants Workforce Advisory
9 Panel for the purpose of examining and advising the
10 Secretary and Congress on workforce issues related
11 to personal care attendant workers, including with
12 respect to the adequacy of the number of such work-
13 ers, the salaries, wages, and benefits of such work-
14 ers, and access to the services provided by such
15 workers.

16 (2) MEMBERSHIP.—In appointing members to
17 the Personal Care Attendants Workforce Advisory
18 Panel, the Secretary shall ensure that such members
19 include the following:

20 (A) Individuals with disabilities of all ages.

21 (B) Senior individuals.

22 (C) Representatives of individuals with dis-
23 abilities.

24 (D) Representatives of senior individuals.

1 (E) Representatives of workforce and labor
2 organizations.

3 (F) Representatives of home and commu-
4 nity-based service providers.

5 (G) Representatives of assisted living pro-
6 viders.

7 (d) INCLUSION OF INFORMATION ON SUPPLEMENTAL
8 COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR
9 LONG-TERM CARE INFORMATION; EXTENSION OF FUND-
10 ING.—Section 6021(d) of the Deficit Reduction Act of
11 2005 (42 U.S.C. 1396p note) is amended—

12 (1) in paragraph (2)(A)—

13 (A) in clause (ii), by striking “and” at the
14 end;

15 (B) in clause (iii), by striking the period at
16 the end and inserting “; and”; and

17 (C) by adding at the end the following:

18 “(iv) include information regarding
19 the CLASS program established under
20 title XXXII of the Public Health Service
21 Act and coverage available for purchase
22 through a Exchange established under sec-
23 tion 1311 of the Patient Protection and
24 Affordable Care Act that is supplemental
25 coverage to the benefits provided under a

1 CLASS Independence Benefit Plan under
2 that program, and information regarding
3 how benefits provided under a CLASS
4 Independence Benefit Plan differ from dis-
5 ability insurance benefits.”; and

6 (2) in paragraph (3), by striking “2010” and
7 inserting “2015”.

8 (e) EFFECTIVE DATE.—The amendments made by
9 subsections (a), (b), and (d) take effect on January 1,
10 2011.

11 (f) RULE OF CONSTRUCTION.—Nothing in this title
12 or the amendments made by this title are intended to re-
13 place or displace public or private disability insurance ben-
14 efits, including such benefits that are for income replace-
15 ment.

16 TITLE IX—REVENUE 17 PROVISIONS

18 Subtitle A—Revenue Offset 19 Provisions

20 SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPON- 21 SORED HEALTH COVERAGE.

22 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
23 enue Code of 1986, as amended by section 1513, is
24 amended by adding at the end the following:

1 **“SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPON-**
2 **SORED HEALTH COVERAGE.**

3 “(a) IMPOSITION OF TAX.—If—

4 “(1) an employee is covered under any applica-
5 ble employer-sponsored coverage of an employer at
6 any time during a taxable period, and

7 “(2) there is any excess benefit with respect to
8 the coverage,

9 there is hereby imposed a tax equal to 40 percent of the
10 excess benefit.

11 “(b) EXCESS BENEFIT.—For purposes of this sec-
12 tion—

13 “(1) IN GENERAL.—The term ‘excess benefit’
14 means, with respect to any applicable employer-spon-
15 sored coverage made available by an employer to an
16 employee during any taxable period, the sum of the
17 excess amounts determined under paragraph (2) for
18 months during the taxable period.

19 “(2) MONTHLY EXCESS AMOUNT.—The excess
20 amount determined under this paragraph for any
21 month is the excess (if any) of—

22 “(A) the aggregate cost of the applicable
23 employer-sponsored coverage of the employee
24 for the month, over

1 “(B) an amount equal to $\frac{1}{12}$ of the annual
2 limitation under paragraph (3) for the calendar
3 year in which the month occurs.

4 “(3) ANNUAL LIMITATION.—For purposes of
5 this subsection—

6 “(A) IN GENERAL.—The annual limitation
7 under this paragraph for any calendar year is
8 the dollar limit determined under subparagraph
9 (C) for the calendar year.

10 “(B) APPLICABLE ANNUAL LIMITATION.—
11 The annual limitation which applies for any
12 month shall be determined on the basis of the
13 type of coverage (as determined under sub-
14 section (f)(1)) provided to the employee by the
15 employer as of the beginning of the month.

16 “(C) APPLICABLE DOLLAR LIMIT.—Except
17 as provided in subparagraph (D)—

18 “(i) 2013.—In the case of 2013, the
19 dollar limit under this subparagraph is—

20 “(I) in the case of an employee
21 with self-only coverage, \$8,500, and

22 “(II) in the case of an employee
23 with coverage other than self-only cov-
24 erage, \$23,000.

1 “(ii) EXCEPTION FOR CERTAIN INDI-
2 VIDUALS.—In the case of an individual
3 who is a qualified retiree or who partici-
4 pates in a plan sponsored by an employer
5 the majority of whose employees are en-
6 gaged in a high-risk profession or em-
7 ployed to repair or install electrical or tele-
8 communications lines—

9 “(I) the dollar amount in clause
10 (i)(I) (determined after the applica-
11 tion of subparagraph (D)) shall be in-
12 creased by \$1,350, and

13 “(II) the dollar amount in clause
14 (i)(II) (determined after the applica-
15 tion of subparagraph (D)) shall be in-
16 creased by \$3,000.

17 “(iii) SUBSEQUENT YEARS.—In the
18 case of any calendar year after 2013, each
19 of the dollar amounts under clauses (i) and
20 (ii) shall be increased to the amount equal
21 to such amount as in effect for the cal-
22 endar year preceding such year, increased
23 by an amount equal to the product of—

24 “(I) such amount as so in effect,
25 multiplied by

1 “(II) the cost-of-living adjust-
2 ment determined under section 1(f)(3)
3 for such year (determined by sub-
4 stituting the calendar year that is 2
5 years before such year for ‘1992’ in
6 subparagraph (B) thereof), increased
7 by 1 percentage point.

8 If any amount determined under this
9 clause is not a multiple of \$50, such
10 amount shall be rounded to the nearest
11 multiple of \$50.

12 “(D) TRANSITION RULE FOR STATES WITH
13 HIGHEST COVERAGE COSTS.—

14 “(i) IN GENERAL.—If an employee is
15 a resident of a high cost State on the first
16 day of any month beginning in 2013,
17 2014, or 2015, the annual limitation under
18 this paragraph for such month with re-
19 spect to such employee shall be an amount
20 equal to the applicable percentage of the
21 annual limitation (determined without re-
22 gard to this subparagraph or subparagraph
23 (C)(ii)).

24 “(ii) APPLICABLE PERCENTAGE.—The
25 applicable percentage is 120 percent for

1 2013, 110 percent for 2014, and 105 per-
2 cent for 2015.

3 “(iii) HIGH COST STATE.—The term
4 ‘high cost State’ means each of the 17
5 States which the Secretary of Health and
6 Human Services, in consultation with the
7 Secretary, estimates had the highest aver-
8 age cost during 2012 for employer-spon-
9 sored coverage under health plans. The
10 Secretary’s estimate shall be made on the
11 basis of aggregate premiums paid in the
12 State for such health plans, determined
13 using the most recent data available as of
14 August 31, 2012.

15 “(c) LIABILITY TO PAY TAX.—

16 “(1) IN GENERAL.—Each coverage provider
17 shall pay the tax imposed by subsection (a) on its
18 applicable share of the excess benefit with respect to
19 an employee for any taxable period.

20 “(2) COVERAGE PROVIDER.—For purposes of
21 this subsection, the term ‘coverage provider’ means
22 each of the following:

23 “(A) HEALTH INSURANCE COVERAGE.—If
24 the applicable employer-sponsored coverage con-
25 sists of coverage under a group health plan

1 which provides health insurance coverage, the
2 health insurance issuer.

3 “(B) HSA AND MSA CONTRIBUTIONS.—If
4 the applicable employer-sponsored coverage con-
5 sists of coverage under an arrangement under
6 which the employer makes contributions de-
7 scribed in subsection (b) or (d) of section 106,
8 the employer.

9 “(C) OTHER COVERAGE.—In the case of
10 any other applicable employer-sponsored cov-
11 erage, the person that administers the plan ben-
12 efits.

13 “(3) APPLICABLE SHARE.—For purposes of
14 this subsection, a coverage provider’s applicable
15 share of an excess benefit for any taxable period is
16 the amount which bears the same ratio to the
17 amount of such excess benefit as—

18 “(A) the cost of the applicable employer-
19 sponsored coverage provided by the provider to
20 the employee during such period, bears to

21 “(B) the aggregate cost of all applicable
22 employer-sponsored coverage provided to the
23 employee by all coverage providers during such
24 period.

1 “(4) RESPONSIBILITY TO CALCULATE TAX AND
2 APPLICABLE SHARES.—

3 “(A) IN GENERAL.—Each employer shall—

4 “(i) calculate for each taxable period
5 the amount of the excess benefit subject to
6 the tax imposed by subsection (a) and the
7 applicable share of such excess benefit for
8 each coverage provider, and

9 “(ii) notify, at such time and in such
10 manner as the Secretary may prescribe,
11 the Secretary and each coverage provider
12 of the amount so determined for the pro-
13 vider.

14 “(B) SPECIAL RULE FOR MULTIEMPLOYER
15 PLANS.—In the case of applicable employer-
16 sponsored coverage made available to employees
17 through a multiemployer plan (as defined in
18 section 414(f)), the plan sponsor shall make the
19 calculations, and provide the notice, required
20 under subparagraph (A).

21 “(d) APPLICABLE EMPLOYER-SPONSORED COV-
22 ERAGE; COST.—For purposes of this section—

23 “(1) APPLICABLE EMPLOYER-SPONSORED COV-
24 ERAGE.—

1 “(A) IN GENERAL.—The term ‘applicable
2 employer-sponsored coverage’ means, with re-
3 spect to any employee, coverage under any
4 group health plan made available to the em-
5 ployee by an employer which is excludable from
6 the employee’s gross income under section 106,
7 or would be so excludable if it were employer-
8 provided coverage (within the meaning of such
9 section 106).

10 “(B) EXCEPTIONS.—The term ‘applicable
11 employer-sponsored coverage’ shall not in-
12 clude—

13 “(i) any coverage (whether through
14 insurance or otherwise) described in sec-
15 tion 9832(c)(1)(A) or for long-term care,
16 or

17 “(ii) any coverage described in section
18 9832(c)(3) the payment for which is not
19 excludable from gross income and for
20 which a deduction under section 162(l) is
21 not allowable.

22 “(C) COVERAGE INCLUDES EMPLOYEE
23 PAID PORTION.—Coverage shall be treated as
24 applicable employer-sponsored coverage without

1 regard to whether the employer or employee
2 pays for the coverage.

3 “(D) SELF-EMPLOYED INDIVIDUAL.—In
4 the case of an individual who is an employee
5 within the meaning of section 401(c)(1), cov-
6 erage under any group health plan providing
7 health insurance coverage shall be treated as
8 applicable employer-sponsored coverage if a de-
9 duction is allowable under section 162(l) with
10 respect to all or any portion of the cost of the
11 coverage.

12 “(E) GOVERNMENTAL PLANS INCLUDED.—
13 Applicable employer-sponsored coverage shall
14 include coverage under any group health plan
15 established and maintained primarily for its ci-
16 vilian employees by the Government of the
17 United States, by the government of any State
18 or political subdivision thereof, or by any agen-
19 cy or instrumentality of any such government.

20 “(2) DETERMINATION OF COST.—

21 “(A) IN GENERAL.—The cost of applicable
22 employer-sponsored coverage shall be deter-
23 mined under rules similar to the rules of section
24 4980B(f)(4), except that in determining such
25 cost, any portion of the cost of such coverage

1 which is attributable to the tax imposed under
2 this section shall not be taken into account and
3 the amount of such cost shall be calculated sep-
4 arately for self-only coverage and other cov-
5 erage. In the case of applicable employer-spon-
6 sored coverage which provides coverage to re-
7 tired employees, the plan may elect to treat a
8 retired employee who has not attained the age
9 of 65 and a retired employee who has attained
10 the age of 65 as similarly situated beneficiaries.

11 “(B) HEALTH FSAS.—In the case of appli-
12 cable employer-sponsored coverage consisting of
13 coverage under a flexible spending arrangement
14 (as defined in section 106(c)(2)), the cost of the
15 coverage shall be equal to the sum of—

16 “(i) the amount of employer contribu-
17 tions under any salary reduction election
18 under the arrangement, plus

19 “(ii) the amount determined under
20 subparagraph (A) with respect to any re-
21 imbursement under the arrangement in ex-
22 cess of the contributions described in
23 clause (i).

24 “(C) ARCHER MSAS AND HSAS.—In the
25 case of applicable employer-sponsored coverage

1 consisting of coverage under an arrangement
2 under which the employer makes contributions
3 described in subsection (b) or (d) of section
4 106, the cost of the coverage shall be equal to
5 the amount of employer contributions under the
6 arrangement.

7 “(D) ALLOCATION ON A MONTHLY
8 BASIS.—If cost is determined on other than a
9 monthly basis, the cost shall be allocated to
10 months in a taxable period on such basis as the
11 Secretary may prescribe.

12 “(e) PENALTY FOR FAILURE TO PROPERLY CAL-
13 CULATE EXCESS BENEFIT.—

14 “(1) IN GENERAL.—If, for any taxable period,
15 the tax imposed by subsection (a) exceeds the tax
16 determined under such subsection with respect to
17 the total excess benefit calculated by the employer or
18 plan sponsor under subsection (c)(4)—

19 “(A) each coverage provider shall pay the
20 tax on its applicable share (determined in the
21 same manner as under subsection (c)(4)) of the
22 excess, but no penalty shall be imposed on the
23 provider with respect to such amount, and

24 “(B) the employer or plan sponsor shall, in
25 addition to any tax imposed by subsection (a),

1 pay a penalty in an amount equal to such ex-
2 cess, plus interest at the underpayment rate de-
3 termined under section 6621 for the period be-
4 ginning on the due date for the payment of tax
5 imposed by subsection (a) to which the excess
6 relates and ending on the date of payment of
7 the penalty.

8 “(2) LIMITATIONS ON PENALTY.—

9 “(A) PENALTY NOT TO APPLY WHERE
10 FAILURE NOT DISCOVERED EXERCISING REA-
11 SONABLE DILIGENCE.—No penalty shall be im-
12 posed by paragraph (1)(B) on any failure to
13 properly calculate the excess benefit during any
14 period for which it is established to the satisfac-
15 tion of the Secretary that the employer or plan
16 sponsor neither knew, nor exercising reasonable
17 diligence would have known, that such failure
18 existed.

19 “(B) PENALTY NOT TO APPLY TO FAIL-
20 URES CORRECTED WITHIN 30 DAYS.—No pen-
21 alty shall be imposed by paragraph (1)(B) on
22 any such failure if—

23 “(i) such failure was due to reason-
24 able cause and not to willful neglect, and

1 “(ii) such failure is corrected during
2 the 30-day period beginning on the 1st
3 date that the employer knew, or exercising
4 reasonable diligence would have known,
5 that such failure existed.

6 “(C) WAIVER BY SECRETARY.—In the case
7 of any such failure which is due to reasonable
8 cause and not to willful neglect, the Secretary
9 may waive part or all of the penalty imposed by
10 paragraph (1), to the extent that the payment
11 of such penalty would be excessive or otherwise
12 inequitable relative to the failure involved.

13 “(f) OTHER DEFINITIONS AND SPECIAL RULES.—
14 For purposes of this section—

15 “(1) COVERAGE DETERMINATIONS.—

16 “(A) IN GENERAL.—Except as provided in
17 subparagraph (B), an employee shall be treated
18 as having self-only coverage with respect to any
19 applicable employer-sponsored coverage of an
20 employer.

21 “(B) MINIMUM ESSENTIAL COVERAGE.—

22 An employee shall be treated as having coverage
23 other than self-only coverage only if the em-
24 ployee is enrolled in coverage other than self-
25 only coverage in a group health plan which pro-

1 vides minimum essential coverage (as defined in
2 section 5000A(f)) to the employee and at least
3 one other beneficiary, and the benefits provided
4 under such minimum essential coverage do not
5 vary based on whether any individual covered
6 under such coverage is the employee or another
7 beneficiary.

8 “(2) QUALIFIED RETIREE.—The term ‘qualified
9 retiree’ means any individual who—

10 “(A) is receiving coverage by reason of
11 being a retiree,

12 “(B) has attained age 55, and

13 “(C) is not entitled to benefits or eligible
14 for enrollment under the Medicare program
15 under title XVIII of the Social Security Act.

16 “(3) EMPLOYEES ENGAGED IN HIGH-RISK PRO-
17 FESSION.—The term ‘employees engaged in a high-
18 risk profession’ means law enforcement officers (as
19 such term is defined in section 1204 of the Omnibus
20 Crime Control and Safe Streets Act of 1968), em-
21 ployees in fire protection activities (as such term is
22 defined in section 3(y) of the Fair Labor Standards
23 Act of 1938), individuals who provide out-of-hospital
24 emergency medical care (including emergency med-
25 ical technicians, paramedics, and first-responders),

1 and individuals engaged in the construction, mining,
2 agriculture (not including food processing), forestry,
3 and fishing industries. Such term includes an em-
4 ployee who is retired from a high-risk profession de-
5 scribed in the preceding sentence, if such employee
6 satisfied the requirements of such sentence for a pe-
7 riod of not less than 20 years during the employee's
8 employment.

9 “(4) GROUP HEALTH PLAN.—The term ‘group
10 health plan’ has the meaning given such term by
11 section 5000(b)(1).

12 “(5) HEALTH INSURANCE COVERAGE; HEALTH
13 INSURANCE ISSUER.—

14 “(A) HEALTH INSURANCE COVERAGE.—

15 The term ‘health insurance coverage’ has the
16 meaning given such term by section 9832(b)(1)
17 (applied without regard to subparagraph (B)
18 thereof, except as provided by the Secretary in
19 regulations).

20 “(B) HEALTH INSURANCE ISSUER.—The

21 term ‘health insurance issuer’ has the meaning
22 given such term by section 9832(b)(2).

23 “(6) PERSON THAT ADMINISTERS THE PLAN
24 BENEFITS.—The term ‘person that administers the

1 plan benefits' shall include the plan sponsor if the
2 plan sponsor administers benefits under the plan.

3 “(7) PLAN SPONSOR.—The term ‘plan sponsor’
4 has the meaning given such term in section 3(16)(B)
5 of the Employee Retirement Income Security Act of
6 1974.

7 “(8) TAXABLE PERIOD.—The term ‘taxable pe-
8 riod’ means the calendar year or such shorter period
9 as the Secretary may prescribe. The Secretary may
10 have different taxable periods for employers of vary-
11 ing sizes.

12 “(9) AGGREGATION RULES.—All employers
13 treated as a single employer under subsection (b),
14 (c), (m), or (o) of section 414 shall be treated as a
15 single employer.

16 “(10) DENIAL OF DEDUCTION.—For denial of a
17 deduction for the tax imposed by this section, see
18 section 275(a)(6).

19 “(g) REGULATIONS.—The Secretary shall prescribe
20 such regulations as may be necessary to carry out this
21 section.”.

22 (b) CLERICAL AMENDMENT.—The table of sections
23 for chapter 43 of such Code, as amended by section 1513,
24 is amended by adding at the end the following new item:

“Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2012.

4 **SEC. 9002. INCLUSION OF COST OF EMPLOYER-SPONSORED**
5 **HEALTH COVERAGE ON W-2.**

6 (a) IN GENERAL.—Section 6051(a) of the Internal
7 Revenue Code of 1986 (relating to receipts for employees)
8 is amended by striking “and” at the end of paragraph
9 (12), by striking the period at the end of paragraph (13)
10 and inserting “, and”, and by adding after paragraph (13)
11 the following new paragraph:

12 “(14) the aggregate cost (determined under
13 rules similar to the rules of section 4980B(f)(4)) of
14 applicable employer-sponsored coverage (as defined
15 in section 4980I(d)(1)), except that this paragraph
16 shall not apply to—

17 “(A) coverage to which paragraphs (11)
18 and (12) apply, or

19 “(B) the amount of any salary reduction
20 contributions to a flexible spending arrange-
21 ment (within the meaning of section 125).”.

22 (b) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to taxable years beginning after
24 December 31, 2010.

1 **SEC. 9003. DISTRIBUTIONS FOR MEDICINE QUALIFIED**
2 **ONLY IF FOR PRESCRIBED DRUG OR INSU-**
3 **LIN.**

4 (a) HSAs.—Subparagraph (A) of section 223(d)(2)
5 of the Internal Revenue Code of 1986 is amended by add-
6 ing at the end the following: “Such term shall include an
7 amount paid for medicine or a drug only if such medicine
8 or drug is a prescribed drug (determined without regard
9 to whether such drug is available without a prescription)
10 or is insulin.”.

11 (b) ARCHER MSAs.—Subparagraph (A) of section
12 220(d)(2) of the Internal Revenue Code of 1986 is amend-
13 ed by adding at the end the following: “Such term shall
14 include an amount paid for medicine or a drug only if such
15 medicine or drug is a prescribed drug (determined without
16 regard to whether such drug is available without a pre-
17 scription) or is insulin.”.

18 (c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS
19 AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Sec-
20 tion 106 of the Internal Revenue Code of 1986 is amended
21 by adding at the end the following new subsection:

22 “(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED
23 TO PRESCRIBED DRUGS AND INSULIN.—For purposes of
24 this section and section 105, reimbursement for expenses
25 incurred for a medicine or a drug shall be treated as a
26 reimbursement for medical expenses only if such medicine

1 or drug is a prescribed drug (determined without regard
2 to whether such drug is available without a prescription)
3 or is insulin.”.

4 (d) EFFECTIVE DATES.—

5 (1) DISTRIBUTIONS FROM SAVINGS AC-
6 COUNTS.—The amendments made by subsections (a)
7 and (b) shall apply to amounts paid with respect to
8 taxable years beginning after December 31, 2010.

9 (2) REIMBURSEMENTS.—The amendment made
10 by subsection (c) shall apply to expenses incurred
11 with respect to taxable years beginning after Decem-
12 ber 31, 2010.

13 **SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.**

16 (a) HSAs.—Section 223(f)(4)(A) of the Internal
17 Revenue Code of 1986 is amended by striking “10 per-
18 cent” and inserting “20 percent”.

19 (b) ARCHER MSAs.—Section 220(f)(4)(A) of the In-
20 ternal Revenue Code of 1986 is amended by striking “15
21 percent” and inserting “20 percent”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to distributions made after Decem-
24 ber 31, 2010.

1 **SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING**
2 **ARRANGEMENTS UNDER CAFETERIA PLANS.**

3 (a) IN GENERAL.—Section 125 of the Internal Rev-
4 enue Code of 1986 is amended—

5 (1) by redesignating subsections (i) and (j) as
6 subsections (j) and (k), respectively, and

7 (2) by inserting after subsection (h) the fol-
8 lowing new subsection:

9 “(i) LIMITATION ON HEALTH FLEXIBLE SPENDING
10 ARRANGEMENTS.—For purposes of this section, if a ben-
11 efit is provided under a cafeteria plan through employer
12 contributions to a health flexible spending arrangement,
13 such benefit shall not be treated as a qualified benefit un-
14 less the cafeteria plan provides that an employee may not
15 elect for any taxable year to have salary reduction con-
16 tributions in excess of \$2,500 made to such arrange-
17 ment.”.

18 (b) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to taxable years beginning after
20 December 31, 2010.

21 **SEC. 9006. EXPANSION OF INFORMATION REPORTING RE-**
22 **QUIREMENTS.**

23 (a) IN GENERAL.—Section 6041 of the Internal Rev-
24 enue Code of 1986 is amended by adding at the end the
25 following new subsections:

1 “(h) APPLICATION TO CORPORATIONS.—Notwith-
2 standing any regulation prescribed by the Secretary before
3 the date of the enactment of this subsection, for purposes
4 of this section the term ‘person’ includes any corporation
5 that is not an organization exempt from tax under section
6 501(a).

7 “(i) REGULATIONS.—The Secretary may prescribe
8 such regulations and other guidance as may be appro-
9 priate or necessary to carry out the purposes of this sec-
10 tion, including rules to prevent duplicative reporting of
11 transactions.”.

12 (b) PAYMENTS FOR PROPERTY AND OTHER GROSS
13 PROCEEDS.—Subsection (a) of section 6041 of the Inter-
14 nal Revenue Code of 1986 is amended—

15 (1) by inserting “amounts in consideration for
16 property,” after “wages,”

17 (2) by inserting “gross proceeds,” after “emolu-
18 ments, or other”, and

19 (3) by inserting “gross proceeds,” after “setting
20 forth the amount of such”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to payments made after December
23 31, 2011.

1 **SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE**
2 **HOSPITALS.**

3 (a) REQUIREMENTS TO QUALIFY AS SECTION
4 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Sec-
5 tion 501 of the Internal Revenue Code of 1986 (relating
6 to exemption from tax on corporations, certain trusts, etc.)
7 is amended by redesignating subsection (r) as subsection
8 (s) and by inserting after subsection (q) the following new
9 subsection:

10 “(r) ADDITIONAL REQUIREMENTS FOR CERTAIN
11 HOSPITALS.—

12 “(1) IN GENERAL.—A hospital organization to
13 which this subsection applies shall not be treated as
14 described in subsection (c)(3) unless the organiza-
15 tion—

16 “(A) meets the community health needs
17 assessment requirements described in para-
18 graph (3),

19 “(B) meets the financial assistance policy
20 requirements described in paragraph (4),

21 “(C) meets the requirements on charges
22 described in paragraph (5), and

23 “(D) meets the billing and collection re-
24 quirement described in paragraph (6).

25 “(2) HOSPITAL ORGANIZATIONS TO WHICH
26 SUBSECTION APPLIES.—

1 “(A) IN GENERAL.—This subsection shall
2 apply to—

3 “(i) an organization which operates a
4 facility which is required by a State to be
5 licensed, registered, or similarly recognized
6 as a hospital, and

7 “(ii) any other organization which the
8 Secretary determines has the provision of
9 hospital care as its principal function or
10 purpose constituting the basis for its ex-
11 emption under subsection (c)(3) (deter-
12 mined without regard to this subsection).

13 “(B) ORGANIZATIONS WITH MORE THAN 1
14 HOSPITAL FACILITY.—If a hospital organization
15 operates more than 1 hospital facility—

16 “(i) the organization shall meet the
17 requirements of this subsection separately
18 with respect to each such facility, and

19 “(ii) the organization shall not be
20 treated as described in subsection (c)(3)
21 with respect to any such facility for which
22 such requirements are not separately met.

23 “(3) COMMUNITY HEALTH NEEDS ASSESS-
24 MENTS.—

1 “(A) IN GENERAL.—An organization meets
2 the requirements of this paragraph with respect
3 to any taxable year only if the organization—

4 “(i) has conducted a community
5 health needs assessment which meets the
6 requirements of subparagraph (B) in such
7 taxable year or in either of the 2 taxable
8 years immediately preceding such taxable
9 year, and

10 “(ii) has adopted an implementation
11 strategy to meet the community health
12 needs identified through such assessment.

13 “(B) COMMUNITY HEALTH NEEDS ASSESS-
14 MENT.—A community health needs assessment
15 meets the requirements of this paragraph if
16 such community health needs assessment—

17 “(i) takes into account input from
18 persons who represent the broad interests
19 of the community served by the hospital
20 facility, including those with special knowl-
21 edge of or expertise in public health, and

22 “(ii) is made widely available to the
23 public.

1 “(4) FINANCIAL ASSISTANCE POLICY.—An or-
2 ganization meets the requirements of this paragraph
3 if the organization establishes the following policies:

4 “(A) FINANCIAL ASSISTANCE POLICY.—A
5 written financial assistance policy which in-
6 cludes—

7 “(i) eligibility criteria for financial as-
8 sistance, and whether such assistance in-
9 cludes free or discounted care,

10 “(ii) the basis for calculating amounts
11 charged to patients,

12 “(iii) the method for applying for fi-
13 nancial assistance,

14 “(iv) in the case of an organization
15 which does not have a separate billing and
16 collections policy, the actions the organiza-
17 tion may take in the event of non-payment,
18 including collections action and reporting
19 to credit agencies, and

20 “(v) measures to widely publicize the
21 policy within the community to be served
22 by the organization.

23 “(B) POLICY RELATING TO EMERGENCY
24 MEDICAL CARE.—A written policy requiring the
25 organization to provide, without discrimination,

1 care for emergency medical conditions (within
2 the meaning of section 1867 of the Social Secu-
3 rity Act (42 U.S.C. 1395dd)) to individuals re-
4 gardless of their eligibility under the financial
5 assistance policy described in subparagraph (A).

6 “(5) LIMITATION ON CHARGES.—An organiza-
7 tion meets the requirements of this paragraph if the
8 organization—

9 “(A) limits amounts charged for emer-
10 gency or other medically necessary care pro-
11 vided to individuals eligible for assistance under
12 the financial assistance policy described in para-
13 graph (4)(A) to not more than the lowest
14 amounts charged to individuals who have insur-
15 ance covering such care, and

16 “(B) prohibits the use of gross charges.

17 “(6) BILLING AND COLLECTION REQUIRE-
18 MENTS.—An organization meets the requirement of
19 this paragraph only if the organization does not en-
20 gage in extraordinary collection actions before the
21 organization has made reasonable efforts to deter-
22 mine whether the individual is eligible for assistance
23 under the financial assistance policy described in
24 paragraph (4)(A).

1 “(7) REGULATORY AUTHORITY.—The Secretary
2 shall issue such regulations and guidance as may be
3 necessary to carry out the provisions of this sub-
4 section, including guidance relating to what con-
5 stitutes reasonable efforts to determine the eligibility
6 of a patient under a financial assistance policy for
7 purposes of paragraph (6).”.

8 (b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL
9 EXEMPTION REQUIREMENTS.—

10 (1) IN GENERAL.—Subchapter D of chapter 42
11 of the Internal Revenue Code of 1986 (relating to
12 failure by certain charitable organizations to meet
13 certain qualification requirements) is amended by
14 adding at the end the following new section:

15 **“SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZA-**
16 **TIONS.**

17 “‘If a hospital organization to which section 501(r)
18 applies fails to meet the requirement of section 501(r)(3)
19 for any taxable year, there is imposed on the organization
20 a tax equal to \$50,000.’”.

21 (2) CONFORMING AMENDMENT.—The table of
22 sections for subchapter D of chapter 42 of such
23 Code is amended by adding at the end the following
24 new item:

“Sec. 4959. Taxes on failures by hospital organizations.”.

1 (c) MANDATORY REVIEW OF TAX EXEMPTION FOR
2 HOSPITALS.—The Secretary of the Treasury or the Sec-
3 retary’s delegate shall review at least once every 3 years
4 the community benefit activities of each hospital organiza-
5 tion to which section 501(r) of the Internal Revenue Code
6 of 1986 (as added by this section) applies.

7 (d) ADDITIONAL REPORTING REQUIREMENTS.—

8 (1) COMMUNITY HEALTH NEEDS ASSESSMENTS
9 AND AUDITED FINANCIAL STATEMENTS.—Section
10 6033(b) of the Internal Revenue Code of 1986 (re-
11 lating to certain organizations described in section
12 501(c)(3)) is amended by striking “and” at the end
13 of paragraph (14), by redesignating paragraph (15)
14 as paragraph (16), and by inserting after paragraph
15 (14) the following new paragraph:

16 “(15) in the case of an organization to which
17 the requirements of section 501(r) apply for the tax-
18 able year—

19 “(A) a description of how the organization
20 is addressing the needs identified in each com-
21 munity health needs assessment conducted
22 under section 501(r)(3) and a description of
23 any such needs that are not being addressed to-
24 gether with the reasons why such needs are not
25 being addressed, and

1 “(B) the audited financial statements of
2 such organization (or, in the case of an organi-
3 zation the financial statements of which are in-
4 cluded in a consolidated financial statement
5 with other organizations, such consolidated fi-
6 nancial statement).”.

7 (2) TAXES.—Section 6033(b)(10) of such Code
8 is amended by striking “and” at the end of subpara-
9 graph (B), by inserting “and” at the end of sub-
10 paragraph (C), and by adding at the end the fol-
11 lowing new subparagraph:

12 “(D) section 4959 (relating to taxes on
13 failures by hospital organizations),”.

14 (e) REPORTS.—

15 (1) REPORT ON LEVELS OF CHARITY CARE.—
16 The Secretary of the Treasury, in consultation with
17 the Secretary of Health and Human Services, shall
18 submit to the Committees on Ways and Means,
19 Education and Labor, and Energy and Commerce of
20 the House of Representatives and to the Committees
21 on Finance and Health, Education, Labor, and Pen-
22 sions of the Senate an annual report on the fol-
23 lowing:

1 (A) Information with respect to private
2 tax-exempt, taxable, and government-owned
3 hospitals regarding—

4 (i) levels of charity care provided,

5 (ii) bad debt expenses,

6 (iii) unreimbursed costs for services
7 provided with respect to means-tested gov-
8 ernment programs, and

9 (iv) unreimbursed costs for services
10 provided with respect to non-means tested
11 government programs.

12 (B) Information with respect to private
13 tax-exempt hospitals regarding costs incurred
14 for community benefit activities.

15 (2) REPORT ON TRENDS.—

16 (A) STUDY.—The Secretary of the Treas-
17 ury, in consultation with the Secretary of
18 Health and Human Services, shall conduct a
19 study on trends in the information required to
20 be reported under paragraph (1).

21 (B) REPORT.—Not later than 5 years after
22 the date of the enactment of this Act, the Sec-
23 retary of the Treasury, in consultation with the
24 Secretary of Health and Human Services, shall
25 submit a report on the study conducted under

1 subparagraph (A) to the Committees on Ways
2 and Means, Education and Labor, and Energy
3 and Commerce of the House of Representatives
4 and to the Committees on Finance and Health,
5 Education, Labor, and Pensions of the Senate.

6 (f) EFFECTIVE DATES.—

7 (1) IN GENERAL.—Except as provided in para-
8 graphs (2) and (3), the amendments made by this
9 section shall apply to taxable years beginning after
10 the date of the enactment of this Act.

11 (2) COMMUNITY HEALTH NEEDS ASSESS-
12 MENT.—The requirements of section 501(r)(3) of
13 the Internal Revenue Code of 1986, as added by
14 subsection (a), shall apply to taxable years beginning
15 after the date which is 2 years after the date of the
16 enactment of this Act.

17 (3) EXCISE TAX.—The amendments made by
18 subsection (b) shall apply to failures occurring after
19 the date of the enactment of this Act.

20 **SEC. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRE-**
21 **SCRIPTION PHARMACEUTICAL MANUFAC-**
22 **TURERS AND IMPORTERS.**

23 (a) IMPOSITION OF FEE.—

24 (1) IN GENERAL.—Each covered entity engaged
25 in the business of manufacturing or importing

1 branded prescription drugs shall pay to the Sec-
2 retary of the Treasury not later than the annual
3 payment date of each calendar year beginning after
4 2009 a fee in an amount determined under sub-
5 section (b).

6 (2) ANNUAL PAYMENT DATE.—For purposes of
7 this section, the term “annual payment date” means
8 with respect to any calendar year the date deter-
9 mined by the Secretary, but in no event later than
10 September 30 of such calendar year.

11 (b) DETERMINATION OF FEE AMOUNT.—

12 (1) IN GENERAL.—With respect to each covered
13 entity, the fee under this section for any calendar
14 year shall be equal to an amount that bears the
15 same ratio to \$2,300,000,000 as—

16 (A) the covered entity’s branded prescrip-
17 tion drug sales taken into account during the
18 preceding calendar year, bear to

19 (B) the aggregate branded prescription
20 drug sales of all covered entities taken into ac-
21 count during such preceding calendar year.

22 (2) SALES TAKEN INTO ACCOUNT.—For pur-
23 poses of paragraph (1), the branded prescription
24 drug sales taken into account during any calendar

1 year with respect to any covered entity shall be de-
 2 termined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$125,000,000.	10 percent
More than \$125,000,000 but not more than \$225,000,000.	40 percent
More than \$225,000,000 but not more than \$400,000,000.	75 percent
More than \$400,000,000	100 percent.

3 (3) SECRETARIAL DETERMINATION.—The Sec-
 4 retary of the Treasury shall calculate the amount of
 5 each covered entity's fee for any calendar year under
 6 paragraph (1). In calculating such amount, the Sec-
 7 retary of the Treasury shall determine such covered
 8 entity's branded prescription drug sales on the basis
 9 of reports submitted under subsection (g) and
 10 through the use of any other source of information
 11 available to the Secretary of the Treasury.

12 (c) TRANSFER OF FEES TO MEDICARE PART B
 13 TRUST FUND.—There is hereby appropriated to the Fed-
 14 eral Supplementary Medical Insurance Trust Fund estab-
 15 lished under section 1841 of the Social Security Act an
 16 amount equal to the fees received by the Secretary of the
 17 Treasury under subsection (a).

18 (d) COVERED ENTITY.—

1 (1) IN GENERAL.—For purposes of this section,
2 the term “covered entity” means any manufacturer
3 or importer with gross receipts from branded pre-
4 scription drug sales.

5 (2) CONTROLLED GROUPS.—

6 (A) IN GENERAL.—For purposes of this
7 subsection, all persons treated as a single em-
8 ployer under subsection (a) or (b) of section 52
9 of the Internal Revenue Code of 1986 or sub-
10 section (m) or (o) of section 414 of such Code
11 shall be treated as a single covered entity.

12 (B) INCLUSION OF FOREIGN CORPORA-
13 TIONS.—For purposes of subparagraph (A), in
14 applying subsections (a) and (b) of section 52
15 of such Code to this section, section 1563 of
16 such Code shall be applied without regard to
17 subsection (b)(2)(C) thereof.

18 (e) BRANDED PRESCRIPTION DRUG SALES.—For
19 purposes of this section—

20 (1) IN GENERAL.—The term “branded prescrip-
21 tion drug sales” means sales of branded prescription
22 drugs to any specified government program or pur-
23 suant to coverage under any such program.

24 (2) BRANDED PRESCRIPTION DRUGS.—

1 (A) IN GENERAL.—The term “branded
2 prescription drug” means—

3 (i) any prescription drug the applica-
4 tion for which was submitted under section
5 505(b) of the Federal Food, Drug, and
6 Cosmetic Act (21 U.S.C. 355(b)), or

7 (ii) any biological product the license
8 for which was submitted under section
9 351(a) of the Public Health Service Act
10 (42 U.S.C. 262(a)).

11 (B) PRESCRIPTION DRUG.—For purposes
12 of subparagraph (A)(i), the term “prescription
13 drug” means any drug which is subject to sec-
14 tion 503(b) of the Federal Food, Drug, and
15 Cosmetic Act (21 U.S.C. 353(b)).

16 (3) EXCLUSION OF ORPHAN DRUG SALES.—The
17 term “branded prescription drug sales” shall not in-
18 clude sales of any drug or biological product with re-
19 spect to which a credit was allowed for any taxable
20 year under section 45C of the Internal Revenue
21 Code of 1986. The preceding sentence shall not
22 apply with respect to any such drug or biological
23 product after the date on which such drug or bio-
24 logical product is approved by the Food and Drug
25 Administration for marketing for any indication

1 other than the treatment of the rare disease or con-
2 dition with respect to which such credit was allowed.

3 (4) SPECIFIED GOVERNMENT PROGRAM.—The
4 term “specified government program” means—

5 (A) the Medicare Part D program under
6 part D of title XVIII of the Social Security Act,

7 (B) the Medicare Part B program under
8 part B of title XVIII of the Social Security Act,

9 (C) the Medicaid program under title XIX
10 of the Social Security Act,

11 (D) any program under which branded
12 prescription drugs are procured by the Depart-
13 ment of Veterans Affairs,

14 (E) any program under which branded pre-
15 scription drugs are procured by the Department
16 of Defense, or

17 (F) the TRICARE retail pharmacy pro-
18 gram under section 1074g of title 10, United
19 States Code.

20 (f) TAX TREATMENT OF FEES.—The fees imposed
21 by this section—

22 (1) for purposes of subtitle F of the Internal
23 Revenue Code of 1986, shall be treated as excise
24 taxes with respect to which only civil actions for re-

1 fund under procedures of such subtitle shall apply,
2 and

3 (2) for purposes of section 275 of such Code,
4 shall be considered to be a tax described in section
5 275(a)(6).

6 (g) REPORTING REQUIREMENT.—Not later than the
7 date determined by the Secretary of the Treasury fol-
8 lowing the end of any calendar year, the Secretary of
9 Health and Human Services, the Secretary of Veterans
10 Affairs, and the Secretary of Defense shall report to the
11 Secretary of the Treasury, in such manner as the Sec-
12 retary of the Treasury prescribes, the total branded pre-
13 scription drug sales for each covered entity with respect
14 to each specified government program under such Sec-
15 retary's jurisdiction using the following methodology:

16 (1) MEDICARE PART D PROGRAM.—The Sec-
17 retary of Health and Human Services shall report,
18 for each covered entity and for each branded pre-
19 scription drug of the covered entity covered by the
20 Medicare Part D program, the product of—

21 (A) the per-unit ingredient cost, as re-
22 ported to the Secretary of Health and Human
23 Services by prescription drug plans and Medi-
24 care Advantage prescription drug plans, minus
25 any per-unit rebate, discount, or other price

1 concession provided by the covered entity, as re-
2 ported to the Secretary of Health and Human
3 Services by the prescription drug plans and
4 Medicare Advantage prescription drug plans,
5 and

6 (B) the number of units of the branded
7 prescription drug paid for under the Medicare
8 Part D program.

9 (2) MEDICARE PART B PROGRAM.—The Sec-
10 retary of Health and Human Services shall report,
11 for each covered entity and for each branded pre-
12 scription drug of the covered entity covered by the
13 Medicare Part B program under section 1862(a) of
14 the Social Security Act, the product of—

15 (A) the per-unit average sales price (as de-
16 fined in section 1847A(c) of the Social Security
17 Act) or the per-unit Part B payment rate for
18 a separately paid branded prescription drug
19 without a reported average sales price, and

20 (B) the number of units of the branded
21 prescription drug paid for under the Medicare
22 Part B program.

23 The Centers for Medicare and Medicaid Services
24 shall establish a process for determining the units
25 and the allocated price for purposes of this section

1 for those branded prescription drugs that are not
2 separately payable or for which National Drug
3 Codes are not reported.

4 (3) MEDICAID PROGRAM.—The Secretary of
5 Health and Human Services shall report, for each
6 covered entity and for each branded prescription
7 drug of the covered entity covered under the Med-
8 icaid program, the product of—

9 (A) the per-unit ingredient cost paid to
10 pharmacies by States for the branded prescrip-
11 tion drug dispensed to Medicaid beneficiaries,
12 minus any per-unit rebate paid by the covered
13 entity under section 1927 of the Social Security
14 Act and any State supplemental rebate, and

15 (B) the number of units of the branded
16 prescription drug paid for under the Medicaid
17 program.

18 (4) DEPARTMENT OF VETERANS AFFAIRS PRO-
19 GRAMS.—The Secretary of Veterans Affairs shall re-
20 port, for each covered entity and for each branded
21 prescription drug of the covered entity the total
22 amount paid for each such branded prescription
23 drug procured by the Department of Veterans Af-
24 fairs for its beneficiaries.

1 (5) DEPARTMENT OF DEFENSE PROGRAMS AND
2 TRICARE.—The Secretary of Defense shall report,
3 for each covered entity and for each branded pre-
4 scription drug of the covered entity, the sum of—

5 (A) the total amount paid for each such
6 branded prescription drug procured by the De-
7 partment of Defense for its beneficiaries, and

8 (B) for each such branded prescription
9 drug dispensed under the TRICARE retail
10 pharmacy program, the product of—

11 (i) the per-unit ingredient cost, minus
12 any per-unit rebate paid by the covered en-
13 tity, and

14 (ii) the number of units of the brand-
15 ed prescription drug dispensed under such
16 program.

17 (h) SECRETARY.—For purposes of this section, the
18 term “Secretary” includes the Secretary’s delegate.

19 (i) GUIDANCE.—The Secretary of the Treasury shall
20 publish guidance necessary to carry out the purposes of
21 this section.

22 (j) APPLICATION OF SECTION.—This section shall
23 apply to any branded prescription drug sales after Decem-
24 ber 31, 2008.

1 (k) CONFORMING AMENDMENT.—Section 1841(a) of
2 the Social Security Act is amended by inserting “or sec-
3 tion 9008(c) of the Patient Protection and Affordable
4 Care Act of 2009” after “this part”.

5 **SEC. 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DE-**
6 **VICE MANUFACTURERS AND IMPORTERS.**

7 (a) IMPOSITION OF FEE.—

8 (1) IN GENERAL.—Each covered entity engaged
9 in the business of manufacturing or importing med-
10 ical devices shall pay to the Secretary not later than
11 the annual payment date of each calendar year be-
12 ginning after 2009 a fee in an amount determined
13 under subsection (b).

14 (2) ANNUAL PAYMENT DATE.—For purposes of
15 this section, the term “annual payment date” means
16 with respect to any calendar year the date deter-
17 mined by the Secretary, but in no event later than
18 September 30 of such calendar year.

19 (b) DETERMINATION OF FEE AMOUNT.—

20 (1) IN GENERAL.—With respect to each covered
21 entity, the fee under this section for any calendar
22 year shall be equal to an amount that bears the
23 same ratio to \$2,000,000,000 as—

1 (A) the covered entity’s gross receipts from
 2 medical device sales taken into account during
 3 the preceding calendar year, bear to

4 (B) the aggregate gross receipts of all cov-
 5 ered entities from medical device sales taken
 6 into account during such preceding calendar
 7 year.

8 (2) GROSS RECEIPTS FROM SALES TAKEN INTO
 9 ACCOUNT.—For purposes of paragraph (1), the
 10 gross receipts from medical device sales taken into
 11 account during any calendar year with respect to
 12 any covered entity shall be determined in accordance
 13 with the following table:

With respect to a covered entity’s aggregate gross re- cepts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$25,000,000.	50 percent
More than \$25,000,000	100 percent.

14 (3) SECRETARIAL DETERMINATION.—The Sec-
 15 retary shall calculate the amount of each covered en-
 16 tity’s fee for any calendar year under paragraph (1).
 17 In calculating such amount, the Secretary shall de-
 18 termine such covered entity’s gross receipts from
 19 medical device sales on the basis of reports sub-
 20 mitted by the covered entity under subsection (f)

1 and through the use of any other source of informa-
2 tion available to the Secretary.

3 (c) COVERED ENTITY.—

4 (1) IN GENERAL.—For purposes of this section,
5 the term “covered entity” means any manufacturer
6 or importer with gross receipts from medical device
7 sales.

8 (2) CONTROLLED GROUPS.—

9 (A) IN GENERAL.—For purposes of this
10 subsection, all persons treated as a single em-
11 ployer under subsection (a) or (b) of section 52
12 of the Internal Revenue Code of 1986 or sub-
13 section (m) or (o) of section 414 of such Code
14 shall be treated as a single covered entity.

15 (B) INCLUSION OF FOREIGN CORPORA-
16 TIONS.—For purposes of subparagraph (A), in
17 applying subsections (a) and (b) of section 52
18 of such Code to this section, section 1563 of
19 such Code shall be applied without regard to
20 subsection (b)(2)(C) thereof.

21 (d) MEDICAL DEVICE SALES.—For purposes of this
22 section—

23 (1) IN GENERAL.—The term “medical device
24 sales” means sales for use in the United States of

1 any medical device, other than the sales of a medical
2 device that—

3 (A) has been classified in class II under
4 section 513 of the Federal Food, Drug, and
5 Cosmetic Act (21 U.S.C. 360c) and is primarily
6 sold to consumers at retail for not more than
7 \$100 per unit, or

8 (B) has been classified in class I under
9 such section.

10 (2) UNITED STATES.—For purposes of para-
11 graph (1), the term “United States” means the sev-
12 eral States, the District of Columbia, the Common-
13 wealth of Puerto Rico, and the possessions of the
14 United States.

15 (3) MEDICAL DEVICE.—For purposes of para-
16 graph (1), the term “medical device” means any de-
17 vice (as defined in section 201(h) of the Federal
18 Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)))
19 intended for humans.

20 (e) TAX TREATMENT OF FEES.—The fees imposed
21 by this section—

22 (1) for purposes of subtitle F of the Internal
23 Revenue Code of 1986, shall be treated as excise
24 taxes with respect to which only civil actions for re-

1 fund under procedures of such subtitle shall apply,
2 and

3 (2) for purposes of section 275 of such Code,
4 shall be considered to be a tax described in section
5 275(a)(6).

6 (f) REPORTING REQUIREMENT.—

7 (1) IN GENERAL.—Not later than the date de-
8 termined by the Secretary following the end of any
9 calendar year, each covered entity shall report to the
10 Secretary, in such manner as the Secretary pre-
11 scribes, the gross receipts from medical device sales
12 of such covered entity during such calendar year.

13 (2) PENALTY FOR FAILURE TO REPORT.—

14 (A) IN GENERAL.—In the case of any fail-
15 ure to make a report containing the information
16 required by paragraph (1) on the date pre-
17 scribed therefor (determined with regard to any
18 extension of time for filing), unless it is shown
19 that such failure is due to reasonable cause,
20 there shall be paid by the covered entity failing
21 to file such report, an amount equal to—

22 (i) \$10,000, plus

23 (ii) the lesser of—

1 (I) an amount equal to \$1,000,
2 multiplied by the number of days dur-
3 ing which such failure continues, or

4 (II) the amount of the fee im-
5 posed by this section for which such
6 report was required.

7 (B) TREATMENT OF PENALTY.—The pen-
8 alty imposed under subparagraph (A)—

9 (i) shall be treated as a penalty for
10 purposes of subtitle F of the Internal Rev-
11 enue Code of 1986,

12 (ii) shall be paid on notice and de-
13 mand by the Secretary and in the same
14 manner as tax under such Code, and

15 (iii) with respect to which only civil
16 actions for refund under procedures of
17 such subtitle F shall apply.

18 (g) SECRETARY.—For purposes of this section, the
19 term “Secretary” means the Secretary of the Treasury or
20 the Secretary’s delegate.

21 (h) GUIDANCE.—The Secretary shall publish guid-
22 ance necessary to carry out the purposes of this section,
23 including identification of medical devices described in
24 subsection (d)(1)(A) and with respect to the treatment of
25 gross receipts from sales of medical devices to another cov-

1 ered entity or to another entity by reason of the applica-
2 tion of subsection (c)(2).

3 (i) APPLICATION OF SECTION.—This section shall
4 apply to any medical device sales after December 31,
5 2008.

6 **SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSUR-**
7 **ANCE PROVIDERS.**

8 (a) IMPOSITION OF FEE.—

9 (1) IN GENERAL.—Each covered entity engaged
10 in the business of providing health insurance shall
11 pay to the Secretary not later than the annual pay-
12 ment date of each calendar year beginning after
13 2009 a fee in an amount determined under sub-
14 section (b).

15 (2) ANNUAL PAYMENT DATE.—For purposes of
16 this section, the term “annual payment date” means
17 with respect to any calendar year the date deter-
18 mined by the Secretary, but in no event later than
19 September 30 of such calendar year.

20 (b) DETERMINATION OF FEE AMOUNT.—

21 (1) IN GENERAL.—With respect to each covered
22 entity, the fee under this section for any calendar
23 year shall be equal to an amount that bears the
24 same ratio to \$6,700,000,000 as—

25 (A) the sum of—

1 (i) the covered entity's net premiums
2 written with respect to health insurance for
3 any United States health risk that are
4 taken into account during the preceding
5 calendar year, plus

6 (ii) 200 percent of the covered entity's
7 third party administration agreement fees
8 that are taken into account during the pre-
9 ceding calendar year, bears to

10 (B) the sum of—

11 (i) the aggregate net premiums writ-
12 ten with respect to such health insurance
13 of all covered entities that are taken into
14 account during such preceding calendar
15 year, plus

16 (ii) 200 percent of the aggregate third
17 party administration agreement fees of all
18 covered entities that are taken into account
19 during such preceding calendar year.

20 (2) AMOUNTS TAKEN INTO ACCOUNT.—For
21 purposes of paragraph (1)—

22 (A) NET PREMIUMS WRITTEN.—The net
23 premiums written with respect to health insur-
24 ance for any United States health risk that are
25 taken into account during any calendar year

1 with respect to any covered entity shall be de-
 2 termined in accordance with the following table:

With respect to a covered entity's net premiums written during the calendar year that are:	The percentage of net premiums written that are taken into account is:
Not more than \$25,000,000	0 percent
More than \$25,000,000 but not more than \$50,000,000.	50 percent
More than \$50,000,000	100 percent.

3 (B) THIRD PARTY ADMINISTRATION
 4 AGREEMENT FEES.—The third party adminis-
 5 tration agreement fees that are taken into ac-
 6 count during any calendar year with respect to
 7 any covered entity shall be determined in ac-
 8 cordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	The percentage of third party administration agreement fees that are taken into account is:
Not more than \$5,000,000	0 percent
More than \$5,000,000 but not more than \$10,000,000.	50 percent
More than \$10,000,000	100 percent.

9 (3) SECRETARIAL DETERMINATION.—The Sec-
 10 retary shall calculate the amount of each covered en-
 11 tity's fee for any calendar year under paragraph (1).
 12 In calculating such amount, the Secretary shall de-
 13 termine such covered entity's net premiums written
 14 with respect to any United States health risk and
 15 third party administration agreement fees on the

1 basis of reports submitted by the covered entity
2 under subsection (g) and through the use of any
3 other source of information available to the Sec-
4 retary.

5 (c) COVERED ENTITY.—

6 (1) IN GENERAL.—For purposes of this section,
7 the term “covered entity” means any entity which
8 provides health insurance for any United States
9 health risk.

10 (2) EXCLUSION.—Such term does not include—

11 (A) any employer to the extent that such
12 employer self-insures its employees’ health
13 risks, or

14 (B) any governmental entity (except to the
15 extent such an entity provides health insurance
16 coverage through the community health insur-
17 ance option under section 1323).

18 (3) CONTROLLED GROUPS.—

19 (A) IN GENERAL.—For purposes of this
20 subsection, all persons treated as a single em-
21 ployer under subsection (a) or (b) of section 52
22 of the Internal Revenue Code of 1986 or sub-
23 section (m) or (o) of section 414 of such Code
24 shall be treated as a single covered entity (or
25 employer for purposes of paragraph (2)).

1 (B) INCLUSION OF FOREIGN CORPORA-
2 TIONS.—For purposes of subparagraph (A), in
3 applying subsections (a) and (b) of section 52
4 of such Code to this section, section 1563 of
5 such Code shall be applied without regard to
6 subsection (b)(2)(C) thereof.

7 (d) UNITED STATES HEALTH RISK.—For purposes
8 of this section, the term “United States health risk”
9 means the health risk of any individual who is—

- 10 (1) a United States citizen,
11 (2) a resident of the United States (within the
12 meaning of section 7701(b)(1)(A) of the Internal
13 Revenue Code of 1986), or
14 (3) located in the United States, with respect to
15 the period such individual is so located.

16 (e) THIRD PARTY ADMINISTRATION AGREEMENT
17 FEES.—For purposes of this section, the term “third
18 party administration agreement fees” means, with respect
19 to any covered entity, amounts received from an employer
20 which are in excess of payments made by such covered
21 entity for health benefits under an arrangement under
22 which such employer self-insures the United States health
23 risk of its employees.

24 (f) TAX TREATMENT OF FEES.—The fees imposed
25 by this section—

1 (1) for purposes of subtitle F of the Internal
2 Revenue Code of 1986, shall be treated as excise
3 taxes with respect to which only civil actions for re-
4 fund under procedures of such subtitle shall apply,
5 and

6 (2) for purposes of section 275 of such Code
7 shall be considered to be a tax described in section
8 275(a)(6).

9 (g) REPORTING REQUIREMENT.—

10 (1) IN GENERAL.—Not later than the date de-
11 termined by the Secretary following the end of any
12 calendar year, each covered entity shall report to the
13 Secretary, in such manner as the Secretary pre-
14 scribes, the covered entity's net premiums written
15 with respect to health insurance for any United
16 States health risk and third party administration
17 agreement fees for such calendar year.

18 (2) PENALTY FOR FAILURE TO REPORT.—

19 (A) IN GENERAL.—In the case of any fail-
20 ure to make a report containing the information
21 required by paragraph (1) on the date pre-
22 scribed therefor (determined with regard to any
23 extension of time for filing), unless it is shown
24 that such failure is due to reasonable cause,

1 there shall be paid by the covered entity failing
2 to file such report, an amount equal to—

3 (i) \$10,000, plus

4 (ii) the lesser of—

5 (I) an amount equal to \$1,000,
6 multiplied by the number of days dur-
7 ing which such failure continues, or

8 (II) the amount of the fee im-
9 posed by this section for which such
10 report was required.

11 (B) TREATMENT OF PENALTY.—The pen-
12 alty imposed under subparagraph (A)—

13 (i) shall be treated as a penalty for
14 purposes of subtitle F of the Internal Rev-
15 enue Code of 1986,

16 (ii) shall be paid on notice and de-
17 mand by the Secretary and in the same
18 manner as tax under such Code, and

19 (iii) with respect to which only civil
20 actions for refund under procedures of
21 such subtitle F shall apply.

22 (h) ADDITIONAL DEFINITIONS.—For purposes of
23 this section—

1 “(f) SPECIAL RULE FOR 2013, 2014, 2015, AND
2 2016.—In the case of any taxable year beginning after
3 December 31, 2012, and ending before January 1, 2017,
4 subsection (a) shall be applied with respect to a taxpayer
5 by substituting ‘7.5 percent’ for ‘10 percent’ if such tax-
6 payer or such taxpayer’s spouse has attained age 65 before
7 the close of such taxable year.”.

8 (c) CONFORMING AMENDMENT.—Section
9 56(b)(1)(B) of the Internal Revenue Code of 1986 is
10 amended by striking “by substituting ‘10 percent’ for ‘7.5
11 percent’” and inserting “without regard to subsection (f)
12 of such section”.

13 (d) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to taxable years beginning after
15 December 31, 2012.

16 **SEC. 9014. LIMITATION ON EXCESSIVE REMUNERATION**
17 **PAID BY CERTAIN HEALTH INSURANCE PRO-**
18 **VIDERS.**

19 (a) IN GENERAL.—Section 162(m) of the Internal
20 Revenue Code of 1986 is amended by adding at the end
21 the following new subparagraph:

22 “(6) SPECIAL RULE FOR APPLICATION TO CER-
23 TAIN HEALTH INSURANCE PROVIDERS.—

24 “(A) IN GENERAL.—No deduction shall be
25 allowed under this chapter—

1 “(i) in the case of applicable indi-
2 vidual remuneration which is for any dis-
3 qualified taxable year beginning after De-
4 cember 31, 2012, and which is attributable
5 to services performed by an applicable indi-
6 vidual during such taxable year, to the ex-
7 tent that the amount of such remuneration
8 exceeds \$500,000, or

9 “(ii) in the case of deferred deduction
10 remuneration for any taxable year begin-
11 ning after December 31, 2012, which is at-
12 tributable to services performed by an ap-
13 plicable individual during any disqualified
14 taxable year beginning after December 31,
15 2009, to the extent that the amount of
16 such remuneration exceeds \$500,000 re-
17 duced (but not below zero) by the sum
18 of—

19 “(I) the applicable individual re-
20 muneration for such disqualified tax-
21 able year, plus

22 “(II) the portion of the deferred
23 deduction remuneration for such serv-
24 ices which was taken into account
25 under this clause in a preceding tax-

1 able year (or which would have been
2 taken into account under this clause
3 in a preceding taxable year if this
4 clause were applied by substituting
5 ‘December 31, 2009’ for ‘December
6 31, 2012’ in the matter preceding
7 subclause (I)).

8 “(B) DISQUALIFIED TAXABLE YEAR.—For
9 purposes of this paragraph, the term ‘disquali-
10 fied taxable year’ means, with respect to any
11 employer, any taxable year for which such em-
12 ployer is a covered health insurance provider.

13 “(C) COVERED HEALTH INSURANCE PRO-
14 VIDER.—For purposes of this paragraph—

15 “(i) IN GENERAL.—The term ‘covered
16 health insurance provider’ means—

17 “(I) with respect to taxable years
18 beginning after December 31, 2009,
19 and before January 1, 2013, any em-
20 ployer which is a health insurance
21 issuer (as defined in section
22 9832(b)(2)) and which receives pre-
23 miums from providing health insur-
24 ance coverage (as defined in section
25 9832(b)(1)), and

1 “(II) with respect to taxable
2 years beginning after December 31,
3 2012, any employer which is a health
4 insurance issuer (as defined in section
5 9832(b)(2)) and with respect to which
6 not less than 25 percent of the gross
7 premiums received from providing
8 health insurance coverage (as defined
9 in section 9832(b)(1)) is from min-
10 imum essential coverage (as defined in
11 section 5000A(f)).

12 “(ii) AGGREGATION RULES.—Two or
13 more persons who are treated as a single
14 employer under subsection (b), (c), (m), or
15 (o) of section 414 shall be treated as a sin-
16 gle employer, except that in applying sec-
17 tion 1563(a) for purposes of any such sub-
18 section, paragraphs (2) and (3) thereof
19 shall be disregarded.

20 “(D) APPLICABLE INDIVIDUAL REMUNERA-
21 TION.—For purposes of this paragraph, the
22 term ‘applicable individual remuneration’
23 means, with respect to any applicable individual
24 for any disqualified taxable year, the aggregate
25 amount allowable as a deduction under this

1 chapter for such taxable year (determined with-
2 out regard to this subsection) for remuneration
3 (as defined in paragraph (4) without regard to
4 subparagraphs (B), (C), and (D) thereof) for
5 services performed by such individual (whether
6 or not during the taxable year). Such term shall
7 not include any deferred deduction remunera-
8 tion with respect to services performed during
9 the disqualified taxable year.

10 “(E) DEFERRED DEDUCTION REMUNERA-
11 TION.—For purposes of this paragraph, the
12 term ‘deferred deduction remuneration’ means
13 remuneration which would be applicable indi-
14 vidual remuneration for services performed in a
15 disqualified taxable year but for the fact that
16 the deduction under this chapter (determined
17 without regard to this paragraph) for such re-
18 muneration is allowable in a subsequent taxable
19 year.

20 “(F) APPLICABLE INDIVIDUAL.—For pur-
21 poses of this paragraph, the term ‘applicable in-
22 dividual’ means, with respect to any covered
23 health insurance provider for any disqualified
24 taxable year, any individual—

1 “(i) who is an officer, director, or em-
2 ployee in such taxable year, or

3 “(ii) who provides services for or on
4 behalf of such covered health insurance
5 provider during such taxable year.

6 “(G) COORDINATION.—Rules similar to
7 the rules of subparagraphs (F) and (G) of para-
8 graph (4) shall apply for purposes of this para-
9 graph.

10 “(H) REGULATORY AUTHORITY.—The Sec-
11 retary may prescribe such guidance, rules, or
12 regulations as are necessary to carry out the
13 purposes of this paragraph.”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 this section shall apply to taxable years beginning after
16 December 31, 2009, with respect to services performed
17 after such date.

18 **SEC. 9015. ADDITIONAL HOSPITAL INSURANCE TAX ON**
19 **HIGH-INCOME TAXPAYERS.**

20 (a) FICA.—

21 (1) IN GENERAL.—Section 3101(b) of the In-
22 ternal Revenue Code of 1986 is amended—

23 (A) by striking “In addition” and inserting
24 the following:

25 “(1) IN GENERAL.—In addition”,

1 (B) by striking “the following percentages
2 of the” and inserting “1.45 percent of the”,

3 (C) by striking “(as defined in section
4 3121(b))—” and all that follows and inserting
5 “(as defined in section 3121(b)).”, and

6 (D) by adding at the end the following new
7 paragraph:

8 “(2) ADDITIONAL TAX.—In addition to the tax
9 imposed by paragraph (1) and the preceding sub-
10 section, there is hereby imposed on every taxpayer
11 (other than a corporation, estate, or trust) a tax
12 equal to 0.5 percent of wages which are received
13 with respect to employment (as defined in section
14 3121(b)) during any taxable year beginning after
15 December 31, 2012, and which are in excess of—

16 “(A) in the case of a joint return,
17 \$250,000, and

18 “(B) in any other case, \$200,000.”.

19 (2) COLLECTION OF TAX.—Section 3102 of the
20 Internal Revenue Code of 1986 is amended by add-
21 ing at the end the following new subsection:

22 “(f) SPECIAL RULES FOR ADDITIONAL TAX.—

23 “(1) IN GENERAL.—In the case of any tax im-
24 posed by section 3101(b)(2), subsection (a) shall
25 only apply to the extent to which the taxpayer re-

1 ceives wages from the employer in excess of
2 \$200,000, and the employer may disregard the
3 amount of wages received by such taxpayer's spouse.

4 “(2) COLLECTION OF AMOUNTS NOT WITH-
5 HELD.—To the extent that the amount of any tax
6 imposed by section 3101(b)(2) is not collected by the
7 employer, such tax shall be paid by the employee.

8 “(3) TAX PAID BY RECIPIENT.—If an employer,
9 in violation of this chapter, fails to deduct and with-
10 hold the tax imposed by section 3101(b)(2) and
11 thereafter the tax is paid by the employee, the tax
12 so required to be deducted and withheld shall not be
13 collected from the employer, but this paragraph shall
14 in no case relieve the employer from liability for any
15 penalties or additions to tax otherwise applicable in
16 respect of such failure to deduct and withhold.”.

17 (b) SECA.—

18 (1) IN GENERAL.—Section 1401(b) of the In-
19 ternal Revenue Code of 1986 is amended—

20 (A) by striking “In addition” and inserting
21 the following:

22 “(1) IN GENERAL.—In addition”, and

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

25 “(2) ADDITIONAL TAX.—

1 “(A) IN GENERAL.—In addition to the tax
2 imposed by paragraph (1) and the preceding
3 subsection, there is hereby imposed on every
4 taxpayer (other than a corporation, estate, or
5 trust) for each taxable year beginning after De-
6 cember 31, 2012, a tax equal to 0.5 percent of
7 the self-employment income for such taxable
8 year which is in excess of—

9 “(i) in the case of a joint return,
10 \$250,000, and

11 “(ii) in any other case, \$200,000.

12 “(B) COORDINATION WITH FICA.—The
13 amounts under clauses (i) and (ii) of subpara-
14 graph (A) shall be reduced (but not below zero)
15 by the amount of wages taken into account in
16 determining the tax imposed under section
17 3121(b)(2) with respect to the taxpayer.”.

18 (2) NO DEDUCTION FOR ADDITIONAL TAX.—

19 (A) IN GENERAL.—Section 164(f) of such
20 Code is amended by inserting “(other than the
21 taxes imposed by section 1401(b)(2))” after
22 “section 1401”.

23 (B) DEDUCTION FOR NET EARNINGS FROM
24 SELF-EMPLOYMENT.—Subparagraph (B) of sec-
25 tion 1402(a)(12) is amended by inserting “(de-

1 terminated without regard to the rate imposed
2 under paragraph (2) of section 1401(b))” after
3 “for such year”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply with respect to remuneration re-
6 ceived, and taxable years beginning, after December 31,
7 2012.

8 **SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF**
9 **CERTAIN HEALTH ORGANIZATIONS.**

10 (a) IN GENERAL.—Subsection (c) of section 833 of
11 the Internal Revenue Code of 1986 is amended by adding
12 at the end the following new paragraph:

13 “(5) NONAPPLICATION OF SECTION IN CASE OF
14 LOW MEDICAL LOSS RATIO.—Notwithstanding the
15 preceding paragraphs, this section shall not apply to
16 any organization unless such organization’s percent-
17 age of total premium revenue expended on reim-
18 bursement for clinical services provided to enrollees
19 under its policies during such taxable year (as re-
20 ported under section 2718 of the Public Health
21 Service Act) is not less than 85 percent.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 this section shall apply to taxable years beginning after
24 December 31, 2009.

1 **SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL**
 2 **PROCEDURES.**

3 (a) IN GENERAL.—Subtitle D of the Internal Rev-
 4 enue Code of 1986, as amended by this Act, is amended
 5 by adding at the end the following new chapter:

6 **“CHAPTER 49—ELECTIVE COSMETIC**
 7 **MEDICAL PROCEDURES**

“Sec. 5000B. Imposition of tax on elective cosmetic medical procedures.

8 **“SEC. 5000B. IMPOSITION OF TAX ON ELECTIVE COSMETIC**
 9 **MEDICAL PROCEDURES.**

10 “(a) IN GENERAL.—There is hereby imposed on any
 11 cosmetic surgery and medical procedure a tax equal to 5
 12 percent of the amount paid for such procedure (deter-
 13 mined without regard to this section), whether paid by in-
 14 surance or otherwise.

15 “(b) COSMETIC SURGERY AND MEDICAL PROCE-
 16 DURE.—For purposes of this section, the term ‘cosmetic
 17 surgery and medical procedure’ means any cosmetic sur-
 18 gery (as defined in section 213(d)(9)(B)) or other similar
 19 procedure which—

20 “(1) is performed by a licensed medical profes-
 21 sional, and

22 “(2) is not necessary to ameliorate a deformity
 23 arising from, or directly related to, a congenital ab-
 24 normality, a personal injury resulting from an acci-
 25 dent or trauma, or disfiguring disease.

1 “(c) PAYMENT OF TAX.—

2 “(1) IN GENERAL.—The tax imposed by this
3 section shall be paid by the individual on whom the
4 procedure is performed.

5 “(2) COLLECTION.—Every person receiving a
6 payment for procedures on which a tax is imposed
7 under subsection (a) shall collect the amount of the
8 tax from the individual on whom the procedure is
9 performed and remit such tax quarterly to the Sec-
10 retary at such time and in such manner as provided
11 by the Secretary.

12 “(3) SECONDARY LIABILITY.—Where any tax
13 imposed by subsection (a) is not paid at the time
14 payments for cosmetic surgery and medical proce-
15 dures are made, then to the extent that such tax is
16 not collected, such tax shall be paid by the person
17 who performs the procedure.”.

18 (b) CLERICAL AMENDMENT.—The table of chapters
19 for subtitle D of the Internal Revenue Code of 1986, as
20 amended by this Act, is amended by inserting after the
21 item relating to chapter 48 the following new item:

“CHAPTER 49—ELECTIVE COSMETIC MEDICAL PROCEDURES”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section shall apply to procedures performed on or
24 after January 1, 2010.

1 **Subtitle B—Other Provisions**

2 **SEC. 9021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY**
3 **INDIAN TRIBAL GOVERNMENTS.**

4 (a) IN GENERAL.—Part III of subchapter B of chap-
5 ter 1 of the Internal Revenue Code of 1986 is amended
6 by inserting after section 139C the following new section:

7 **“SEC. 139D. INDIAN HEALTH CARE BENEFITS.**

8 “(a) GENERAL RULE.—Except as otherwise provided
9 in this section, gross income does not include the value
10 of any qualified Indian health care benefit.

11 “(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—
12 For purposes of this section, the term ‘qualified Indian
13 health care benefit’ means—

14 “(1) any health service or benefit provided or
15 purchased, directly or indirectly, by the Indian
16 Health Service through a grant to or a contract or
17 compact with an Indian tribe or tribal organization,
18 or through a third-party program funded by the In-
19 dian Health Service,

20 “(2) medical care provided or purchased by, or
21 amounts to reimburse for such medical care provided
22 by, an Indian tribe or tribal organization for, or to,
23 a member of an Indian tribe, including a spouse or
24 dependent of such a member,

1 “(3) coverage under accident or health insur-
2 ance (or an arrangement having the effect of acci-
3 dent or health insurance), or an accident or health
4 plan, provided by an Indian tribe or tribal organiza-
5 tion for medical care to a member of an Indian
6 tribe, include a spouse or dependent of such a mem-
7 ber, and

8 “(4) any other medical care provided by an In-
9 dian tribe or tribal organization that supplements,
10 replaces, or substitutes for a program or service re-
11 lating to medical care provided by the Federal gov-
12 ernment to Indian tribes or members of such a tribe.

13 “(c) DEFINITIONS.—For purposes of this section—

14 “(1) INDIAN TRIBE.—The term ‘Indian tribe’
15 has the meaning given such term by section
16 45A(c)(6).

17 “(2) TRIBAL ORGANIZATION.—The term ‘tribal
18 organization’ has the meaning given such term by
19 section 4(l) of the Indian Self-Determination and
20 Education Assistance Act.

21 “(3) MEDICAL CARE.—The term ‘medical care’
22 has the same meaning as when used in section 213.

23 “(4) ACCIDENT OR HEALTH INSURANCE; ACCI-
24 DENT OR HEALTH PLAN.—The terms ‘accident or

1 health insurance' and 'accident or health plan' have
2 the same meaning as when used in section 105.

3 “(5) DEPENDENT.—The term 'dependent' has
4 the meaning given such term by section 152, deter-
5 mined without regard to subsections (b)(1), (b)(2),
6 and (d)(1)(B) thereof.

7 “(d) DENIAL OF DOUBLE BENEFIT.—Subsection (a)
8 shall not apply to the amount of any qualified Indian
9 health care benefit which is not includible in gross income
10 of the beneficiary of such benefit under any other provi-
11 sion of this chapter, or to the amount of any such benefit
12 for which a deduction is allowed to such beneficiary under
13 any other provision of this chapter.”

14 (b) CLERICAL AMENDMENT.—The table of sections
15 for part III of subchapter B of chapter 1 of the Internal
16 Revenue Code of 1986 is amended by inserting after the
17 item relating to section 139C the following new item:

“Sec. 139D. Indian health care benefits.”

18 (c) EFFECTIVE DATE.—The amendments made by
19 this section shall apply to benefits and coverage provided
20 after the date of the enactment of this Act.

21 (d) NO INFERENCE.—Nothing in the amendments
22 made by this section shall be construed to create an infer-
23 ence with respect to the exclusion from gross income of—

1 “(B) with respect to which the contribution
2 requirements of paragraph (3), and the eligi-
3 bility and participation requirements of para-
4 graph (4), are met.

5 “(3) CONTRIBUTION REQUIREMENTS.—

6 “(A) IN GENERAL.—The requirements of
7 this paragraph are met if, under the plan the
8 employer is required, without regard to whether
9 a qualified employee makes any salary reduc-
10 tion contribution, to make a contribution to
11 provide qualified benefits under the plan on be-
12 half of each qualified employee in an amount
13 equal to—

14 “(i) a uniform percentage (not less
15 than 2 percent) of the employee’s com-
16 pensation for the plan year, or

17 “(ii) an amount which is not less than
18 the lesser of—

19 “(I) 6 percent of the employee’s
20 compensation for the plan year, or

21 “(II) twice the amount of the sal-
22 ary reduction contributions of each
23 qualified employee.

24 “(B) MATCHING CONTRIBUTIONS ON BE-
25 HALF OF HIGHLY COMPENSATED AND KEY EM-

1 PLOYEES.—The requirements of subparagraph
2 (A)(ii) shall not be treated as met if, under the
3 plan, the rate of contributions with respect to
4 any salary reduction contribution of a highly
5 compensated or key employee at any rate of
6 contribution is greater than that with respect to
7 an employee who is not a highly compensated or
8 key employee.

9 “(C) ADDITIONAL CONTRIBUTIONS.—Sub-
10 subject to subparagraph (B), nothing in this para-
11 graph shall be treated as prohibiting an em-
12 ployer from making contributions to provide
13 qualified benefits under the plan in addition to
14 contributions required under subparagraph (A).

15 “(D) DEFINITIONS.—For purposes of this
16 paragraph—

17 “(i) SALARY REDUCTION CONTRIBU-
18 TION.—The term ‘salary reduction con-
19 tribution’ means, with respect to a cafe-
20 teria plan, any amount which is contrib-
21 uted to the plan at the election of the em-
22 ployee and which is not includible in gross
23 income by reason of this section.

24 “(ii) QUALIFIED EMPLOYEE.—The
25 term ‘qualified employee’ means, with re-

1 spect to a cafeteria plan, any employee who
2 is not a highly compensated or key em-
3 ployee and who is eligible to participate in
4 the plan.

5 “(iii) HIGHLY COMPENSATED EM-
6 PLOYEE.—The term ‘highly compensated
7 employee’ has the meaning given such term
8 by section 414(q).

9 “(iv) KEY EMPLOYEE.—The term ‘key
10 employee’ has the meaning given such term
11 by section 416(i).

12 “(4) MINIMUM ELIGIBILITY AND PARTICIPA-
13 TION REQUIREMENTS.—

14 “(A) IN GENERAL.—The requirements of
15 this paragraph shall be treated as met with re-
16 spect to any year if, under the plan—

17 “(i) all employees who had at least
18 1,000 hours of service for the preceding
19 plan year are eligible to participate, and

20 “(ii) each employee eligible to partici-
21 pate in the plan may, subject to terms and
22 conditions applicable to all participants,
23 elect any benefit available under the plan.

24 “(B) CERTAIN EMPLOYEES MAY BE EX-
25 CLUDED.—For purposes of subparagraph

1 (A)(i), an employer may elect to exclude under
2 the plan employees—

3 “(i) who have not attained the age of
4 21 before the close of a plan year,

5 “(ii) who have less than 1 year of
6 service with the employer as of any day
7 during the plan year,

8 “(iii) who are covered under an agree-
9 ment which the Secretary of Labor finds to
10 be a collective bargaining agreement if
11 there is evidence that the benefits covered
12 under the cafeteria plan were the subject
13 of good faith bargaining between employee
14 representatives and the employer, or

15 “(iv) who are described in section
16 410(b)(3)(C) (relating to nonresident
17 aliens working outside the United States).

18 A plan may provide a shorter period of service
19 or younger age for purposes of clause (i) or (ii).

20 “(5) ELIGIBLE EMPLOYER.—For purposes of
21 this subsection—

22 “(A) IN GENERAL.—The term ‘eligible em-
23 ployer’ means, with respect to any year, any
24 employer if such employer employed an average
25 of 100 or fewer employees on business days

1 during either of the 2 preceding years. For pur-
2 poses of this subparagraph, a year may only be
3 taken into account if the employer was in exist-
4 ence throughout the year.

5 “(B) EMPLOYERS NOT IN EXISTENCE DUR-
6 ING PRECEDING YEAR.—If an employer was not
7 in existence throughout the preceding year, the
8 determination under subparagraph (A) shall be
9 based on the average number of employees that
10 it is reasonably expected such employer will em-
11 ploy on business days in the current year.

12 “(C) GROWING EMPLOYERS RETAIN
13 TREATMENT AS SMALL EMPLOYER.—

14 “(i) IN GENERAL.—If—

15 “(I) an employer was an eligible
16 employer for any year (a ‘qualified
17 year’), and

18 “(II) such employer establishes a
19 simple cafeteria plan for its employees
20 for such year,

21 then, notwithstanding the fact the em-
22 ployer fails to meet the requirements of
23 subparagraph (A) for any subsequent year,
24 such employer shall be treated as an eligi-
25 ble employer for such subsequent year with

1 respect to employees (whether or not em-
2 ployees during a qualified year) of any
3 trade or business which was covered by the
4 plan during any qualified year.

5 “(ii) EXCEPTION.—This subpara-
6 graph shall cease to apply if the employer
7 employs an average of 200 or more em-
8 ployees on business days during any year
9 preceding any such subsequent year.

10 “(D) SPECIAL RULES.—

11 “(i) PREDECESSORS.—Any reference
12 in this paragraph to an employer shall in-
13 clude a reference to any predecessor of
14 such employer.

15 “(ii) AGGREGATION RULES.—All per-
16 sons treated as a single employer under
17 subsection (a) or (b) of section 52, or sub-
18 section (n) or (o) of section 414, shall be
19 treated as one person.

20 “(6) APPLICABLE NONDISCRIMINATION RE-
21 QUIREMENT.—For purposes of this subsection, the
22 term ‘applicable nondiscrimination requirement’
23 means any requirement under subsection (b) of this
24 section, section 79(d), section 105(h), or paragraph
25 (2), (3), (4), or (8) of section 129(d).

1 “(7) COMPENSATION.—The term ‘compensa-
2 tion’ has the meaning given such term by section
3 414(s).”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to years beginning after December
6 31, 2010.

7 **SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY**
8 **PROJECT CREDIT.**

9 (a) IN GENERAL.—Subpart E of part IV of sub-
10 chapter A of chapter 1 of the Internal Revenue Code of
11 1986 is amended by inserting after section 48C the fol-
12 lowing new section:

13 **“SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY**
14 **PROJECT CREDIT.**

15 “(a) IN GENERAL.—For purposes of section 46, the
16 qualifying therapeutic discovery project credit for any tax-
17 able year is an amount equal to 50 percent of the qualified
18 investment for such taxable year with respect to any quali-
19 fying therapeutic discovery project of an eligible taxpayer.

20 “(b) QUALIFIED INVESTMENT.—

21 “(1) IN GENERAL.—For purposes of subsection
22 (a), the qualified investment for any taxable year is
23 the aggregate amount of the costs paid or incurred
24 in such taxable year for expenses necessary for and

1 directly related to the conduct of a qualifying thera-
2 peutic discovery project.

3 “(2) LIMITATION.—The amount which is treat-
4 ed as qualified investment for all taxable years with
5 respect to any qualifying therapeutic discovery
6 project shall not exceed the amount certified by the
7 Secretary as eligible for the credit under this sec-
8 tion.

9 “(3) EXCLUSIONS.—The qualified investment
10 for any taxable year with respect to any qualifying
11 therapeutic discovery project shall not take into ac-
12 count any cost—

13 “(A) for remuneration for an employee de-
14 scribed in section 162(m)(3),

15 “(B) for interest expenses,

16 “(C) for facility maintenance expenses,

17 “(D) which is identified as a service cost
18 under section 1.263A-1(e)(4) of title 26, Code
19 of Federal Regulations, or

20 “(E) for any other expense as determined
21 by the Secretary as appropriate to carry out the
22 purposes of this section.

23 “(4) CERTAIN PROGRESS EXPENDITURE RULES
24 MADE APPLICABLE.—In the case of costs described
25 in paragraph (1) that are paid for property of a

1 character subject to an allowance for depreciation,
2 rules similar to the rules of subsections (c)(4) and
3 (d) of section 46 (as in effect on the day before the
4 date of the enactment of the Revenue Reconciliation
5 Act of 1990) shall apply for purposes of this section.

6 “(5) APPLICATION OF SUBSECTION.—An invest-
7 ment shall be considered a qualified investment
8 under this subsection only if such investment is
9 made in a taxable year beginning in 2009 or 2010.

10 “(c) DEFINITIONS.—

11 “(1) QUALIFYING THERAPEUTIC DISCOVERY
12 PROJECT.—The term ‘qualifying therapeutic dis-
13 covery project’ means a project which is designed—

14 “(A) to treat or prevent diseases or condi-
15 tions by conducting pre-clinical activities, clin-
16 ical trials, and clinical studies, or carrying out
17 research protocols, for the purpose of securing
18 approval of a product under section 505(b) of
19 the Federal Food, Drug, and Cosmetic Act or
20 section 351(a) of the Public Health Service Act,

21 “(B) to diagnose diseases or conditions or
22 to determine molecular factors related to dis-
23 eases or conditions by developing molecular
24 diagnostics to guide therapeutic decisions, or

1 “(C) to develop a product, process, or tech-
2 nology to further the delivery or administration
3 of therapeutics.

4 “(2) ELIGIBLE TAXPAYER.—

5 “(A) IN GENERAL.—The term ‘eligible tax-
6 payer’ means a taxpayer which employs not
7 more than 250 employees in all businesses of
8 the taxpayer at the time of the submission of
9 the application under subsection (d)(2).

10 “(B) AGGREGATION RULES.—All persons
11 treated as a single employer under subsection
12 (a) or (b) of section 52, or subsection (m) or
13 (o) of section 414, shall be so treated for pur-
14 poses of this paragraph.

15 “(3) FACILITY MAINTENANCE EXPENSES.—The
16 term ‘facility maintenance expenses’ means costs
17 paid or incurred to maintain a facility, including—

18 “(A) mortgage or rent payments,

19 “(B) insurance payments,

20 “(C) utility and maintenance costs, and

21 “(D) costs of employment of maintenance
22 personnel.

23 “(d) QUALIFYING THERAPEUTIC DISCOVERY
24 PROJECT PROGRAM.—

25 “(1) ESTABLISHMENT.—

1 “(A) IN GENERAL.—Not later than 60
2 days after the date of the enactment of this sec-
3 tion, the Secretary, in consultation with the
4 Secretary of Health and Human Services, shall
5 establish a qualifying therapeutic discovery
6 project program to consider and award certifi-
7 cations for qualified investments eligible for
8 credits under this section to qualifying thera-
9 peutic discovery project sponsors.

10 “(B) LIMITATION.—The total amount of
11 credits that may be allocated under the pro-
12 gram shall not exceed \$1,000,000,000 for the
13 2-year period beginning with 2009.

14 “(2) CERTIFICATION.—

15 “(A) APPLICATION PERIOD.—Each appli-
16 cant for certification under this paragraph shall
17 submit an application containing such informa-
18 tion as the Secretary may require during the
19 period beginning on the date the Secretary es-
20 tablishes the program under paragraph (1).

21 “(B) TIME FOR REVIEW OF APPLICA-
22 TIONS.—The Secretary shall take action to ap-
23 prove or deny any application under subpara-
24 graph (A) within 30 days of the submission of
25 such application.

1 “(C) MULTI-YEAR APPLICATIONS.—An ap-
2 plication for certification under subparagraph
3 (A) may include a request for an allocation of
4 credits for more than 1 of the years described
5 in paragraph (1)(B).

6 “(3) SELECTION CRITERIA.—In determining
7 the qualifying therapeutic discovery projects with re-
8 spect to which qualified investments may be certified
9 under this section, the Secretary—

10 “(A) shall take into consideration only
11 those projects that show reasonable potential—

12 “(i) to result in new therapies—

13 “(I) to treat areas of unmet med-
14 ical need, or

15 “(II) to prevent, detect, or treat
16 chronic or acute diseases and condi-
17 tions,

18 “(ii) to reduce long-term health care
19 costs in the United States, or

20 “(iii) to significantly advance the goal
21 of curing cancer within the 30-year period
22 beginning on the date the Secretary estab-
23 lishes the program under paragraph (1),
24 and

1 “(B) shall take into consideration which
2 projects have the greatest potential—

3 “(i) to create and sustain (directly or
4 indirectly) high quality, high-paying jobs in
5 the United States, and

6 “(ii) to advance United States com-
7 petitiveness in the fields of life, biological,
8 and medical sciences.

9 “(4) DISCLOSURE OF ALLOCATIONS.—The Sec-
10 retary shall, upon making a certification under this
11 subsection, publicly disclose the identity of the appli-
12 cant and the amount of the credit with respect to
13 such applicant.

14 “(e) SPECIAL RULES.—

15 “(1) BASIS ADJUSTMENT.—For purposes of
16 this subtitle, if a credit is allowed under this section
17 for an expenditure related to property of a character
18 subject to an allowance for depreciation, the basis of
19 such property shall be reduced by the amount of
20 such credit.

21 “(2) DENIAL OF DOUBLE BENEFIT.—

22 “(A) BONUS DEPRECIATION.—A credit
23 shall not be allowed under this section for any
24 investment for which bonus depreciation is al-

1 lowed under section 168(k), 1400L(b)(1), or
2 1400N(d)(1).

3 “(B) DEDUCTIONS.—No deduction under
4 this subtitle shall be allowed for the portion of
5 the expenses otherwise allowable as a deduction
6 taken into account in determining the credit
7 under this section for the taxable year which is
8 equal to the amount of the credit determined
9 for such taxable year under subsection (a) at-
10 tributable to such portion. This subparagraph
11 shall not apply to expenses related to property
12 of a character subject to an allowance for de-
13 preciation the basis of which is reduced under
14 paragraph (1), or which are described in section
15 280C(g).

16 “(C) CREDIT FOR RESEARCH ACTIVI-
17 TIES.—

18 “(i) IN GENERAL.—Except as pro-
19 vided in clause (ii), any expenses taken
20 into account under this section for a tax-
21 able year shall not be taken into account
22 for purposes of determining the credit al-
23 lowable under section 41 or 45C for such
24 taxable year.

1 “(ii) EXPENSES INCLUDED IN DETER-
2 MINING BASE PERIOD RESEARCH EX-
3 PENSES.—Any expenses for any taxable
4 year which are qualified research expenses
5 (within the meaning of section 41(b)) shall
6 be taken into account in determining base
7 period research expenses for purposes of
8 applying section 41 to subsequent taxable
9 years.

10 “(f) COORDINATION WITH DEPARTMENT OF TREAS-
11 URY GRANTS.—In the case of any investment with respect
12 to which the Secretary makes a grant under section
13 9023(e) of the Patient Protection and Affordable Care Act
14 of 2009—

15 “(1) DENIAL OF CREDIT.—No credit shall be
16 determined under this section with respect to such
17 investment for the taxable year in which such grant
18 is made or any subsequent taxable year.

19 “(2) RECAPTURE OF CREDITS FOR PROGRESS
20 EXPENDITURES MADE BEFORE GRANT.—If a credit
21 was determined under this section with respect to
22 such investment for any taxable year ending before
23 such grant is made—

24 “(A) the tax imposed under subtitle A on
25 the taxpayer for the taxable year in which such

1 grant is made shall be increased by so much of
2 such credit as was allowed under section 38,

3 “(B) the general business carryforwards
4 under section 39 shall be adjusted so as to re-
5 capture the portion of such credit which was
6 not so allowed, and

7 “(C) the amount of such grant shall be de-
8 termined without regard to any reduction in the
9 basis of any property of a character subject to
10 an allowance for depreciation by reason of such
11 credit.

12 “(3) TREATMENT OF GRANTS.—Any such grant
13 shall not be includible in the gross income of the
14 taxpayer.”.

15 (b) INCLUSION AS PART OF INVESTMENT CREDIT.—
16 Section 46 of the Internal Revenue Code of 1986 is
17 amended—

18 (1) by adding a comma at the end of paragraph

19 (2),

20 (2) by striking the period at the end of para-
21 graph (5) and inserting “, and”, and

22 (3) by adding at the end the following new
23 paragraph:

24 “(6) the qualifying therapeutic discovery project
25 credit.”.

1 (c) CONFORMING AMENDMENTS.—

2 (1) Section 49(a)(1)(C) of the Internal Revenue
3 Code of 1986 is amended—

4 (A) by striking “and” at the end of clause
5 (iv),

6 (B) by striking the period at the end of
7 clause (v) and inserting “, and”, and

8 (C) by adding at the end the following new
9 clause:

10 “(vi) the basis of any property to
11 which paragraph (1) of section 48D(e) ap-
12 plies which is part of a qualifying thera-
13 peutic discovery project under such section
14 48D.”.

15 (2) Section 280C of such Code is amended by
16 adding at the end the following new subsection:

17 “(g) QUALIFYING THERAPEUTIC DISCOVERY
18 PROJECT CREDIT.—

19 “(1) IN GENERAL.—No deduction shall be al-
20 lowed for that portion of the qualified investment (as
21 defined in section 48D(b)) otherwise allowable as a
22 deduction for the taxable year which—

23 “(A) would be qualified research expenses
24 (as defined in section 41(b)), basic research ex-
25 penses (as defined in section 41(e)(2)), or quali-

1 fied clinical testing expenses (as defined in sec-
2 tion 45C(b)) if the credit under section 41 or
3 section 45C were allowed with respect to such
4 expenses for such taxable year, and

5 “(B) is equal to the amount of the credit
6 determined for such taxable year under section
7 48D(a), reduced by—

8 “(i) the amount disallowed as a de-
9 duction by reason of section 48D(e)(2)(B),
10 and

11 “(ii) the amount of any basis reduc-
12 tion under section 48D(e)(1).

13 “(2) SIMILAR RULE WHERE TAXPAYER CAP-
14 ITALIZES RATHER THAN DEDUCTS EXPENSES.—In
15 the case of expenses described in paragraph (1)(A)
16 taken into account in determining the credit under
17 section 48D for the taxable year, if—

18 “(A) the amount of the portion of the
19 credit determined under such section with re-
20 spect to such expenses, exceeds

21 “(B) the amount allowable as a deduction
22 for such taxable year for such expenses (deter-
23 mined without regard to paragraph (1)),

1 the amount chargeable to capital account for the
2 taxable year for such expenses shall be reduced by
3 the amount of such excess.

4 “(3) CONTROLLED GROUPS.—Paragraph (3) of
5 subsection (b) shall apply for purposes of this sub-
6 section.”.

7 (d) CLERICAL AMENDMENT.—The table of sections
8 for subpart E of part IV of subchapter A of chapter 1
9 of the Internal Revenue Code of 1986 is amended by in-
10 serting after the item relating to section 48C the following
11 new item:

“Sec. 48D. Qualifying therapeutic discovery project credit.”.

12 (e) GRANTS FOR QUALIFIED INVESTMENTS IN
13 THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX
14 CREDITS.—

15 (1) IN GENERAL.—Upon application, the Sec-
16 retary of the Treasury shall, subject to the require-
17 ments of this subsection, provide a grant to each
18 person who makes a qualified investment in a quali-
19 fying therapeutic discovery project in the amount of
20 50 percent of such investment. No grant shall be
21 made under this subsection with respect to any in-
22 vestment unless such investment is made during a
23 taxable year beginning in 2009 or 2010.

24 (2) APPLICATION.—

1 (A) IN GENERAL.—At the stated election
2 of the applicant, an application for certification
3 under section 48D(d)(2) of the Internal Rev-
4 enue Code of 1986 for a credit under such sec-
5 tion for the taxable year of the applicant which
6 begins in 2009 shall be considered to be an ap-
7 plication for a grant under paragraph (1) for
8 such taxable year.

9 (B) TAXABLE YEARS BEGINNING IN
10 2010.—An application for a grant under para-
11 graph (1) for a taxable year beginning in 2010
12 shall be submitted—

13 (i) not earlier than the day after the
14 last day of such taxable year, and

15 (ii) not later than the due date (in-
16 cluding extensions) for filing the return of
17 tax for such taxable year.

18 (C) INFORMATION TO BE SUBMITTED.—An
19 application for a grant under paragraph (1)
20 shall include such information and be in such
21 form as the Secretary may require to state the
22 amount of the credit allowable (but for the re-
23 ceipt of a grant under this subsection) under
24 section 48D for the taxable year for the quali-

1 fied investment with respect to which such ap-
2 plication is made.

3 (3) TIME FOR PAYMENT OF GRANT.—

4 (A) IN GENERAL.—The Secretary of the
5 Treasury shall make payment of the amount of
6 any grant under paragraph (1) during the 30-
7 day period beginning on the later of—

8 (i) the date of the application for such
9 grant, or

10 (ii) the date the qualified investment
11 for which the grant is being made is made.

12 (B) REGULATIONS.—In the case of invest-
13 ments of an ongoing nature, the Secretary shall
14 issue regulations to determine the date on
15 which a qualified investment shall be deemed to
16 have been made for purposes of this paragraph.

17 (4) QUALIFIED INVESTMENT.—For purposes of
18 this subsection, the term “qualified investment”
19 means a qualified investment that is certified under
20 section 48D(d) of the Internal Revenue Code of
21 1986 for purposes of the credit under such section
22 48D.

23 (5) APPLICATION OF CERTAIN RULES.—

24 (A) IN GENERAL.—In making grants
25 under this subsection, the Secretary of the

1 Treasury shall apply rules similar to the rules
2 of section 50 of the Internal Revenue Code of
3 1986. In applying such rules, any increase in
4 tax under chapter 1 of such Code by reason of
5 an investment ceasing to be a qualified invest-
6 ment shall be imposed on the person to whom
7 the grant was made.

8 (B) SPECIAL RULES.—

9 (i) RECAPTURE OF EXCESSIVE GRANT
10 AMOUNTS.—If the amount of a grant made
11 under this subsection exceeds the amount
12 allowable as a grant under this subsection,
13 such excess shall be recaptured under sub-
14 paragraph (A) as if the investment to
15 which such excess portion of the grant re-
16 lates had ceased to be a qualified invest-
17 ment immediately after such grant was
18 made.

19 (ii) GRANT INFORMATION NOT TREAT-
20 ED AS RETURN INFORMATION.—In no
21 event shall the amount of a grant made
22 under paragraph (1), the identity of the
23 person to whom such grant was made, or
24 a description of the investment with re-
25 spect to which such grant was made be

1 treated as return information for purposes
2 of section 6103 of the Internal Revenue
3 Code of 1986.

4 (6) EXCEPTION FOR CERTAIN NON-TAX-
5 PAYERS.—The Secretary of the Treasury shall not
6 make any grant under this subsection to—

7 (A) any Federal, State, or local govern-
8 ment (or any political subdivision, agency, or
9 instrumentality thereof),

10 (B) any organization described in section
11 501(c) of the Internal Revenue Code of 1986
12 and exempt from tax under section 501(a) of
13 such Code,

14 (C) any entity referred to in paragraph (4)
15 of section 54(j) of such Code, or

16 (D) any partnership or other pass-thru en-
17 tity any partner (or other holder of an equity
18 or profits interest) of which is described in sub-
19 paragraph (A), (B) or (C).

20 In the case of a partnership or other pass-thru enti-
21 ty described in subparagraph (D), partners and
22 other holders of any equity or profits interest shall
23 provide to such partnership or entity such informa-
24 tion as the Secretary of the Treasury may require to
25 carry out the purposes of this paragraph.

1 (7) SECRETARY.—Any reference in this sub-
2 section to the Secretary of the Treasury shall be
3 treated as including the Secretary’s delegate.

4 (8) OTHER TERMS.—Any term used in this sub-
5 section which is also used in section 48D of the In-
6 ternal Revenue Code of 1986 shall have the same
7 meaning for purposes of this subsection as when
8 used in such section.

9 (9) DENIAL OF DOUBLE BENEFIT.—No credit
10 shall be allowed under section 46(6) of the Internal
11 Revenue Code of 1986 by reason of section 48D of
12 such Code for any investment for which a grant is
13 awarded under this subsection.

14 (10) APPROPRIATIONS.—There is hereby appro-
15 priated to the Secretary of the Treasury such sums
16 as may be necessary to carry out this subsection.

17 (11) TERMINATION.—The Secretary of the
18 Treasury shall not make any grant to any person
19 under this subsection unless the application of such
20 person for such grant is received before January 1,
21 2013.

22 (f) EFFECTIVE DATE.—The amendments made by
23 subsections (a) through (d) of this section shall apply to
24 amounts paid or incurred after December 31, 2008, in
25 taxable years beginning after such date.

Amendment No. 2786

H.R. 3590