I am particularly mindful of the fact that the continued closure of the Theological School of Halki stands in clear violation of Turkey’s obligations under the 1989 OSCE Vienna Concluding Document, which affirmed the right of religious communities to provide “training of religious personnel in appropriate institutions.”

At a time when Turkey is seeking to chart a new course, the resolution of this longstanding issue would not only be a demonstration of Ankara’s good will, but, as President Obama mentioned in his address to the Turkish Grand National Assembly in April, will send such an important signal inside Turkey and beyond. I remain hopeful and encourage Prime Minister Erdoğan to act decisively and without condition on this matter before his upcoming visit to Washington in early December.

To underscore the importance attached to the reopening of the Theological School of Halki and our solidarity with the Ecumenical Patriarch, I am pleased to introduce a resolution on this issue together with Mr. BROWNBACK, Mr. REID, * * *

SENATE RESOLUTION 357—URGING THE PEOPLE OF THE UNITED STATES TO OBSERVE GLOBAL FAMILY DAY AND ONE DAY OF PEACE AND SHARING

Mr. INOUYE (for himself and Mr. REID) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. Res. 357

 Whereas in 2009, the people of the world suffered many calamitous events, including devastation from tsunamis, terror attacks, wars, famines, genocides, hurricanes, earthquakes, political and religious conflicts, disasters, poverty, and rioting, all necessitating global cooperation, and unity previously unprecedented among diverse cultures, faiths, and economic classes;

 Whereas grave global challenges in 2010 may require provision and innovative problem-solving among citizens and nations on an even greater scale;

 Whereas on December 15, 2000, Congress adopted Senate Concurrent Resolution 138, expressing the sense of Congress that the President of the United States should issue a proclamation each year calling upon the people of the United States and interested organizations to observe an international day of peace and sharing at the beginning of each year;

 Whereas in 2001, the United Nations General Assembly adopted Resolution 56/2, which invited “Member States, intergovernmental and non-governmental organizations and all the peoples of the world to celebrate One Day in Peace, 1 January 2002, and every year thereafter”;

 Whereas many foreign heads of State have recognized the importance of establishing Global Family Day, a special day of international unity, peace, and sharing, on the first day of each year; and

 Whereas family is the basic structure of humanity, thus, we must all look to the stability and love within our individual families to create stability in the global community: Now, therefore be it

Resolved, That the Senate urgently requests—

(1) the people of the United States to observe Global Family Day and One Day of Peace and Sharing with appropriate activities stressing the need—

(A) to eradicate violence, hunger, poverty, and suffering; and

(B) to establish greater trust and fellowship among peace-loving countries and families everywhere; and

(2) American businesses, labor organizations, and faith and civic leaders to join in promoting appropriate activities for Americans and in extending appropriate greetings from the families of the United States to families in the rest of the world.

Mr. INOUYE, Mr. President, today, I am submitting a Senate resolution to observe Global Family Day, One Day of Peace and Sharing, and am pleased to be joined in this endeavor by Senator REID.

We are a global society, interconnected by highly efficient modes of communication and transportation. With continued advancements in technology, nations will become even more interdependent upon each other. For this reason, I will continue to support and advocate for world peace. This is not a lofty pursuit. I have great confidence that if nations use everything at their disposal, they can promote peaceful, diplomatic options instead of war.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2786. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table.

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) Table of Contents—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

Subtitle A—Immediate Improving Coverage

“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.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1001. Effective dates.

Sec. 1002. Health insurance consumer information.

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

Sec. 1004. Effective dates.

Subtitle C—Quality Health Insurance Coverage for All Americans

PART I—HEALTH INSURANCE MARKET REFORMS

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

Sec. 1202. Reinsurance for early retirees.

Sec. 1203. Immediate information that allows consumers to identify affordable coverage options.

Sec. 1204. Administrative simplification.

Sec. 1205. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

PART II—OThER PROVISIONS

Sec. 1251. Preservation of right to maintain coverage.

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

Sec. 1253. Effective dates.

Subtitle E—Available Coverage Choices for All Americans

PART III—STATE FLEXIBILITY RELATING TO HEALTH INSURANCE MARKET REFORMS

Sec. 1301. Qualified health plan defined.

Sec. 1302. Essential health benefits requirement.

Sec. 1303. Special rules.

Sec. 1304. Related definitions.

PART IV—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.

Sec. 1314. Consumer choice.

PART III—STATE FLEXIBILITY RELATING TO SERVICES AND BENEFITS EXCHANGES

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.
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. Non-Medicare shared program on payment bundling.
Sec. 3024. Independence at home demonstration program.
Sec. 3025. Hospital readmissions reduction program.
Sec. 3026. Community-Based Care Transition Program.
Sec. 3027. Extension of gauze-sharing demonstration.

Subtitle B—Improving Medicare for Patients Care services.

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES
Sec. 3101. Increase in the physician payment update.
Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.
Sec. 3103. Extension of exceptions process for Medicare therapy caps.
Sec. 3104. Extension of payment for 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. Medicare 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) payment.
Sec. 3134. Misvalued codes under the physician fee schedule.
Sec. 3135. Modification of equipment utilization factor for advanced imaging services.
Sec. 3136. Revision of payment for power-driven wheelchairs.
Sec. 3137. Hospital wage index improvement.
Sec. 3138. Treatment of certain cancer hospitals.
Sec. 3139. Payment for biosimilar biological products.
Sec. 3140. Medicare hospice concurrent care demonstration program.
Sec. 3141. Application of budget neutrality on a national basis in the calculation of the Medicare hospital wage index floor.
Sec. 3142. HHS study on urban Medicare-dependent hospital fee schedule.

Subtitle C—Provisions Relating to Part C
Sec. 3201. Medicare Advantage payment.
Sec. 3202. Benefit protection and simplification.
Sec. 3203. Application of coding intensity adjustment during MA payment transition.
Sec. 3204. Simplification of annual beneficiary electronic claim 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. Improved pharmacy coverage requirements for prescription drug plans and MA–PD plans with respect to certain categories 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. 3314. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out-of-pocket threshold under part D.
Sec. 3315. Immediate reduction in coverage gap in 2010.

Subtitle E—Ensuring Medicare Sustainability
Sec. 3401. Revision of certain market basket updates and incorporation of productivity improvements into market basket updates that do not already incorporate such improvements.
Sec. 3402. Temporary adjustment to the calculation of part B premiums.
Sec. 3403. Independent Medicare Advisory Board.

Subtitle F—Health Care Quality Improvement
Sec. 3501. Health care delivery system research; Quality improvement technical assistance.
Sec. 3502. Establishing community health teams to support the patient-centered medical home.
Sec. 3503. Medication management services in treatment of chronic disease.
Sec. 3504. Design and implementation of regionalized systems for emergency care.
Sec. 3505. Trauma care centers and service availability.
Sec. 3506. Program to facilitate shared decisionmaking.
Sec. 3507. Presentation of prescription drug benefit and risk information.
Sec. 3508. Demonstration program to integrate quality improvement and patient safety training into clinical education of health professionals.
Sec. 3509. Improving women’s health.
Sec. 3510. Patient navigator program.
Sec. 3511. Authorization of appropriations.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH
Subtitle A—Modernizing Disease Prevention and Public Health Systems
Sec. 4002. Prevention and Public Health Fund.
Sec. 4003. Clinical and community preventive services.
Sec. 4004. Education and outreach campaign regarding preventive benefit.

Subtitle B—Increasing Access to Clinical Preventive Services
Sec. 4101. School-based health centers.
Sec. 4102. Oral healthcare prevention activities.
Sec. 4103. Medicaid.
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.
November 19, 2009

CONGRESSIONAL RECORD — SENATE
S11611

Sec. 6410. Adjustments to the Medicare durable medical equipment, prosthetics, orthotics, and supplies competitive acquisition program. (continued)

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

Subtitle F—Additional Medicaid Program Integrity Provisions

Sec. 6501. Termination of provider participation under Medicaid if terminated under Medicare or other State programs.

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.

Subtitle G—Additional Program Integrity Provisions

Sec. 6601. Prohibition on false statements and representations.

Sec. 6602. Clarifying definition.

Sec. 6603. Development of model uniform report form.

Sec. 6604. Applicability of State law to combat fraud and abuse.

Sec. 6605. Enabling the Department of Labor to issue administrative summary cease and desist orders and entry seizures orders against plans that are in financially hazardous condition.

Sec. 6606. MEWA plan registration with Department of Labor.

Sec. 6607. Peremptory evidentiary privilege and confidential communications.

Subtitle H—Elder Justice Act

Sec. 6701. Short title of subtitle.

Sec. 6702. Definitions.

Sec. 6703. General effective date.

Subtitle I—Sense of the Senate Regarding Medical Malpractice

Sec. 6801. Sense of the Senate regarding medical malpractice.

TITLE II—INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

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 arrangements services and support.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

Sec. 9001. Excise tax on high cost employer-sponsored health coverage.

Sec. 9002. Inclusion of cost of employer-sponsored health coverage on W-2.

Sec. 9003. Distributions for medical qualified plans for prescribed drug or insulin.

Sec. 9004. Increase in additional tax on distributions from HSAs and Archer MAs 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 organizations.

Sec. 9008. Imposition of annual fee on brand 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 veterinarians 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 government.

Sec. 9022. Establishment of simple cafeteria plans for small businesses.

Sec. 9023. Qualifying therapeutic discovery investment credit.

TITLE I—QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS

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

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

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

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

"PART A—INDIVIDUAL AND GROUP MARKET REFORMS;"

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

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

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

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

"Subpart II—Improving Coverage

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

"(a) In General.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2722(b).

"(b) Prohibition on Rescissions.

"A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan or coverage. Such plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under section 2722(b).

"SEC. 2713. COVERAGE OF PREVENTIVE HEALTH SERVICES.

"(a) In General.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost-sharing requirements for preventive health services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the immunization in question; and (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

"(b) INTERVAL.—

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

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

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

"SEC. 2714. EXTENSION OF DEPENDENT COVERAGE.

"(a) In General.—A group health plan and a health insurance issuer offering group or individual health insurance coverage that provides dependent coverage of children shall continue to make coverage available for an adult child (who is not married) until the child turns 26 years of age. Nothing in this section shall require a health plan or health insurance coverage to provide coverage for and shall not impose any cost-sharing requirement for preventive health services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force; (2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the immunization in question; and (3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

"(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to modify the

---

Synergy Code of 1986) on the dollar value of benefits for any participant or beneficiary.
definition of ‘dependent’ as used in the Internal Revenue Code of 1986 with respect to the tax treatment of the cost of coverage.

**SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM DEFINITIONS OF COVER-AGE DOCUMENTS AND STANDARDIZED DEFINITIONS.**

(a) In General.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a group health plan and a health insurance issuer offering group or individual health insurance coverage, in compiling and providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance and consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) REQUIREMENTS.—The standards for the summary of benefits and coverage described under subsection (a) shall provide for the following:

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

(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes:

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (b)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost sharing for:

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

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

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

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

(E) the renewability and continuation of coverage provisions;

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

(G) a statement of whether the plan or coverage satisfy the elements described in paragraph (2) and the medical terms described in paragraph (3).

(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, coinsurance, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network provider, plan cost-sharing provisions (including customary and reasonable) fees, excluded services, grievance and appeals, and other terms as the Secretary determines are important to define and that may impact health insurance coverage and understand the terms of their coverage.

(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, emergency room care, physician services, prescription drugs, durable medical equipment, skilled nursing care, home care, comprehensive discharge planning, and post discharge reimbursement by an appropriate health care professional.

(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the plan or coverage described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act and the health insurance issuer fails to provide the information required under this section, as determined by the Secretary, in consultation with experts in health care quality and stakeholders, shall be construed to prohibit a plan sponsor from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower dollar or percentage contribution than the payment required of similarly situated employees.

(5) IMPLEMENTATION REQUIREMENTS.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities that improve quality and reduce costs of care, including care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model as described in section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage; and

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

(6) IMPLEMENTATION TIMING.—A report under subparagraph (A) shall be made available to
an enrollee under the plan or coverage during each open enrollment period.

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

"(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary may develop and impose appropriate penalties for non-compliance with such requirements.

"(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially and consistently comply with such requirements.

"(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts to participants, and which may include the following wellness and prevention efforts:

"(1) Smoking cessation.

"(2) Weight management.

"(3) Stress management.

"(4) Physical fitness.

"(5) Nutrition.

"(6) Part-disease prevention.

"(7) Healthy lifestyle support.

"(8) Diabetes prevention.

"(c) REGULATIONS.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations that provide criteria for determining whether a reimbursement structure is described in subsection (a).

"(d) STUDY AND REPORT.—Not later than 180 days after the date on which regulations are promulgated under subsection (c), the Government Accountability Office shall review such regulations and conduct a study and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on such regulations that shall include an assessment of the impact of such regulations on the quality and cost of health care.

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

"(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expended—

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

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

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

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

"(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR THEIR DOLLARS.—(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

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

"(B) with respect to each health insurance issuer offering coverage in the individual market, 25 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

"(2) CONSIDERATION IN SETTING PERCENTAGES.—In determining the percentages under paragraph (1), a State shall seek to ensure that—

"(A) for activities that improve health care quality, the percentage provided in section (a)(3) exceeds—

"(1) on reimbursement for clinical services provided by the health care provider, 20 percent, or such lower percentage as a State may by regulation determine, except that such percentage shall be adjusted to the extent the Secretary determines that the application of such percentage with a State may destabilize the existing individual health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements,

"(2) on other non-claims costs, including costs associated with wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts to participants, and which may include the following wellness and prevention efforts:

"(A) smoking cessation.

"(B) weight management.

"(C) stress management.

"(D) physical fitness.

"(E) nutrition.

"(F) part-disease prevention.

"(G) healthy lifestyle support.

"(H) diabetes prevention.

"(3) in an amount that is equal to the hospital's standard charges for items and services provided by the hospital, including for services provided under section 1886(d)(4) of the Social Security Act;

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

"(5) DECISIONS.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall establish uniform definitions for the activities reported under subsection (a).

"SEC. 2719. APPEALS PROCESS.

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

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

"(2) provide notice to enrollees, in a culturally and linguistically appropriate manner, of available internal and external appeals processes, and the availability of any applicable office of health insurance consumer assistance, or an ombudsman, that, directly or through such agencies, as established under section 2793 to assist such enrollees with the appeals processes;

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

"(4) provide an external review process for such plans and issuers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans.

"SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

"(a) IN GENERAL.—To be eligible to receive a grant under this section, a State shall establish an independent office of health insurance consumer assistance, or an ombudsman, or in coordination with State health insurance regulators and consumer assistance organizations, receives and responds to inquiries regarding issues concerning health insurance coverage with respect to Federal health insurance requirements and under State law.

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

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

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

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

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

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


"(d) DATA COLLECTION.—As a condition of receiving a grant under subsection (a), an office of health insurance consumer assistance or an ombudsman shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered under subsection (a). The Secretary shall utilize such data to identify areas where more enforcement action is necessary and shall share such information with State insurance regulators, the Secretary of Labor, and the Secretary of the Treasury for use in the enforcement activities of such agencies.

"(e) FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section.

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

"(a) INITIAL PREMIUM REVIEW PROCESS.—

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

"(2) JUSTIFICATION AND DISCLOSURE.—The process established under paragraph (1) shall require health insurance issuers to submit to the Secretary and the relevant State a justification for an unreasonable premium increase prior to the implementation of the increase. Such issuers shall prominently post such justification on their Internet websites. The Secretary shall ensure the public disclosure of information on such increases and
shall become effective for fiscal years beginning with fiscal year 2010.  

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

Subtitle B—Immediate Actions to Preserve and Expand Coverage

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

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

(b) ADMINISTRATION.—In General.—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

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

(A) be a State or nonprofit private entity; (B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

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

(3) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract under subsection (a)(2), a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(c) QUALIFIED HIGH RISK POOL.—(1) In General.—Out of all funds made available under this section shall be used to establish a qualified high risk pool that meets the requirements of paragraph (2).

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

(A) provides to all eligible individuals health insurance coverage that does not impose any preexisting condition exclusion with respect to such coverage; (B) provides health insurance coverage, in which the issuer's share of the total allowed costs of benefits provided under such coverage is not less than 65 percent of such costs; and

(ii) that has an out of pocket limit no greater than the applicable amount described in section 223(c)(2) of the Internal Revenue Code of 1986 for the year involved, except that the Secretary may modify such limit if necessary to ensure the pool meets the actuarial value limit under clause (i);

(C) ensures that with respect to the premium rate charged for health insurance coverage offered to eligible individuals through the high risk pool, such rate shall—

(i) except as provided in clause (ii), vary only as described for purposes of section 2701 of the Public Health Service Act (as amended by this Act and notwithstanding the date on which such amendments take effect); (ii) vary on the basis of age by a factor of not greater than 4 to 1; and

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

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

(2) ELIGIBLE INDIVIDUAL.—An eligible individual shall be an individual who is enrolled in a high risk pool for eligible individuals during the period beginning on the date of enactment of this Act, except that the amendments made by sections 1002 and 1003

Subtitle C—Sanctions and Enforcement

(1) In General.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

Sanctions.—An issuer or employment-based health plan shall be responsible for reimbursing the program under this section for the medical expenses incurred by the program for an individual on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from health benefits coverage prior to enrolling in coverage through the program. The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer by the employer, group health plan, or the issuer of money or other financial consideration for disenrolling from the coverage.

(B) In the case of prior coverage obtained directly from an issuer or under an employment-based health plan—

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

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

(1) The prior coverage is a policy that is no longer being actively marketed (as defined by the Secretary) by the issuer.

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

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

(1) OVERSIGHT.—The Secretary shall establish—

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

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

(2) FUNDING: TERMINATION OF AUTHORITY.—

(1) In General.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool.

Such funds shall be available without fiscal year limitation.

(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such estimates as are necessary to eliminate such deficit.

(3) TERMINATION OF AUTHORITY.—
(A) In general.—Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool in a State shall terminate on January 1, 2014.

(b) Exchange.—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through high risk pools established under subsection (a) of this section into qualified health plans offered through an exchange. Such procedures shall ensure that there is no lapse in coverage of an individual and may extend coverage after the termination of the risk pool involved, if the Secretary determines necessary to avoid such a lapse.

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

(5) Relation to State laws.—(A) Under paragraph (1), any State or local government or political subdivision of any State, in relation to plan solvency with respect to qualified high risk pools which are established in accordance with this section.

SEC. 1102. REINSURANCE FOR EARLY RETIRES.

(a) Administration.—(1) In general.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary reinsur- ance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health in- surance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) Eligibility.—In this section:

(1) Health benefits.—The term “health benefits” means medical, surgical, hospital, prescription drug, and such other benefits as shall be determined by the Secretary, whether self-funded, or delivered through the purchase of insurance or otherwise.

(2) Employment-based plan.—The term “employment-based plan” means a group health plan that—

(i) is—

(I) a single employer that provides health insurance coverage to one or more employees (or former employees), or a single employment-based plan that—

(A) meets the requirements of paragraph (2); or

(B) submits to the Secretary an application for participation in the program under this section, at such time, in such manner, and containing such information as the Secretary shall require.

(ii) provides health benefits to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(c) Administration.—(1) In general.—A participating employment-based plan is an employment-based plan that—

(A) submits claims under subsection (b) based on the actual amount expended by the participating employment-based plan involved in the plan year for the health benefits provided to any early retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and other payments or reductions) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the employer or the participant (as determined by the Secretary) shall not be included in determining the cost of medical claims involved; and

(B) does not include in determining any such claim any costs related to preexisting conditions.

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

(3) Limit.—To be eligible for reimburse-ment under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for All Urban Consumers (rounded to the nearest multiple of $1,000) for the year involved.

(d) Use of payments.—Amounts paid to a participating employment-based plan under this subsection shall be used to reduce costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce pre- mium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket expenses paid by plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i).

(e) Payment not treated as income.—Payments received under this subsection shall not be included in determining the gross income of an entity described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

(f) Appeals.—The Secretary shall establish—

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

(B) procedures to protect against fraud, waste, and abuse under paragraphs (a) and (b) of section 1101.

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

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

(i) Limitation.—The Secretary has the au-thority to stop taking applications for par-ticipation in the program based on the availability of funding under subsection (e).

SEC. 1103. IMMEDIATE INFORMATION THAT AL-LOWS CONSUMERS TO IDENTIFY AFFORDABLE COVERAGE OPTIONS.

(a) Internet Portal to Affordable Coverage Options.—

(1) Immediate establishment.—Not later than July 1, 2010, the Secretary, in consulta-tion with the States, shall establish a mecha-nism, including an Internet website, through which a resident of any State may identify affordable health insurance coverage options in that State.

(2) Connecting to Affordable Coverage.—An Internet website established under para-graph (1) shall, to the extent practicable, provide ways for residents of any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than credit unions, only for the treatment or mitigation of—

(i) a single disease or condition; or

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

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

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

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

(E) Coverage under a high risk pool under section 1191.

(b) Enhancing Comparative Purchasing Options.—

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

(2) Use of format.—The Secretary shall use this form, or format derived therefrom, to—

(A) provide information concerning coverage options on the Internet website established under subsection (a); and

(B) ensure that contracts entered into with qualified entities.

SEC. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) Purpose of Administrative Sim-plification.—Section 261 of the Health In-surance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended—

(1) by inserting “uniform” before “stand-ards”; and

(2) by inserting “and to reduce the clerical burden on patients, health care providers, and health plans” before the period at the end.
interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

(1) The entity builds on the transaction standard issued under Health Insurance Portability and Accountability Act of 1996.

(2) The entity allows for public review and updates of the operating rules.

(3) If, for any operating rules that represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards.

(4) Evaluate whether such operating rules are consistent with electronic standards adopted for health information technology.

(5) Submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

(6) Implement and enforce the operating rules.

(7) In general.—The Secretary shall—

(A) advise the Secretary as to whether a health plan or equivalent encounter information is in compliance with any applicable standards or operating rules described under paragraph (9) of such section; or

(B) The Secretary may designate independent, outside entities to certify that a health plan or equivalent encounter information is in compliance with any applicable standards or operating rules issued by the Secretary.

(8) Documentation by outside entity.—The Secretary may designate independent, outside entities to certify that a health plan has complied with the requirements under this subsection, providing that such certification standards employed by such entities are in accordance with any standards or operating rules issued by the Secretary.

(9) Ameliorate.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

(10) Compliance—

(A) Eligibility for a health plan, health claim status, electronic funds transfers, health care payment and remittance advice.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards or operating rules described under paragraph (9) of such section.

(B) Health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health claims attachments, referral certification and authorization.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards or operating rules described under paragraph (9) of such section.

(C) Electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.
(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

(B) DATE OF COMPLIANCE.—A health plan shall comply with such requirements not later than the effective date of the applicable transaction standard.

(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described in section 1173(a)(2)(B)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (d).

(7) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING RULES.—

(A) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

(B) EVALUATIONS AND REPORTS.—

(A) HEARINGS.—Not later than April 1, 2014, and not less than biennially thereafter, the Secretary, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and operating rules. The review committee shall recommend a set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

(3) INTERIM FINAL RULEMAKING.—

(A) IN GENERAL.—Any recommendations to amend adopted standards and operating rules under subsection (1) that are approved by the review committee and reported to the Secretary under paragraph (2(B)) shall be adopted by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee’s report.

(B) PUBLIC COMMENT.—

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

(ii) EXTENSION.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be delayed by the length of the public comment period.

(4) REVIEW COMMITTEE.—

(A) DEFINITION.—For the purposes of this subsection, the term ‘review committee’ means a committee chartered by or within the Department of Health and Human Services that is designated by the Secretary to carry out this subsection, including—

(I) the National Committee on Vital and Health Statistics;

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

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

(C) OPERATING RULES FOR OTHER STANDARDS.—The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (e)) for any transaction for which a standard has been adopted pursuant to subsection (a)(1)(B).

(5) PENALTIES.—

(1) Penalty fee.—

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

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

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

(B) FEE AMOUNT.—Subject to subparagraphs (C) and (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (g).

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

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

(E) Penalty fee.—

(I) any amount equal to $20 per covered life under such plan; or

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

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

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

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

(5) PENALTY PER REPORT.—

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

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

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

(6) UNPAID PENALTY.—An amount of a penalty fee assessed against a health plan under this subsection for which payment has not been made by the due date provided under subparagraph (C) shall be—

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

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

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

(c) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (a)(2)).

(E) ADMINISTRATIVE FEES.—Any fee charged to a health plan for any collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.
SEC. 2701. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT

Part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.), as amended by section 101, is further amended—

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

"Subpart 1—General Reform;"

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

"SEC. 2704. PROHIBITION OF PREEXISTING CONDITION EXCLUSION REQUIREMENTS BASED ON HEALTH STATUS.

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

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

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

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

(ii) by striking subsection (b) and inserting the following:

"(I) by striking "health insurance issuer offering group or individual health insurance coverage"; and

(II) in paragraph (2)(A)—

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

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

(iii) in subsection (e)—

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

(II) by striking "2003" and inserting "2004"; and

(III) by striking "2271(a)" and inserting "2375(a)"; and

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

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

"SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

"(a) Prohibiting Discriminatory Premium Rates.—

(I) In General.—With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market—

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

(i) whether such plan or coverage covers an individual's tobacco use;

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

(iii) age, except that such rate shall not vary by more than 1.5 to 1 for adults (consistent with section 2707(c)); and

(iv) tobacco use, except that such rate shall not vary by more than 1.5 to 1, and (B) such rate shall not vary with respect to the particular plan or coverage involved by any other factor not described in subparagraph (A).

(II) RATING AREA.—

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

(B) Secretarial Review.—The Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are inadequate, the Secretary may establish rating areas for that State.

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

(4) APPLICATIONS BASED ON AGE OR TOBACCO USE.—With respect to family coverage under a group health plan or health insurance coverage under the rating variations permitted under clauses (iii) and (iv) of paragraph (1)(A) shall be applied based on the portion of the premium that is attributable to each family member covered under the plan or coverage.

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

"SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

"(a) Guaranteed Issuance of Coverage in the Individual and Group Market.—Subtitle C—Quality Health Insurance Coverage for All Americans

"(8) Disability.

"(9) Any other health status-related factor determined appropriate by the Secretary.

"(j) Programs of Health Promotion or Disease Prevention.

"(k) General Provisions.

"(A) General Rule.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this section as a well-baby visit) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.

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

"(C) Conditions Based on Health Status Factor.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program is based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals and the requirements of paragraphs (2) and (3) are complied with.

"(2) Wellness Programs Not Subject to Requirements.—If none of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if the requirements of paragraphs (2) and (3) are complied with.

"(3) Wellness Programs Subject to Requirements.—If any of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(B) are based on an individual satisfying a standard that is related to a health status factor, such wellness program shall not violate this section if—

(iii) in subsection (1) if participation in the program is made available to all similarly situated individuals; and

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

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

The program that reimburses costs of smoking cessation programs without regard to whether the individual quits smoking.

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

(B) a program that provides a reward to individuals for obtaining wellness programs without regard to whether the individual quits smoking.

(C) a program that provides a reward to individuals for obtaining wellness programs without regard to whether the individual quits smoking.

(D) a program that reimburses individuals for the costs of smoking cessation programs without regard to whether the individual quits smoking.

(E) a program that provides a reward to individuals for obtaining wellness programs without regard to whether the individual quits smoking.

(F) a program that provides a reward to individuals for obtaining wellness programs without regard to whether the individual quits smoking.

(3) Wellness Programs Subject to Requirements.—If any of the conditions for obtaining a premium discount or rebate or other reward under a wellness program as described in paragraph (1)(C) is based on an individual satisfying a standard that is related to a health status factor, the wellness program shall not violate this section if participation in the program is made available to all similarly situated individuals. The following programs shall not have to comply with the requirements of paragraph (3) if participation in the program is made available to all similarly situated individuals:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Z) a program that reimburses all or part of the cost for memberships in a fitness center.
as spouses or spouses and dependent chil-
dren) may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which the employee is enrolled or any substantial equal ben-
efit otherwise applicable standard.

(2) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary, in consultation with the Secretary of Health and Human Services, determines that the demonstration project described in paragraph (1) is effective, such Secretary may, after the date of enactment of this Act, establish a 10-State dem-
stration project to include additional par-
ticipating States.

(3) REQUIREMENTS.—

(A) MAINTENANCE OF COVERAGE.—The Sec-
retary, in consultation with the Secretary of Health and Human Services, shall not approve the participation of a State in the demonstration project involving a program unless the Secretary determines that the State’s program is designed in a manner that—

(i) will not result in any decrease in cov-

(A) The plan or issuer involved shall dis-

(E) The plan or issuer involved shall dis-

(II) for a reasonable alternative standard
(b) INDIVIDUALS.—The provisions of sec-

(iv) shall ensure that consumer data is re-

(v) shall ensure and demonstrate to the

(l) WELLNESS PROGRAM DEMONSTRATION

PROJECT.—If the Secretary, in consultation with the Secretary of Health and Human Services, determines that the demonstration project described in paragraph (1) is effective, such Secretary may, after the date of enactment of this Act, establish a 10-State dem-
stration project to include additional par-
ticipating States.

(3) REQUIREMENTS.—

(A) MAINTENANCE OF COVERAGE.—The Sec-
retary, in consultation with the Secretary of Health and Human Services, shall not approve the participation of a State in the demonstration project involving a program unless the Secretary determines that the State’s program is designed in a manner that—

(i) will not result in any decrease in cov-

(ii) will not increase the cost to the Fed-

eral Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

(B) OTHER REQUIREMENTS.—States that

participate in the demonstration project under this subsection—

(i) may permit premium discounts or re-

bates or the modification of otherwise appli-
cable copayments or deductibles for adher-

ence to, or participation in, a reasonably de-
digned program of health promotion and dis-

ease prevention;

(ii) shall ensure that requirements of con-

sumer protection are met in programs of

health promotion in the individual market;

(iii) shall require verification from health

insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

(I) do not create undue burdens for indi-

viduals insured in the individual market;

(II) do not provide an unreasonable or

medically inadvisable benefit or require a

waiver for an individual for whom, for that period, it is unre-

asonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(ii) if reasonable under the cir-
cumstances involved, the plan or issuer may seek verification, such as a statement from an in-
dividual’s physician, that a health status factor makes it unreasonably difficult or medically inadvisable to attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall dis-

close in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or waiver of the otherwise applicable standard) required under subpara-

graph (D). If plan materials disclose that such a program is available, without describing it and without disclosing the existence under this sub-
paragraph shall not be required.

(k) EXISTING PROGRAMS.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was est-
ablished prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as those regulations remain in effect.

(l) WELLNESS PROGRAM DEMONSTRATION

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

(b) Allowance for family members to join current coverage.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act and which is renewed after such date, family members of such individual shall be permitted to enroll in such plan or coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) Allowance for new employees to join current plan.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrolling of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) Effect on collective bargaining agreements.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employer representatives and one or more employers that was ratified before the date of enactment of this Act, the amendments made by this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage may not be subject to any requirement added by this subtitle or subtitle A (and amendments) shall not be treated as a termination of such collective bargaining agreement.

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

SEC. 1253. RATING REFORMS MUST APPLY UNIFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

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

SEC. 1253. EFFECTIVE DATES.

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

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) Qualified Health Plan.—In this title:

(1) in general.—The term “qualified health plan” means a health plan that

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

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

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

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

(ii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through the Exchange or whether the plan is offered directly from the issuer or through an agent; and

(iii) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) inclusion of co-op plans and community health insurance options.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1323, unless specifically provided for otherwise.

(b) terms relating to health plans.—In this title:

(1) Health plan.—

(A) in general.—The term “health plan” means health insurance coverage and a group health plan.

(B) exception for self-insured plans and mews.—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to section 514 of the Employee Retirement Income Security Act of 1974.

(2) Health insurance coverage and issuers.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 2791(b) of the Public Health Service Act.

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

(c) Essential Health Benefits Requirements.

(a) Essential Health Benefits Package.—In this title, the term “essential health benefits with respect to any health plan, coverage that—

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

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

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

(b) Essential Health Benefits.—

(1) in general.—In defining the essential health benefits, the Secretary shall determine the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories:—

(A) ambulatory patient services.

(B) emergency services.

(C) inpatient hospital services.

(D) maternity and newborn care.

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

(F) prescription drugs.

(G) rehabilitative and habilitative services and devices.

(H) laboratory services.

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

(3) Limitation.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To conduct such surveys, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, and shall provide a report on such survey to the Secretary.

(c) Certification.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(4) required elements for consideration.—In defining the essential health benefits under paragraph (1), the Secretary shall ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

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

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall be treated as providing coverage for the essential health benefits described in paragraph (1) unless the plan provides that—

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

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

(F) provide that if a plan described in section 1311(b)(2)(B)(i) (relating to stand-alone dental benefits plans) is offered through an Exchange, such plan shall not be treated as a qualified health plan solely because the plan does not offer coverage of benefits that are otherwise required under paragraph (1)(J); and

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

(2) Limitation.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary. To conduct such surveys, the Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, and shall provide a report on such survey to the Secretary.
VITAL AND PREGNANCY SERVICES.—A plan in a plan year beginning in
2014 shall be deemed to provide coverage for services related to a parity in its
coverage of coverage for childbirth and pregnancy services, and the
requirements of subsection (d) with respect to pregnant women (as defini
ted in section 112 of the Public Health Service Act). [10]

The dollar amount under subparagraph (A)(ii) shall be increased by an amount not
less than the annual limitation in effect for the calendar year, determined after application

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

(ii) the dollar amount under subparagraph (A)(ii) shall be increased by an amount equal
to twice the amount in effect under subparagraph (A)(i) for plan years beginning in the
calendar year, determined after application of clause (i).

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

ACTUARIAL VALUE.—The limitation under this paragraph shall be applied in such
a manner so as not to affect the actuarial value of any health plan, including a plan in the
bronze level.

COORDINATION WITH PREVENTIVE LIMI-
tations.—Not in this paragraph shall be con-
strued to allow a deductible under the plan apply to benefits described in
section 2713 of the Public Health Service Act.

(3) COST-SHARING.—In this title—
(A) in general.—The term “cost-sharing” includes—
(i) deductibles, coinsurance, copayments, or similar charges; and
(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) with respect to the essential health benefits covered under the plan.

(B) EXCEPTIONS.—Such term does not in-
clude premiums, balance billing amounts for non-network providers, or spending for non-
covered services.

(4) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (1)(B)(i) and
(2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if
any) by which the average per capita premium for health insurance coverage in the
United States for the preceding calendar year (as estimated by the Secretary no later
than October 1 of such preceding calendar year) exceeds such average per capita pre-
mium for 2013 (as determined by the Secretary).

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

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

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

(C) GOLD LEVEL.—A plan in the gold level
shall provide a level of coverage that is designed to provide benefits that are actuari-
ally equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.

(D) PLATINUM LEVEL.—A plan in the plat-
inum level shall provide a level of coverage that is designed to provide benefits that are actuari-
ally equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(2) ACTUARIAL VALUE.—
(A) IN GENERAL.—Under regulations issued by
the Secretary, the level of coverage of a plan shall be determined on the basis that the
essential health benefits described in this title are provided under a group health plan or health
insurance coverage that are provided by such plan or coverage, the rules contained in the
regulations under this paragraph shall apply.

(B) EXCEPTIONS.—The Secretary shall develop guidelines to provide for a de-
minimis variation in the actuarial valu-
ation in determining the level of cov-
erage of a plan to account for differences in actuarial estimates.

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

(e) CATASTROPHIC PLAN.—
(1) IN GENERAL.—A health plan not pro-
viding a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the
requirements of subsection (d) with respect to any plan year if—

(i) the only individuals who are eligible to
enroll in the plan are individuals described in paragraph (2); and

(ii) the plan provides—

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

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

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

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

(B) has a certification in effect for any
plan year under this title that the individual is exempt from the requirement under sec-
tion 5000A(e)(1) of the Internal Revenue Code of
1986 by reason of—

(i) section 5000A(e)(1) of such Code (relat-
ing to individuals without affordable cov-
verage); or

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

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

(f) CHILD-ONLY PLANS.—If a qualified health plan is offered through the Exchange in
any level of coverage specified under subsec-
tion (d), the issuer shall also offer that plan through the Exchange in that level as a plan
in which the only enrollees are individu-
als who, as of the beginning of a plan year, have not attained the age of 21, and such plans shall be treated as a qualified health plan.
B) Abortions.—
(1) A qualified health plan shall be treated as described in clause (ii) if the plan does not provide coverage of services described in subparagraph (B)(ii) or (B)(i); and
(2) The issuer of a qualified health plan shall meet the requirements of clause (i) separately with respect to each such market.

C) Prohibition on federal funds for abortion services in community health insurance option.—
(1) The Secretary may not determine, in accordance with subparagraph (A)(i), that the community health insurance option established under section 1323 of the Affordable Care Act is a qualified health plan if the issuer of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:
   (I) The credit under section 36B of the Internal Revenue Code of 1986 (and the amount of the advance payment of the reduction under section 1412 of the Patient Protection and Affordable Care Act).

D) Assured availability of varied coverage through exchanges.—
(1) In general.—Nothing in this Act shall be construed to preempt or otherwise have any effect with respect to State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

II) WILLINGNESS OR REFUSAL TO PROVIDE ABBORTIONS.—No State option to treat 50 employers as small.—In the case of plan years beginning before January 1, 2016, a State may elect to treat employers described in subsection (b)(1) of section 414 of the Internal Revenue Code of 1986 as 1 employer.

E) Employers not in existence in preceding year.—In the case of an employer that employed an average of at least 1 employee on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

F) Small employers.—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 employee on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
PART II—CONSUMER CHOICES AND INVESTMENT THROUGH AMERICAN HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

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

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

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

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

(i) establishing an Exchange; and

(ii) implementing the reforms described in subsections A and C (and the amendments made applicable to subsections A and C of title II) of the Patient Protection and Affordable Care Act; and

(ii) making available to each Exchange a model template for an Internet portal that

(II) meets the requirements of section 1302(b)(1)(J).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one Exchange for presenting health benefits plan options to qualified individuals and qualified employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) RESPONSIBILITIES OF THE SECRETARY.—(1) IN GENERAL.—The Secretary shall, by regulation, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 1362(d) of the Public Health Service Act, and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, and section 221 of Public Law 111-8, except that nothing in this subparagraph shall be construed to require any health plan to provide coverage for any specific medical procedure;

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

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

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

(F) utilize a uniform enrollment form that

(2) REQUIREMENTS.—(A) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(B) OFFERING OF COVERAGE.—(A) IN GENERAL.—An Exchange shall make available any health plan that is not a qualified health plan.

(C) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall also be an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9801(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(D).

(d) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—(1) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available any qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(2) STATES MAY REQUIRE ADDITIONAL BENEFITS.—(A) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State meet additional requirements to the essential health benefits specified under section 1302(b).

(B) STATE MUST ASSUME COST.—(A) An Exchange shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 for the cost of the essential health benefits specified under section 1302(b) that the Exchange offers in the State.
Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such credit or reduction under section 1411(b)(3)(D) of such Code and section 1402(c)(4).

(4) FUNCTIONS.—An Exchange shall, at a minimum—

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

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

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(8);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange; and

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

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

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

(i) there is no affordable qualified health plan available through the Exchange, or the individual’s employer, covering the individual and each dependent of the individual;

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(iii) transfer to the Secretary of the Treasury—

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

(ii) the name and taxpayer identification number of each individual who was an employee covered by such individual’s plan or coverage, who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—

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

(II) the employer provided such minimum essential coverage but it was determined under section 36B(c)(1)(C) of such Code to either be unaffordable to the employee or not to provide the required minimum actuarial value; and

(iii) the name and taxpayer identification number of each individual who notifies the Exchange under section 1411(b)(4) that they have changed employers and of each individual who notifies the Exchange under section 36B(b)(3)(D) of such Code and section 1402(c)(4), and

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

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

(B) FUNDING LIMITATIONS.—An Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retirement, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(C) CONSULTATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) health care consumers who are enrollees in qualified health plans;

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

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(5) PUBLICATION OF COSTS.—An Exchange shall publish information required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) EXCERPT.—

(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for such certification established by the Secretary under subsection (c)(8); and

(B) the Exchange determines that making available such health plan through such Exchange increases the likelihood of enrollment in qualified health plans and qualified employers in the State or States in which such Exchange operates, except that the Exchange may not exclude a health plan—

(i) on the basis that such plan is a fee-for-service plan;

(ii) through the imposition of premium price controls; or

(iii) on the basis that the plan provides treatments necessary to prevent patients’ deaths in circumstances the Exchange determines would be appropriate under the plan or coverage.

(2) PREMIUM CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to the quality of a plan’s actuarial valuation), into consideration when determining whether to make such health plan available through the Exchange, and shall consider the exchange of any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by each such Exchange is no larger than the rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT.—

(A) IN GENERAL.—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY.—In this paragraph, the term “eligible entity” means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(II) that has demonstrated experience on a State or regional basis in the individual and group health insurance markets and in benefits coverage; and

(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 32 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(ii) the State medical agency under title XIX of the Social Security Act.

(4) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

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

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) the implementation of wellness and health promotion activities.

(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange by the State or States that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) QUALITY IMPROVEMENT.—Beginning on January 1, 2015, a qualified health plan may contract with—
(A) a hospital with greater than 50 beds only if such hospital—
(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act and
(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or
(B) a hospital provider only if such pro-
vider implements such mechanisms to im-
prove health care quality as the Secretary may require.
(2) EXCEPTIONS.—The Secretary may estab-
lish reasonable exceptions to the require-
ments described in paragraph (1).
(3) The Secretary may by regulation adjust the number of beds de-
scribed in paragraph (1)(A).

1) NAVIGATORS.—An Exchange shall estab-
lish a program under which it awards grants to enti-
ties described in paragraph (2) to carry out the duties described in paragraph (3).

2) ELIGIBILITY.—
(A) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall demonstrate to the Exchange involved that the entity has existing relationships, or could readily establish relationships, with employers, employers and employees, insured or uninsured, consumer associa-
tions, or self-employed individuals likely to be enrolled in a qualified health plan.
(B) TYPES.—Entities described in subpara-
graph (A) may include trade, industry, and professional associations, commercial fish-
ing organizations, consumer-assistance and consumer-resource, and consumer-focused nonprofit groups, chambers of commerce, unions, small business development centers, other licensed insurance agents and brokers, and other entities that—
(i) are capable of carrying out the duties described in paragraph (3);
(ii) meet the standards described in para-
graph (4); and
(iii) provide information consistent with the standards described under paragraph (5).
(C) DUTIES.—An entity that serves as a navig-
ator under a grant under this subsection shall—
(1) conduct public education activities to raise awareness of the availability of quali-
fied health plans;
(2) distribute fair and impartial informa-
tion about qualified health plans, and the availability of pre-
mium tax credits and cost-sharing reduc-
tions under section 1402;
(3) facilitate enrollment in qualified health plans;
(4) provide referrals to any applicable off-
cice of health insurance consumer assistance or health insurance ombudsman established under section 2798 of the Public Health Serv-
ice Act, or any other appropriate State agen-
cy or agencies, for any enrollee with a griev-
ance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
(5) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(A) IN GENERAL.—The Secretary shall es-
tablish standards for navigators under this subsection, including provisions to ensure that a public entity that is sele-
cuted as a navigator is qualified, and li-
censed if appropriate, to engage in the navi-
gator activities described in this subsection and to avoid conflicts of interest. Under such standards, a navigator shall not—
(i) be a health insurance issuer; or
(ii) receive any payment directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or employees of a quali-
fied employer or qualified health plan.
(B) FAIR AND IMPARTIAL INFORMATION AND SERVICES.—The Secretary, in collaboration with States, shall develop standards to en-
dorse that choice of a plan or coverage by navigators is fair, accurate, and impartial.
(C) FUNDING.—Grants under this subsec-
tion shall be made from the operational funds of the Exchange and not Federal funds received by the State to establish the Exchange.

1) APPLICABILITY OF MENTAL HEALTH PAR-
TIES.—Section 2726 of the Public Health Serv-
vice Act shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans.
(k) CONFLICT.—An Exchange may not es-
ablish rules that conflict with or prevent the application of regulations promulgated by the Secretary under this subtitle.

SEC. 1312. CONSUMER CHOICE.

(a) CHOICE.—
(1) QUALIFIED INDIVIDUALS.—A qualified in-
dividual may enroll in any qualified health plan available to such individual.
(2) QUALIFIED EMPLOYERS.—
(A) EMPLOYER MAY SPECIFY LEVEL.—A qualified employer may provide support for the enrollment of employees under a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange.
(B) EMPLOYER MAY REQUIRE CONSISTENT WITHIN A LEVEL.—Each employee of a qualified em-
ployer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.
(C) PAYMENT OF PREMIUMS BY QUALIFIED IN-
DIVIDUALS.—A qualified individual enrolled in any qualified health plan may pay any ap-
licable premium owed by such individual to the health insurance issuer issuing such qualified health plan.
(D) SINGLE RISK POOL.—
(1) INDIVIDUAL MARKET.—A health insur-
ance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) as the in-
dividual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.
(2) SMALL GROUP MARKET.—A health insur-
ance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by an issuer in the small group market, including those enrol-
lees who do not enroll in such plans through the Exchange, to be members of a single risk pool.
(3) MERGER OF MARKETS.—A State may re-
quire the individual and small group insur-
ance markets within a State to be merged if the State determines appropriate.
(4) STATE LAW.—A State law requiring grandfathered health plans to be included in a pool described in paragraph (1) or (2) shall not apply.

2) EMPOWERING CONSUMER CHOICE.—
(1) CONTINUOUS OPERATION OF MARKET OUT-
SIDE EXCHANGES.—Nothing in this title shall be construed to compel an individual to enroll in, or to participate in an Exchange.
(2) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—
(1) QUALIFIED INDIVIDUALS.—In this title, "qualified individual" means, with respect to an Exchange, an individual who—
(1) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and
(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(f)).

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

(C) QUALIFIED EMPLOYER.—In this title:
(A) In general.—The term "qualified employer" means a small employer that elects to make all full-time employees of such employer eligible for or more qualified health plans offered through a small group market through an Exchange that offers qualified health plans.

(ii) the requirements set forth in subparagraphs (A) and (C) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(B) DAMAGES.—Notwithstanding paragraph (1) of section 3729(a) of title 31, United States Code, and subject to paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person found liable under such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES

SEC. 1321. ESTABLISHMENT AND OPERATION OF EXCHANGES AND RELATED REQUIREMENTS.

(a) Establishment of Standards.—

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

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

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

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

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

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

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

(a) Establishment of Program.—

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

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

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

(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the award of loans and grants to assist in the establishment of qualified nonprofit health insurance issuers of—

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

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

(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—

(A) IN GENERAL.—In awarding loans and grants under the CO-OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (D);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have a plan to generate private support;

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that the Secretary may reduce the aggregate amount of funds available to any State if the Secretary determines that it is not necessary to maintain such a qualified nonprofit health insurance issuer; and

(B) STATES WITHOUT ISSUERS IN PROGRAM.—

If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within the State, except that the Secretary may reduce the aggregate amount of funds available to any State if the Secretary determines that it is not necessary to maintain such a qualified nonprofit health insurance issuer, the Secretary shall provide through the CO-OP program for the award of loans and grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

GRANTS.—

(A) IN GENERAL.—The Secretary shall not later than July 1, 2013, award the loans and grants described in paragraph (1) to the person that meets the qualifications described in section 1905(c)(2) of the Social Security Act.

(B) RULES RELATING TO APPOINTMENTS.—

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

(ii) ORIGINAL APPOINTMENTS.—The original appointment of any individual appointed under subparagraph (A) shall be filled in the same manner as the original appointment of any person appointed under this subsection (3).

(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment of any person appointed under this subsection (3).

(D) PAY AND REIMBURSEMENT.—

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

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

(E) APPLICABLE FEDERAL ADVISORY COMMITTEE ACT.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section on December 31, 2015.

(c) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—

(1) IN GENERAL.—The term “qualified nonprofit health insurance issuer” means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation; and

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) COUNCIL MAY NOT SET PAYMENT RATES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under chapter 57 of title 5, United States Code.

(3) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—

(A) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO-OP program under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, actuarial services, health information technology, and other cost efficiencies, including claims administration, actuarial services, health information technology, and other cost efficiencies.

(B) RULES RELATING TO APPOINTMENTS.—

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

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

(d) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—

(1) IN GENERAL.—The term “qualified nonprofit health insurance issuer” means—

(A) an organization that is organized under State law as a nonprofit, member corporation; and

(B) substantially all of the activities of which consist of the issuance of qualified health plans in the individual and small group markets in which it is licensed to issue such plans; and

(C) that meets the other requirements of this subsection.

(2) COUNCIL MAY NOT SET PAYMENT RATES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under chapter 57 of title 5, United States Code.

(3) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—

(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) to any qualified nonprofit health insurance issuer participating in such a council.

(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term “antitrust laws” means—


(ii) any provision of the antitrust laws applicable to a governmental entity or a public employee that the Federal Trade Commission deems necessary to prevent anticompetitive conduct, and to promote competition consistent with consumer welfare and the public interest.

(C) COORDINATION WITH STATE INSURANCE LAWS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements of any State law described in section 1224(e).

(D) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.
(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

(2) COMMISSION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(3) COMMISSION.—Nothing in this section shall be construed to require a health plan to provide coverage beyond the essential health benefits described in subparagraph (A), or to impose any penalty for non-participation.

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

(5) STATE OPT OUT.—(A) IN GENERAL.—A State may elect to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) if—

(i) the organization has given notice to the Secretary, in such manner as the Secretary determines necessary or appropriate, of its decision to cease carrying out this section.

(ii) the organization has given notice to the Secretary, in such manner as the Secretary determines necessary or appropriate, of its decision to cease carrying out this section.

(C) EFFECTS OF TERMINATION.—If a State terminates the prohibition under subparagraph (A) on or before December 31 of each year, the provisions of subsection (a) the return required under subsection (a) shall be reduced by the applicable penalty for non-participation.

(6) STATE SUPERVISION OF EXCHANGE.—Nothing in this section shall be construed to require an individual to participate in the essential health benefits described in subparagraph (A).
(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system; 
(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and 
(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

(3) APPLICATION.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.

(c) Start-Up Fund. —

(1) Establishment of fund.—(A) In general.—There is established in the Treasury of the United States a trust fund to be known as the “Health Benefit Plan Start-Up Fund” (referred to in this section as the “Start-Up Fund”), that shall consist of such amounts as may be appropriated or credited to the Start-Up Fund as provided for in this subsection to provide loans for the initial operations of a community health insurance option; and

(ii) pay the costs of making payments on claims submitted during the period that is not more than 90 days before the date on which such option is offered.

(2) Use of Start-Up Fund.—The Secretary shall use amounts contained in the Start-Up Fund to make payments (subject to the repayment requirements in paragraph (4)) for the purposes described in paragraph (1)(B).

(3) Pass-through of rebates.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

(B) Requirements.—(A) Policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system; 
(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and 
(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(B) Funding.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury appropriated for any purpose for which the Secretary deems necessary, a sum not to exceed the amount requested by the Secretary of Health and Human Services as necessary to

(i) the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that the contracting administrator has engaged in fraud, deception, waste, abuse of power, negligence, mismanagement of taxpayer dollars, or gross mismanagement.

(C) Term.—That the Secretary, in any other State, or in all States.

(3) Term.—A contract provided for under paragraph (1) shall be for a term of at least 5 years but not more than 10 years, as determined by the Secretary. At the end of each such term, the Secretary shall conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under such paragraph, as the case may be.

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

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

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

(B) Requirement for high quality administration.—The Secretary may increase the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 1 percent, based on which the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low cost sharing requirements, provided that such requirements are consistent with section 1396.

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

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) Non-renewal.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subsection (b)(6).

(D) Report by HHS and insolvency warnings.— (1) In general.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(i) If the Secretary determines that the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option.

(2) Submission of plan and procedure.—(A) In general.—If there is a community health insurance option solvency warning, the Secretary shall submit to Congress a plan and procedure under this title that could indicate fraud or abuse.

(B)minimum of 90 days before the date on which such option is offered.
the budget submission to Congress under section 1100(a) of title 31, United States Code, for the succeeding year, provided legislation to respond to such warning.

(2) DISCLOSURE.—In the case of a legislative proposal submitted under paragraph (1), such proposal shall be considered by Congress using the same methodology described under sections 802 and 804 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that shall be used for a Medicare funding warning.

(g) MARKETING PARTY.—In a facility controlled by the Federal Government, or by a State, where marketing or promotional materials relating to private health insurance plans are subject to Federal or State law, such marketing or promotional materials are made available to the public, making available marketing or promotional materials relating to private health insurance plans shall not be prohibited. Such materials shall include informational pamphlets, guidebooks, enrollment forms, or other materials determined reasonable for display.

There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 1234. LEVEL PLAYING FIELD.

(a) IN GENERAL.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance plan or any State plan for the individual and the individual’s family, that shall be used for a medicare funding warning.

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

SEC. 1233. ESTABLISHMENT OF ALTERNATIVE PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into agreements with issuers of standard health plans to provide for the inclusion of innovative features in the plan, including:

(1) care coordination and care management for enrollees, especially for those with chronic health conditions;

(2) incentives for use of preventive services; and

(3) the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making, including providing incentives for appropriate care.

(b) HEALTH AND RESOURCE DIFFERENCES.—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers.

Nothing in this subparagraph shall be construed as allowing discrimination on the basis of health status or other health status-related factors.

(c) MANAGED CARE.—Contracting with managed care systems, or with systems that provide access to Medicare.

(d) PERFORMANCE MEASURES.—Establishing special performance measures for issuers of standard health plans that focus on quality of care and improved health outcomes, requiring such plans to report to the Department of Health and Human Services the measures and standards, and making the performance and quality information available to enrollees in a comprehensible form.

(3) ENHANCED AVAILABILITY.—

(A) MULTIPLE PLANS.—A State shall, to the maximum extent feasible, seek to make multiple health plans available to eligible individuals within a State to ensure individuals have a choice of plans.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(C) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and any other State programs for the purposes of providing a seamless approach to care.

(4) TRANSFER OF FUNDS TO STATES.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(5) USE OF FUNDS.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(6) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits and cost-sharing reductions allowed with respect to the standard health plan under subsection (a). The Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are available in the State those amounts and credits determined in accordance with the provisions of section 36B(b)(3) of the Internal Revenue Code of 1986.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(7) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and any other State programs for the purposes of providing a seamless approach to care.

(8) TRANSFER OF FUNDS TO STATES.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(9) USE OF FUNDS.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(10) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits and cost-sharing reductions allowed with respect to the standard health plan under subsection (a). The Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are available in the State those amounts and credits determined in accordance with the provisions of section 36B(b)(3) of the Internal Revenue Code of 1986.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(C) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and any other State programs for the purposes of providing a seamless approach to care.

(D) TRANSFER OF FUNDS TO STATES.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(11) USE OF FUNDS.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(12) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits and cost-sharing reductions allowed with respect to the standard health plan under subsection (a). The Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are available in the State those amounts and credits determined in accordance with the provisions of section 36B(b)(3) of the Internal Revenue Code of 1986.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(C) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and any other State programs for the purposes of providing a seamless approach to care.

(D) TRANSFER OF FUNDS TO STATES.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(13) USE OF FUNDS.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(14) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits and cost-sharing reductions allowed with respect to the standard health plan under subsection (a). The Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are available in the State those amounts and credits determined in accordance with the provisions of section 36B(b)(3) of the Internal Revenue Code of 1986.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(C) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and any other State programs for the purposes of providing a seamless approach to care.

(D) TRANSFER OF FUNDS TO STATES.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(15) USE OF FUNDS.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.

(16) AMOUNT OF PAYMENT.—

(A) SECRETARIAL DETERMINATION.—

(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the premium tax credits and cost-sharing reductions allowed with respect to the standard health plan under subsection (a). The Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are available in the State those amounts and credits determined in accordance with the provisions of section 36B(b)(3) of the Internal Revenue Code of 1986.

(B) REGIONAL COMPACTS.—A State may negotiate a regional compact with States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

(C) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title XIX of the Social Security Act, the State child health plan under title XXI of such Act, and any other State programs for the purposes of providing a seamless approach to care.

(D) TRANSFER OF FUNDS TO STATES.—A State shall establish a trust fund for the payment of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State for the fiscal year.
focus on enrollees with income below 200 percent of poverty.

(11) Certification.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph and such determinations, meet the requirements of clause (ii). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(b) Corrections.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

(2) APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

(e) ELIGIBLE INDIVIDUAL.—

(1) In General.—In this section, the term ‘‘eligible individual’’ means, with respect to any State, an individual—

(A) who a resident of the State who is not eligible to enroll in the State’s Medicaid program or the State Health Insurance Program for benefits that at a minimum consist of the essential health benefits described in section 1302(b);

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved;

(C) who is not eligible for minimum essential coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986); and

(D) who has not attained age 65 as of the beginning of the plan year.

Such term shall not include any individual who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange.

(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 1312 for eligible enrollment in a qualified health plan offered through an Exchange established under section 1331.

(f) SECRETARIAL OVERSIGHT.—The Secretary shall conduct a review of each State program to ensure compliance with the requirements of this section, including ensuring that the State program meets—

(1) eligibility verification requirements for participation in the program;

(2) requirements for use of Federal funds received by the program; and

(3) the quality and performance standards under this section.

(g) STANDARD HEALTH PLAN OFFERERS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section as a plan available for enrollment in a qualified health plan offered through an Exchange established under section 1331.

(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.
notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

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

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

(a) Health Care Choice Compacts.—

(1) IN GENERAL.—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating, including dressings disputes as to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in which the plan will be offered. An issuer may appeal the determination of the Secretary under this paragraph in accordance with paragraph (2) of subsection (a) of section 1321.

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides;

(iv) must notify the State in which the plan is offered. An issuer may appeal the determination of the Secretary under this paragraph in accordance with paragraph (2) of subsection (a) of section 1321.

(b) Authority for Nationwide Plans.—

(1) IN GENERAL.—Notwithstanding any contrary provision of State law, the Secretary shall, not later than January 1, 2011, establish a nationwide qualified health plan that meets the requirements of this subsection with respect to a nationwide qualified health plan—

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

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

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

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

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

(B) the plan is offered in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with this paragraph, including addressing disputes as to the performance of the contract, of the State in which the purchaser resides;

(C) the issuer meets all requirements of this title with respect to a qualified health plan, including the requirement to offer the silver or gold levels of the plan in each exchange in the State for the market in which the plan is offered;

(D) the issuer determines the premiums for the plan in any State on the basis of the rating rules in effect in that State for the rating areas in which it is offered;

(E) the issuer offers the nationwide qualified health plan in at least 60 percent of the States in the first year and in which the plan is offered, 65 percent of such States in the second year, 75 percent of such States in the third year, and 80 percent of such States in the fourth year, and 80 percent of such States in the fifth and subsequent years;

(F) the plan shall meet all requirements of this title in each State in the fifth and subsequent years;

(G) the plan may not be subject to all the laws and regulations of the State in which such plan is offered.

(h) PROVIDE COVERAGE.—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include the essential benefits package described in section 1302.

(7) STATE LAW MANDATING BENEFIT COVERAGE BY A HEALTH BENEFITS PLAN.—For the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific services or specific diseases. A law that mandates health insurance coverage or reimbursement for services by certain carriers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

(a) IN GENERAL.—Each State shall, not later than January 1, 2011—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subparagraph (A) of section 1322(d) for the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific services or specific diseases. A law that mandates health insurance coverage or reimbursement for services by certain carriers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

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

(b) Model Regulation.—

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

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

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health plans described in subparagraph (A) that cover high-risk individuals in the individual market that has in effect under section 1321(b) the provisions described in subparagraph (A) of section 1322(d) for the purposes of this subsection, a State law mandating benefit coverage by a health plan is a law that mandates health insurance coverage or the offer of health insurance coverage for specific services or specific diseases. A law that mandates health insurance coverage or reimbursement for services by certain carriers of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a State law mandating benefit coverage by a health benefits plan.

(2) HIGH-RISK INDIVIDUAL PAYMENT AMOUNTS.—The Secretary shall include the following in the provisions under paragraph (1):—

(A) Determination of High-Risk Individuals.—The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) Payment Amount.—The formula for determining the amount that will be paid to health insurance issuers described in paragraph (1)(A) that insure high-risk individuals. Such formula shall provide for the distribution of funds through reconciliation and may be designed—
(1) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or

(ii) any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care management and care management programs for high risk conditions.

(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.—

(A) IN GENERAL.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health plan or the reinsurance program described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph and any plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) SPECIFIC REQUIREMENTS.—The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer’s fully insured commercial book of business for all major medical products and the total value of all claims by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (i), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning in 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iii) in addition to the aggregate contribution amounts under clause (iii), each issuer’s contribution amount for any calendar year under clause (iii) reflects its proportionate share, based on the ratio of the total amount that would be required under clause (iv) to the total amount that should be required to satisfy the provisions of this section, of all contributions to be deposited into the general State in the individual market in effect in the State in the individual market in effect in such State for such year that are not self-insured small group health plans.

(C) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan’s allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount;

(B) a participating plan’s allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) if—

(A) a participating plan’s allowable costs for any plan year are less than 92 percent but not less than 97 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan’s allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs.

(2) HIGH ACTUARIAL RISK PLANS.—Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in plans and coverage in such State for such year that are not self-insured small group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) CRITERIA AND METHODS.—The Secretary, in consultation with the NAIC, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 1321.

(c) SCOPE.—A health plan or a health insurance issuer is described in this subsection if such plan or issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to such plan.

Subtitle K—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-Sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by adding after section 36A the following new section:

"SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

"(1) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the applicable taxpayer for the taxable year for which the taxpayer elects to claim the credit under this section.

"(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

"(1) Planning and Analysis.
‘‘(1) In general.—The term ‘premium assistance credit amount’ means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) for the taxable year.

‘‘(2) Premium assistance amount.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

‘‘(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State in which the taxpayer resides; or

‘‘(B) the excess (if any) of—

‘‘(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

‘‘(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer’s household income for the taxable year.

‘‘(3) Other terms and rules relating to premium assistance amounts.—For purposes of paragraph (2)—

‘‘(A) Applicable percentage.—

‘‘(i) In general.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to 60 percent of the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as the poverty line for a family of the size involved bears to the poverty line for a family of the size involved for the taxable year.

‘‘(ii) Special rule for taxpayers under 133 percent of poverty line.—If a taxpayer’s household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer’s applicable percentage shall be 2 percent.

‘‘(B) Indexing.—In the case of taxable years beginning after calendar years 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i) and the 2 percent under clause (ii), for the calendar year in which the tax rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

‘‘(2) Applicable second lowest cost silver plan.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

‘‘(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (1)(A) were offered, and

‘‘(ii) provides—

‘‘(I) self-only coverage in the case of an applicable taxpayer

‘‘(aa) whose tax for the taxable year is determined under section 1(c) (relating to unincorporated entity other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

‘‘(bb) who is not described in item (aa) but who purchases only self-only coverage, and

‘‘(II) family coverage in the case of any other applicable taxpayer

‘‘If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (i)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than the spouse and subsection (e) does not apply to the dependent.

‘‘(C) Adjusted monthly premium.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the taxable year) to the taxpayer by the plans determined under paragraph (2)(A) were determined for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under subsection 2701 of the Public Health Service Act.

In the case of a State participating in the wellness discount demonstration project under section 2701(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

‘‘(D) Application of percentage.—

‘‘(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits prescribed by the Secretary and the plan’s share of the total allowed costs of services required to be provided by the plan, or

‘‘(ii) a State requires a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section (that is, under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits prescribed by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

‘‘(E) Special rule for pediatric dental coverage.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(i) or (ii) of the Patient Protection and Affordable Care Act for any plan year, the amount of the premium for the plan described in such section (that is, under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits prescribed by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

‘‘(F) Definition of applicable taxpayers, coverage months, and qualified health plan.—For purposes of this section—

‘‘(1) Applicable taxpayer.—

‘‘(A) In general.—The term ‘applicable taxpayer’ means, with respect to any taxable year, a taxpayer whose household income for the taxable year exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

‘‘(B) Special rule for certain individuals lawfully present in the United States.—If—

‘‘(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved,

‘‘(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer for purposes of this section (unless a deduction under section 151 is allowable to an other taxpayer for a taxable year beginning in the calendar year in which such individual taxable year begins to any degree under subsection (a) of section 151 that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act).

‘‘(2) Exemption for minimum essential coverage.—

‘‘(A) In general.—The term ‘coverage month’ shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage or other coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

‘‘(B) Exception for minimum essential coverage.—The term ‘minimum essential coverage’ has the meaning given in section 5000A(f)(2) and consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

‘‘(ii) the employee’s required contribution with respect to the coverage (as defined in section 5000A(a)(1)) with respect to which the premium exceeds 9.8 percent of the applicable taxpayer’s household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

‘‘(ii) Coverage must be affordable.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

‘‘(i) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

‘‘(ii) the employee’s required contribution with respect to the coverage (as defined in section 5000A(a)(1)) with respect to which the premium exceeds 9.8 percent of the applicable taxpayer’s household income.

‘‘(iii) Employer or family must not be covered under employer plan.—Clauses (i) and (ii) shall not be applied if the employee or any individual described in the last sentence of clause (i) is covered under an eligible employer-sponsored plan or the grandfathersed health plan.

‘‘(iv) Indexing.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent taken into account under clause (i)(II) as if the percentages are adjusted under subsection (b)(3)(A)(ii).
[ snip ]

"(b) MODIFIED GROSS INCOME.—The term 'modified gross income' means gross income—

(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (18) of section 62, or

(ii) increased by the amount of any interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

(iii) determined without regard to sections 911, 931, and 933.

(3) POVERTY LINE.—

(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 216(c) of the Social Security Act (42 U.S.C. 1397c(c)5).

(B) TYPICAL USE.—In the case of any qualified health plan offered through an Exchange during a taxable year beginning in a calendar year, the poverty line will be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(C) LIMITATIONS ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

(1) IN GENERAL.—In the case of an applicable taxpayer whose adjusted gross income is less than 400 percent of the poverty line for the family size involved for the taxable year, the amount of the increase under sub-paragraph (A) shall in no event exceed $50 (in the case of a single individual) or $100 (in the case of a married individual or a spouse). The amount of any decrease under this subparagraph shall be applied against such increase.

(2) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

(I) such dollar amount multiplied by—

(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof.

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

(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 32(b) of title 31, United States Code, is amended by inserting—

"36B", after "36A,".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:—

"Sec. 36B. Refundable credit for coverage under a qualified health plan.''

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—In the case of an eligible insured enrolled in a qualified health plan—

(I) the Secretary shall notify the issuer of the plan of such eligibility; and

(II) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c), (d), or (e).

(b) ELIGIBLE INSURED.—In this section, the term "eligible insured" means an individual who enrolled in a qualified health plan in the silver level of coverage in the individual marketplace offered through an Exchange; and
or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan described in section 1311(d)(2)(B)(i)(1) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (d) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(b) APPLICABILITY TO OTHER PLANS.—(1) IN GENERAL.—An issuer of a qualified health plan to which this section applies shall take into account the value of periodic and timely payments to the issuer of the plan made by the Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed on the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian Tribe, Tribal Organization, or Urban Indian Organization for the payment to any such entity for such item or service.

(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—(A) IN GENERAL.—The reduction in cost-sharing under this section shall not be achieved by reducing the applicable out-of-pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by one-half; and

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-third.

(2) ADJUSTMENT.—The Secretary shall adjust the out-of-pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(d) ADJUSTMENT TO REDUCE FEE-SHARING.—Any term used in this section shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(A) 90 percent in the case of an eligible insured described in paragraph (2)(A);

(B) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(C) 70 percent in the case of an eligible insured described in clause (II) or (III) of subparagraph (A).

(e) LIMITATION ON REDUCTION.—(1) IN GENERAL.—(i) A method under which—

(A) no cost-sharing reduction under this section shall apply with respect to the individual responsibility requirement for essential health benefits; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(I) a method under which—

(A) the taxpayer's family size is determined by not taking such individuals into account, and

(B) the amount of the tax credit or reduced cost-sharing;

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to clause (I), and

(2) LAWFULLY PRESENT.—(A) METHOD.—For purposes of this section, an individual shall be treated as lawfully present if such individual is on the basis of the taxable year for which the determination under this section is made lawfully present in the United States or an alien lawfully present in the United States.

(3) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this section. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

(4) ADDITIONAL BENEFITS.—If a qualified health plan provides additional benefits in addition to the essential health benefits required to be provided by the plan, or the plan is treated as an integrated health plan for purposes of section 1311(d)(3)(B), any such benefit shall be treated as essential health benefits for purposes of this section.

(5) DETERMINATION OF REDUCTION IN COST-SHARING.—(A) IN GENERAL.—(i) A method under which—

(A) no cost-sharing reduction under this section shall apply with respect to the individual responsibility requirement for essential health benefits; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(I) a method under which—

(A) the taxpayer's family size is determined by not taking such individuals into account, and

(B) the amount of the tax credit or reduced cost-sharing;
plan (in this subsection referred to as an "enrollee"); and
(B) the information required by any of the following paragraphs that is applicable to an enrollee.
(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:
(A) if the enrollee is an individual whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee’s social security number;
(B) in the case of an individual whose eligibility is based on an attestation of the enrollee’s immigration status, the enrollee’s immigration status, the enrollee’s social security number;
(C) the name, date of birth, and social security number of the enrollee, the enrollee’s immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate;
(D) verification of information contained in records of specific federal official.
(1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) for verification in accordance with the requirements of this subsection and subsection (d).
(C) VERIFICATION OF INFORMATION.—
(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
(ii) The attestation of an individual that the individual is a citizen.
(B) SECRETARY OF HOMELAND SECURITY.—
(i) In general.—In the case of an individual who:
(A) attests that the individual is a citizen; or
(B) is a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.
(B) in the case of an individual seeking exemption based on the lack of affordable coverage or the individual’s status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.
(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIAL.—
(1) INFORMATION.—
(A) The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
(ii) The attestation of an individual that the individual is a citizen.
(B) SECRETARY OF HOMELAND SECURITY.—
(i) In general.—In the case of an individual who:
(A) attests that the individual is a citizen; or
(B) is a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.
(B) in the case of an individual seeking exemption based on the lack of affordable coverage or the individual’s status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.
(2) CITIZENSHIP OR IMMIGRATION STATUS.—
(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
(ii) The attestation of an individual that the individual is a citizen.
(B) SECRETARY OF HOMELAND SECURITY.—
(i) In general.—In the case of an individual who:
(A) attests that the individual is a citizen; or
(B) is a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.
(B) in the case of an individual seeking exemption based on the lack of affordable coverage or the individual’s status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.
(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIAL.—
(1) INFORMATION.—
(A) The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
(ii) The attestation of an individual that the individual is a citizen.
(B) SECRETARY OF HOMELAND SECURITY.—
(i) In general.—In the case of an individual who:
(A) attests that the individual is a citizen; or
(B) is a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.
(B) in the case of an individual seeking exemption based on the lack of affordable coverage or the individual’s status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.
(2) CITIZENSHIP OR IMMIGRATION STATUS.—
(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
(ii) The attestation of an individual that the individual is a citizen.
(B) SECRETARY OF HOMELAND SECURITY.—
(i) In general.—In the case of an individual who:
(A) attests that the individual is a citizen; or
(B) is a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.
(B) in the case of an individual seeking exemption based on the lack of affordable coverage or the individual’s status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.
(2) CITIZENSHIP OR IMMIGRATION STATUS.—
(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).
(ii) The attestation of an individual that the individual is a citizen.
(B) SECRETARY OF HOMELAND SECURITY.—
(i) In general.—In the case of an individual who:
(A) attests that the individual is a citizen; or
(B) is a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.
(B) in the case of an individual seeking exemption based on the lack of affordable coverage or the individual’s status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.
(1) Reasonable Effort.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors. The Exchange shall act to promptly verify the Applicant's statement to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may prescribe.

(ii) Notice and Opportunity to Correct.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall:

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence or resolve the inconsistency with the information the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under subclause (II) for enrollments occurring during 2014.

(B) Specific Actions Not Involving Citizenship or Lawful Presence.—

(i) In General.—Except as provided in paragraph (3), the Exchange shall, during any period during which the period under subparagraph (A)(i)(II) make any determination under paragraphs (2), (3), and (4) of subsection (c) or (d) during the 90-day period, the information contained on the application.

(ii) Eligibility or Amount of Credit or Reduction.—If an inconsistency involving the eligibility for, or amount of, any premium tax credit or cost-sharing reduction is unresolved under this subsection as of the close of the period under subparagraph (A)(i)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined on the basis of the records maintained by persons under subsection (c).

(iii) Employer Affordability.—If the Secretary notifies an Exchange that an enrollee is eligible for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 because the enrollee's (or related individual's) employer does not provide minimum essential coverage under section 1402, the Exchange shall notify the applicant that no certification of exemption from any requirement or payment under section 5000A of such Code will be issued.

(iv) Determination Process.—The Exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

(C) Appeals and Redeterminations.—

(i) In General.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal Officers—

(A) hears and makes decisions with respect to applications for any determination under subsection (e); and

(B) redetermines eligibility on a periodic basis in appropriate circumstances.

(ii) Notices and Determinations.—

(A) In General.—The Secretary shall establish a separate appeals process for employers who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan, or that the employer does provide that coverage but it is not affordable coverage with respect to an employee. Such process shall provide an employer the opportunity to—

(I) present information to the Exchange for review of the determination either by the Exchange or the person making the determination, including evidence of the employer-sponsored plan and employer contributions to the plan; and

(II) have access to the data used to make the determination to the extent allowable by law.

Such process shall be in addition to any rules of appeal the employer may have under subtitle F of such Code.

(B) Confidentiality.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer's return information shall be shared with the person verifying the information under subsection (b)(5) on the basis of the records maintained by persons under subsection (c). The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(C) Confidentiality of Applicant Information.—

(i) In General.—An applicant for insurance coverage or for a premium tax credit or cost-sharing reduction shall be required to provide only the information strictly necessary to determine eligibility, and determine the amount of the credit or reduction.

(ii) Receipt of Information.—Any person who receives information by a person receiving notice under this section, or receives information from a Federal agency under subsection (c), shall—

(A) use the information only for the purposes, and to the extent necessary in, ensuring the efficient operation of the Exchange, including verifying the eligibility of an individual to enroll through an Exchange or to claim a premium tax credit or cost-sharing reduction; and

(B) not disclose the information to any other person except as provided in this section.

(D) Penalties.—

(i) False or Fraudulent Information.—

(A) Civil Penalties.—

(I) In General.—If—

(I) any person fails to provide correct information under subsection (b); and

(II) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, such person shall be subject, in addition to any other penalties that may be prescribed in subchapter H of chapter 44 of title 26, to a penalty of not more than $25,000 with respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms "negligence" and "disregard" shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(ii) Imprudent Use or Disclosure of Information.—Any person who knowingly and willfully provides false or fraudulent information under such section (b) shall be subject to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(ii) Improper Use or Disclosure of Information.—Any person who knowingly and willfully uses or discloses information in violation of subsection (c) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(E) Limitations on Liens and Levies.—The Secretary (or, if applicable, the Attorney General of the United States) shall not—

(A) file notice of lien with respect to any property of a person because of any failure to pay the penalty imposed by this subsection; or

(B) levy on any such property with respect to such failure.

(F) Study of Administration of Employer Responsibilities.—

(i) In General.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of this title and section 4980H of the Internal Revenue Code of 1986 (as added by section 1513) that the following rights are protected:

(ii) The rights of employers to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified health plan through an Exchange if an employer does not provide affordable coverage.

(G) The rights of employers to adequate due process and access to information necessary to accurately determine any payment assessed on employers.

(2) Report.—Not later than January 1, 2013, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance, Ways and Means of the House of Representatives, and the Committees of Education and Labor and Ways and Means of the Senate.
(i) the employer did not provide minimum essential coverage; or
(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(7)(C) of such Code that it would be unaffordable to the employee or not provided the required minimum actuarial value; and
(iii) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce premiums payable by individuals eligible for such credit.

(b) ADVANCE DETERMINATION.—

(1) IN GENERAL.—The Secretary shall provide for the second preceding taxable year.

(2) C HANGES IN CIRCUMSTANCES .—The Secretary shall ensure that if an individual applying to participate in a data matching arrangement under paragraph (2) or (3) shall receive assistance from an applicable State health subsidy programs.

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary shall provide procedures for making advance determinations of the basis for the most recent taxable year for which the Secretary, after consultation with the Secretary of the Treasury, determines the determination is available.

(2) C HANGES IN CIRCUMSTANCES .—The Secretary shall provide for the second preceding taxable year.

(c) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined eligibility determination form—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable subsidy programs; and

(iv) is structured to maximize an applicant’s ability to complete the form satisfactorily, taking into account the characteristics of income and other information for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—

A State may develop and use its own single, streamlined eligibility determination form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(D) NO FEDERAL PAYMENTS FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

No Federal payments for individuals who are not lawfully present in the United States.

(E) NO FEDERAL PAYMENTS FOR INDIVIDUALS IN THE COUNTRY FROM MAKING PAYMENTS TO OR ON BEHALF OF AN INDIVIDUAL FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN OFFERED THROUGH AN EXCHANGE THAT ARE IN ADDITION TO ANY CREDITS OR COST-SHARING REDUCTIONS ALLOWABLE TO THE INDIVIDUAL UNDER THIS SUBTITLE AND SUCH AMENDMENTS.

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE OR STATE HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange is found through screening to be eligible for participation in the State mediicaid plan under title XIX, or eligible for enrollment under a State children’s health insurance program (CHIP) under title XXI of such Act, the individual is enrolled for assistance under such plan or program.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined eligibility determination form—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable subsidy programs; and

(iv) is structured to maximize an applicant’s ability to complete the form satisfactorily, taking into account the characteristics of income and other information for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—

A State may develop and use its own single, streamlined eligibility determination form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income.

(2) SECRETARIAL STANDARDS .—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(1) AGREEMENTS.—Subject to section 1411 and section 6109(e)(21) of the Internal Revenue Code of 1986 and any other requirement pertaining to data safeguards and integrity, the Secretary may establish model agreements, and enter into agreements, for the sharing of data under this section.

(2) NO CONTRACT OUT.—Nothing in this section shall be construed to—
(a) prohibit contractual arrangements through which a State Medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency satisfies, with the Secretary of Health and Human Services, requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(b) impose any requirement under title XIX that eligibility for participation in a State’s Medicaid program must be determined on a predictable basis.

c) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term “applicable State health subsidy program” means—

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State Medicaid program under title XIX of such Act; and

(3) a State children’s health insurance program (CHIP) under title XXI of such Act.

(d) State program described in subparagraph (A) or to a State agency administering a program, or to a State agency administering a program and Affordable Care Act or its contractor, or to the State Medicaid agency administering a State program under subsection (c)(1) or its contractor, any inconsistency between the information provided by the Exchange or State agency to the Secretary and the information provided to the Secretary under paragraph (A).

(c) RESTRICTION ON USE OF DISCLOSED INFORMATION.—

(1) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Subsection (A) of section 1321(b) of the Patient Protection and Affordable Care Act, and any regulations promulgated under such subsection, shall not apply to information disclosed under subsection (A) or (B) by the Secretary of Health and Human Services, or any State or local program financed in whole or in part with Federal funds—

(2) to any State or local program, or an exchange, or a State agency only for the purposes of, and to the extent necessary in—

(i) establishing eligibility for participation in the Exchange and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

(ii) determining eligibility for participation in the State programs described in subparagraph (A)."

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

"(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the program and the amendments made by, the act."

(b) CONFIDENTIALITY AND DISCLOSE DISCLOSURE AND RECORDKEEPING RELATING TO DISCLOSURES.—

(4) Section 1402 includes, with respect to the applicable program, the provisions of—

"(1) the program under title XXI of the Social Security Act, the Department of Health and Human Services, shall disclose to the Secretary of Health and Human Services, or any State or local program, or an exchange, or a State agency only for the purposes of, and to the extent necessary in—

(1) establishing eligibility for participation in the Exchange and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

(2) determining eligibility for participation in the State programs described in subparagraph (A)."

(c) PROCEDURES AND RECORDKEEPING RELATING TO DISCLOSURES.—

Paragraph (4) of section 1402 includes, with respect to the applicable program, the provisions of—

(1) the program under title XXI of the Social Security Act, the Department of Health and Human Services, shall disclose to the Secretary of Health and Human Services, or any State or local program, or an exchange, or a State agency only for the purposes of, and to the extent necessary in—

(1) establishing eligibility for participation in the Exchange and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

(2) determining eligibility for participation in the State programs described in subparagraph (A)."

(d) AUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking “(20)” and inserting “(20), (21)”.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—

(1) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Subsection (A) of section 1321(b) of the Patient Protection and Affordable Care Act, and any regulations promulgated under such subsection, shall not apply to information disclosed under subsection (A) or (B) by the Secretary of Health and Human Services, or any State or local program financed in whole or in part with Federal funds—

(2) to any State or local program, or an exchange, or a State agency only for the purposes of, and to the extent necessary in—

(i) establishing eligibility for participation in the Exchange and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

(ii) determining eligibility for participation in the State programs described in subparagraph (A)."

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

"(x) The Secretary of Health and Human Services, and the Exchanges established under section 1311 of the Patient Protection and Affordable Care Act, are authorized to collect and use the names and social security account numbers of individuals as required to administer the program and the amendments made by, the act."

(b) CONFIDENTIALITY AND DISCLOSE DISCLOSURE AND RECORDKEEPING RELATING TO DISCLOSURES.—

(4) Section 1402 includes, with respect to the applicable program, the provisions of—

"(1) the program under title XXI of the Social Security Act, the Department of Health and Human Services, shall disclose to the Secretary of Health and Human Services, or any State or local program, or an exchange, or a State agency only for the purposes of, and to the extent necessary in—

(1) establishing eligibility for participation in the Exchange and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

(2) determining eligibility for participation in the State programs described in subparagraph (A)."

(c) PROCEDURES AND RECORDKEEPING RELATING TO DISCLOSURES.—

Paragraph (4) of section 1402 includes, with respect to the applicable program, the provisions of—

(1) the program under title XXI of the Social Security Act, the Department of Health and Human Services, shall disclose to the Secretary of Health and Human Services, or any State or local program, or an exchange, or a State agency only for the purposes of, and to the extent necessary in—

(1) establishing eligibility for participation in the Exchange and verifying the appropriate amount of, any credit or reduction described in subparagraph (A),

(2) determining eligibility for participation in the State programs described in subparagraph (A)."

(d) AUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking “(20)” and inserting “(20), (21)”.

SEC. 1415. PREMIUM TAX CREDIT AND COST-SHARING REDUCTIONS FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or any State program under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing reduction payment or advance payment of the credit allowed under section 36B of the Internal Revenue Code of 1986 (as added by section 1401) shall be treated as made to the qualified health plan in which an individual is enrolled and not to that individual.

PART II—SMALL BUSINESS TAX CREDIT

SEC. 1421. CREDIT FOR EMPLOYEE HEALTH INSURANCE SUBSIDIES EXPENSES OF SMALL BUSINESSES.

(a) In General.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

"SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

(A) IN GENERAL.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this section for any taxable year in the credit period is the amount determined under subsection (b).

(B) LIMITATION.—

Subject to subsection (c), the amount determined under subsection (b) with respect to any eligible small employer shall not exceed 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

(1) the aggregate amount of nonelective contributions which the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for qualified health plans offered by the employer to its employees through an Exchange, or

(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the rating area in which the employee enrolls for coverage.

(C) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF FULL-TIME EQUIVALENT EMPLOYEES FOR SMALL GROUP MARKET.—The amount of the credit determined under subsection (b) without regard to paragraph (1) shall be reduced (but not below zero) by the sum of the following amounts:

(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d) for the taxable year, and the denominator of which is 15.

(D) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

(1) In General.—The term ‘eligible small employer’ means, with respect to any taxable year, an employer—

(A) which has no more than 25 full-time equivalent employees for the taxable year,

(B) the average annual wages for which do not exceed an amount equal to twice the dollar amount in effect under subsection (d) for the taxable year, and

(C) which has in effect an arrangement described in paragraph (4).

(E) FULL-TIME EQUIVALENT EMPLOYEES.—

For purposes of this section—

(1) Full-time equivalent employees means a number of employees equal to the number determined by dividing—

(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

(ii) the number of hours an employee would be expected to work in the taxable year if the employee worked full-time, and

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

(2) Excess Hours Not Counted.—If an employee works in excess of 2,080 hours of service during any taxable year, such excess shall not be taken into account in determining the dollar amount in effect under subsection (d) for the taxable year, and

(3) Hours of Service.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the number of hours of service of an employee, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

(4) Average Annual Wages.—

(A) In General.—The average annual wages of an eligible small employer for any
taxable year is the amount determined by dividing—

(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(A),—

(i) 2011, 2012, and 2013.—The dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $20,000.

(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be increased by the credit-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.

(C) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonforegone contribution on behalf of each employee who enrolls in a qualified health plan on terms which provide for the employment of more than 120 days during the taxable year.

(3) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

(A) IN GENERAL.—The number of hours of service worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer unless the work is performed on more than 120 days during the taxable year.

(B) DEFINITION OF SEASONAL WORKER.—The term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 500(b)(5) of the Fair Labor Standards Act of 1938, Code of Federal Regulations and retail workers employed exclusively during holiday seasons.

(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

(1) EMPLOYEE.—

(A) IN GENERAL.—The term ‘employee’ shall not include—

(i) any employee within the meaning of section 401(c)(1),

(ii) any 2-percent shareholder (as defined in section 412(g)(1)) of an eligible small business corporation,

(iii) any 5-percent owner (as defined in section 416(l)(1)(B)(ii) of the Internal Revenue Code of 1986),

(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent of a section 15(2d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

(B) LEASED EMPLOYEES.—The term ‘employee’ shall include a leased employee with in the meaning of section 414(l)(1)(A).

(2) CREDIT PERIOD.—The term ‘credit period’ means, with respect to an eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health plans to its employees through an Exchange.

(b) DEFINITION OF ELIGIBLE SMALL EMPLOYER.—The term ‘eligible small employer’ means—

(A) an employee within the meaning of section 3121(a),

(B) the term ‘employee’ shall not include—

(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer,

(ii) amounts required to be withheld from such employees under section 301(a), and

(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 301(a).

(C) PAYROLL TAXES.—For purposes of this subsection—

(A) IN GENERAL.—The term ‘payroll taxes’ means—

(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer,

(ii) the number of full-time equivalent employees and average annual wages of the employer during the calendar year in which the tax-exempt eligible small employer incurs in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

(1) IN GENERAL.—The amendments made by section 1301(c) of the Patient Protection and Affordable Care Act, or for which credit allowed), as amended by section 146(b), is amended by adding at the end the following new paragraph:

(14) the small employer health insurance credit determined under section 45R.

(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

Sec. 45R. Employee health insurance expenses of small employers.
are 26 to 30 percent of premiums in the current individual and small group markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase the scale of the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. This requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(3) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States held that insurance which is interstate commerce subject to Federal regulation.

(b) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end of the following new chapter:

"CHAPTER 48—MAINTENANCE OF
MINIMUM ESSENTIAL COVERAGE

Sec. 5000A. Requirement to maintain minimum essential coverage.

(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—An applicable individual shall for each month beginning after 2013 have minimum essential coverage with respect to such month.

(b) SHARED RESPONSIBILITY PAYMENT.—

(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

(2) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with the taxpayer’s return under chapter 1 for the taxable year which includes such month.

(c) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section fails to pay the entire amount of such penalty at the time such return is filed, the Internal Revenue Service may impose a late payment penalty on such amount.

(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term ‘applicable individual’ means, with respect to any month, any individual who is an applicable individual under section 1402(g)(1) for such month.

(2) FAMILY SIZE.—The family size in determining the taxpayer’s family size under section 151 (relating to allowance of deductions for personal exemptions) shall be determined by substituting ‘calendar month’ for ‘calendar year’ in section 151 for the month in which the penalty is imposed.

(3) HOUSEHOLD INCOME.—The term ‘household income’ is defined in section 62(1).

(4) TERMS RELATING TO INCOME AND FAMILY SIZE.—For purposes of this section—

(1) IN GENERAL.—The term ‘applicable individual’ means, with respect to any month, any individual who is an applicable individual under section 1402(g)(1) for such month.

(2) FILING TAX RETURN.—If an applicable individual has not filed a return for the taxable year to which the penalty is applicable, the Secretary shall not impose a penalty for such taxable year for such failure to file a return.

(3) AMOUNT OF PENALTY.—

(a) IN GENERAL.—The penalty determined under this subsection for any month with respect to any applicable individual is an amount equal to 1⁄12 of the applicable dollar amount for the calendar year.

(b) DOLLAR LIMITATION.—The amount of the penalty for the taxable year on any applicable individual under subsection (a) is the lesser of—

(1) the applicable dollar amount, or

(2) 1⁄12 of the amount determined under paragraph (1) for the calendar year.

(c) APPLICABLE INDIVIDUAL.—For purposes of this section—

(1) IN GENERAL.—The term ‘applicable individual’ means, with respect to any month, any individual who is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

(2) RELIGIOUS EXEMPTIONS.—

(a) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act that certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in such section.

(b) HEALTH CARE SHARING MINISTRY.—

(1) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.
“(1) Health care sharing ministry.—The term ‘health care sharing ministry’ means an organization—

(i) which is described in section 501(c)(3) and is exempt from taxation under section 501(a).

(ii) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

(iii) members of which retain membership even after they develop a medical condition,

(iv) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and

(v) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

(2) Individuals not lawfully present.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

(3) Incarcerated individuals.—Such term shall not include an individual for any month in which the individual is incarcerated, other than incarceration pending the disposition of charges.

(4) Exemptions.—No penalty shall be imposed under subsection (a) with respect to—

(i) individuals who cannot afford coverage to which they are entitled through an eligible employee-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(ii) in the case of an individual eligible to purchase minimum essential coverage consisting of a qualified health plan through an eligible employee-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(iii) in the case of an individual eligible to purchase minimum essential coverage consisting of a qualified health plan through an eligible employee-sponsored plan, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

(iv) in the case of an eligible employee-sponsored plan, the portion of the annual premium for the lowest cost bronze plan available in the individual market through the Exchange in the State in the rating area in which the individual resides (without regard to whether the individual purchased a qualified health plan through the Exchange), reduced by the amount of the credit available under section 36B of the Internal Revenue Code for the taxable year (determined as if the individual were covered by a qualified health plan offered through the Exchange for the entire taxable year).

(C) Special rules for individuals related to employers.—For purposes of subparagraph (B)(i), if an applicable individual is eligible for minimum essential coverage through an employer by reason of a relationship to an employee, the determination shall be made by reference to the affordability of the coverage to the employee.

(2) Indexing.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall prescribe rules for the indexing of coverage under an eligible employer-sponsored plan means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is—

(A) a governmental plan (within the meaning of section 2791(d)(8) of the Public Health Service Act); or

(B) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan as defined in paragraph (1)(D) offered in a group market.

(3) Exceptional benefits not treated as minimum essential coverage.—The term ‘minimum essential coverage’ shall not include health insurance coverage which consists of coverage of excepted benefits.

(4) Reporting of health insurance coverage.—(A) described in paragraph (1) of subsection (b) of section 2791 of the Public Health Service Act; or

(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(5) Individuals residing outside United States or residents of territories.—Any applicable individual shall be treated as having minimum essential coverage for any month if—

(A) in such month occurs during any period described in subparagraph (A) or (B) of section 981(d)(1) which is applicable to the individual, or

(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 937(a)) for such month.

(D) Insurance-related terms.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning and used in such title.

(E) Administration and procedure.—

(1) In general.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter B of chapter 68.

(2) Special rules.—Notwithstanding any other provision of law, the waiver of criminal penalties.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

(B) Limitations on liens and levies.—The Secretary shall not—

(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section,

(ii) levy on any such property with respect to such failure,”

(c) Clerical Amendment.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

“Chapter 48—Maintenance of minimum essential coverage.”

(d) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

SEC. 1502. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) In general.—(A) Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:
"Subpart D—Information Regarding Health Insurance Coverage

Sec. 6055. Reporting of health insurance coverage

(a) In General.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

(b) Form and Manner of Return.—

(1) In general.—A return is described in this section if it—

(A) is in such form as the Secretary may prescribe, and

(B) contains—

(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy,

(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year,

(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

(I) whether or not the coverage is a qualified health plan offered through an Exchange established under title I of Part II of the Patient Protection and Affordable Care Act, and

(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

(iv) such other information as the Secretary may require.

(2) Information relating to employer-provided coverage.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

(A) the name, address, and employer identification number of the employer maintaining the plan,

(B) the portion of the premium (if any) required to be paid by the employer, and

(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 36B (relating to credit for employee health insurance expenses of small employers).

(c) Statements to Be Furnished to Individuals With Respect to Whom Information Is Reported.—

(1) In general.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(A) the address of the person required to make such return and the phone number of the information contact for such person, and

(B) the information required to be shown on the return with respect to such individual.

(2) Time for furnishing statements.—The written statements required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(d) Coverage Provided by Governmental Units.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the employer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

(e) Minimum Essential Coverage.—For purposes of this section, the term 'minimum essential coverage' has the meaning given such term by section 5000A(f).''.

(b) Assumptions.—

(1) Subparagraph (b) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking 'or' at the end of striking 'and' at the end of clause (xxii) and inserting 'and' in the next clause (xxiii) the following new clause (xxiv):—

(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage),''.

(2) Paragraph (2) of section 6724(d) of such Code is amended by amending striking ‘or’ at the end of subparagraph (EE), by striking the period at the end of subparagraph (FF) and inserting ‘; or’ and by inserting after subparagraph (GG) the following new subparagraph:—

(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage),''.

(c) Notification of Nonenrollment.—Not later than June 30 of each year, the Secretary of the Treasury, acting through the Director of the Internal Revenue Service, shall send a notification to each employer of an individual income tax return and who is not enrolled in minimum essential coverage (as defined in section 5000A of the Internal Revenue Code of 1986). Such notification shall contain information on the services available through the Exchange operating in the State in which such individual resides.

(d) Conforming Amendment.—The table of compromises promulgated by the Secretary, an employer to publicize the availability of an Exchange, including a description of the services provided by such Exchange, and the manner in which the employee may contact the Exchange to request assistance; and

(2) if the employer plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs, the employer credit for a premium tax credit under section 36B of the Internal Revenue Code of 1986 and a cost sharing reduction under section 1402 of the Patient Protection and Affordable Care Act if the employee purchases a qualified health plan through the Exchange; and

(3) if the employee purchases a qualified health plan through the Exchange, the employer will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

(e) Effective Date.—Subsection (a) shall take effect with respect to employers in a State for calendar years beginning on or after January 1, 2013.

SEC. 1513. Shared Responsibility for Employers.

(a) In General.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 4980H. Shared responsibility for employers regarding health coverage.

(a) Large Employers Not Offering Health Coverage.—If—

(1) any applicable large employer fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

(b) Large Employers With Waiting Periods Exceeding 30 Days.—

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

(c) Amount.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

(1) in the case of an extended waiting period which exceeds 30 days but does not exceed 60 days, $400, and

(2) in the case of an extended waiting period which exceeds 60 days, $600.

"Sec. 18A. Automatic enrollment for employers.

(a) In General.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding after the last sentence of section 5000A(f)(2) the following:

"(f) Definitions.—For purposes of this section—

(1) the term ‘automatic enrollment’ means any plan established, implemented, or continued in effect any standard or requirement relating to such employer-sponsored plan which this Act applies that has more than 200 full-time employees and that offers employees enrollment in 1 or more health benefits plan shall automatically enroll new full-time employees in one of the plans offered (subject to any waiting period authorized by law) and to continue the enrollment of current employees covered by such employer-sponsored plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee who elects not to enter into any such policy coverage for an individual or employee were automatically enrolled in. Nothing in this section shall be construed to prevent an Exchange, including a description of the services available through the Exchange operating in the State in which such individual resides.

(b) Amendments.—The amendments made by this section shall apply to calendar years beginning after 2013.
Public Health Service Act) which exceeds 30 days.

“(c) LARGE EMPLOYERS OFFERING COVERAGE.—With Employers Who Qualify for Premium Tax Credits or Cost-Sharing Reductions.—

“(1) IN GENERAL.—If—

“(A) an applicable large employer offers to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(1)),

“(B) or more full-time employees of the applicable large employer has been certified to the employer under section 1401 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee,

then there is hereby imposed on the employer an assessable payment equal to the product of the number of full-time employees of the applicable large employer described in subparagraph (B) for such month and 0.5 percent of the applicable payment amount.

“(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month that exceeds the product of the applicable payment amount and the number of individuals employed by the employer as full-time employees during such month.

“(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

“(1) APPLICABLE PAYMENT AMOUNT.—The term ‘applicable payment amount’ means—

“(i) such dollar amount, and

“(ii) the premium adjustment percentage (as defined in section 1402 of the Patient Protection and Affordable Care Act) for the calendar year.

“(B) ROUNDING.—If the amount of any increase under subparagraph (A) is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

“(2) OVERALL LIMITATION.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of the applicable large employer during such month.

“(3) DEFINITION OF SEASONAL WORKERS.—The term ‘seasonal worker’ means a worker who works during the preceding calendar year.

“(4) OTHER DEFINITIONS.—Any term used in this section which is also used in the Patient Protection and Affordable Care Act shall have the same meaning as when used in such Act.

“(f) ADMINISTRATION AND PROCEDURE.—

“(1) IN GENERAL.—Any assessable payment provided by this section shall be paid upon notice and demand by the Secretary, and shall be assessed and collected in the same manner as an assessable penalty under chapter 6B of this title.

“(2) TIME FOR PAYMENT.—The Secretary may prescribe such regulations of any assessable payment provided by this section as an annual, monthly, or other periodic basis as the Secretary may prescribe.

“(3) COLLECTION OF PAYMENTS.—The Secretary shall prescribe rules, regulations, or guidance for the repayment of any assessable payment (including interest) if such payment is based on the allowance or payment of an applicable premium tax credit or cost-sharing reduction with respect to an employee, such allowance or payment is subsequently disallowed or an assessable payment would not have been required to be made but for such allowance or payment.

“(b) CLERICAL AMENDMENT.—The table of sections for this title of the Code is amended by adding at the end the following new item:

“Sec. 4980H. Shared responsibility for employers regarding health coverage

“(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS’ WAGES.—

“(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether—

“(A) the number of full-time employees for each month during the calendar year the determination of whether such employee is an applicable large employer shall be based on the average number of such employees for the period of 12 consecutive calendar months that is reasonably expected such employer will employ on business days during the current calendar year.

“(3) PREDECESSORS.—Any reference in this subpart to any applicable large employer shall be a reference to any predecessor of such employer.
“(d) Coordination With Other Requirements.—To the maximum extent feasible, the Secretary may provide that—

(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

(2) in the case of an applicable large employer which is a governmental unit or any agency or instrumentality thereof, the provisions appropriately designated for purposes of this section shall make the returns and statements required by this section.

(d) Definitions.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.”.

(2) As a substitute for the second paragraph of section 7524(d)(1) of the Internal Revenue Code of 1986 (relating to definitions, as amended by section 1502, is amended by striking “or” at the end of clause (xxiv) and inserting “or”, and by inserting after clause (xxiv) the following new clause:

“(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and”.

(3) Paragraph (2) of section 6056(d) of such Code, as so amended, is amended by striking “or” at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting “or” and by inserting after subparagraph (GG) the following new subparagraph:

“(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).”.

(c) Conforming Amendment.—The table of sections for part D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end the following new item:

“Sec. 6056. Large employers required to report on health insurance coverage.”.

(d) Effective Date.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICIPATING QUALIFIED HEALTH PLANS.

(a) In General.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended—

(1) by striking “The term ‘qualified health plan’” and inserting “For purposes of this section,”

(2) by striking “The term ‘qualified health plan’” and inserting “The term ‘qualified benefit’ shall not include”.

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2013.

Subtitle G—Miscellaneous Provisions

SECTION 1551. DEFINITIONS.

Unless specifically provided for otherwise, the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-21) shall apply with respect to this title.

SECTION 1552. TRANSPARENCY IN GOVERNMENT.

Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall publish on the Internet website of the Department of Health and Human Services, a list of all of the insurers provided to the Secretary under this Act (and the amendments made by this Act).

SECTION 1553. PROHIBITION AGAINST DISCRIMINA-

TION ON ASSISTED SUICIDE.

(a) In General.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or an amendment made by this Act), or any health care plan created under this Act (or an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis of the belief that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) Definition.—In this section, the term ‘health care entity’ includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(c) Construction and Treatment of Certain Services.—Nothing in subsection (a) shall be construed to apply to, or to affect, any limitation relating to—

(1) the withholding or withdrawing of medical treatment, or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) Administration.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section.

SECTION 1554. ACCESS TO THERAPIES.

Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall not promulgate any regulation that—

(1) creates any unreasonable barriers to the ability of individuals to obtain appropriate medical care;

(2) impedes timely access to health care services;

(3) interferes with communications regarding a full range of treatment options between the patient and his or her health care provider; or

(4) restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;

(5) violates the principles of informed consent and the ethical standards of health care professional conduct;

(6) limits the availability of health care treatment for the full duration of a patient’s medical needs.

SECTION 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

SEC. 1555. FREEDOM NOT TO PARTICIPATE IN FEDERAL HEALTH INSURANCE PROGRAMS.

(a) In General.—No individual, company, business, non-profit entity, or health insurance issuer offering group or individual health insurance coverage shall be required to participate in the Federal health insurance program created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any amendments made by this Act), unless specifically provided for otherwise.

(b) Effective Date.—The amendments made by this section shall apply with respect to any such amendments, and there shall be no penalty or fine imposed upon any such issuer for choosing not to participate in such programs.

SECTION 1556. EQUITY FOR CERTAIN ELIGIBLE SUR-

VIVORS.

(a) Rebuttable Presumption.—Section 4116(c)(4) of the Black Lung Benefits Act (30 U.S.C. 921(c)(4)) is amended by striking the last sentence.

(b) Coordination of Benefits.—Section 422(l) of the Black Lung Benefits Act (30 U.S.C. 922(l)) is amended by striking “, except with respect to a claim filed under this Act (or an amendment made by this Act) after December 31, 1991”.

(c) Effective Date.—The amendments made by this section shall apply with respect to a claim filed under such title VI, title IX, section 504, or such program created under this Act.

SECTION 1557. NONDISCRIMINATION.

(a) In General.—Except as otherwise provided in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1968 (42 U.S.C. 2000e et seq.), or title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794a), or section 504 of such amendment made by this Act, be subjected to discrimination under any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive agency or any other agency under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such program expanded by this Act shall apply for purposes of violations of this subsection.

(b) Continued Application of Laws.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved by acts under title VI of such Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (42 U.S.C. 611 et seq.), to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations.—The Secretary may promulgate regulations to implement this section.
**SEC. 18C. PROTECTIONS FOR EMPLOYEES.**

(a) **PROHIBITION.**—No employer shall discharge or in any manner discriminate against any employee with respect to his or her compensation, terms, conditions, or other privileges of employment because the employee (or an individual acting on the request of the employee) has—

(1) under section 383 of the Internal Revenue Code of 1986 or a subsidy under section 1402 of this Act;

(2) provided, caused to be provided, or is about to provide or cause to be provided, to the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission reasonably believed to be a violation of, any provision of this title (or an amendment made by this title);

(3) testified or is about to testify in a proceeding concerning such violation;

(4) assisted or participated, or is about to assist or participate, in such a proceeding;

or (5) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other person) reasonably believed to be in violation of any provision of this title (or amendment), or any regulation, standard, or order, under this title (or amendment).

(b) **COMPLAINT PROCEDURE.**—(1) In general—employee who believes that he or she has been discharged or otherwise discriminated against by any employer in violation of this section may seek relief in accordance with the procedures, notifications, burdens of proof, remedies, and statutes of limitation set forth in section 208(b) of title 15, United States Code.

(2) Rights. Nothing in this section shall be deemed to diminish the rights, privileges, or remedies of any employee under any Federal or State law or under any collective bargaining agreement. The rights and remedies in this section may not be waived by any agreement, policy, form, or condition of employment.

(c) **APPLICATION TO EMPLOYEES OF THE FEDERAL GOVERNMENT.**—Nothing in this title as it relates to such Department shall have any application to employees of the Federal Government.

**SEC. 1559. OVERSIGHT.**

The Inspector General of the Department of Health and Human Services shall have oversight authority with respect to the administration and implementation of this title and the HIT Standards Committee. The Inspector General may require such reports and information, and shall afford such opportunities for consultation, as may be necessary to ensure that the HIT Policy Committee and the HIT Standards Committee perform their responsibilities.

**SEC. 1560. RULES OF CONSTRUCTION.**

(a) **NO EFFECT ON ANTITRUST LAWS.**—Nothing in this title (or an amendment made by this title) shall be construed to modify any existing Federal requirement concerning the antitrust laws, or to increase eligibility for programs identified in section 1431.

(b) **SEC. 3021. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.**

(a) **IN GENERAL.**

(1) **STANDARDS AND PROTOCOLS.**—Not later than 180 days after the date of enactment of this title, the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee, shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in Federal and State health and human services programs, as determined by the Secretary.

(2) **METHODS.**—The Secretary shall facilitate enrollment in such programs through methods determined appropriate by the Secretary, which providing individuals and third parties authorized by such individuals and their designees notification of eligibility and verification of eligibility required under this title.

(b) **CONTENT.**—The standards and protocols for electronic enrollment in the Federal and State programs described in subsection (a) shall allow for one or more of the following:

(1) Electronic matching against existing Federal and State data, including vital records, electronic health history, enrollment systems, tax records, and other data determined appropriate by the Secretary to serve as evidence of eligibility and in lieu of paper-based documentation.

(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

(3) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

(4) Capabilities to apply, re-certify and manage their eligibility information online, including at home, at points of service, and other community-based locations.

(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volumes, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

**SEC. 1561. HEALTH INFORMATION TECHNOLOGY ENROLLMENT STANDARDS AND PROTOCOLS.**

(a) **APPLICATION.**—The Secretary shall award grant to eligible entities to develop new, and adapt existing, technology systems to implement the HIT enrollment standards and protocols developed under subsection (a) (referred to in this subsection as "appropriate HIT technology").

(b) **APPROPRIATE ENROLLMENT HI TS.**—To be eligible for a grant under this subsection, an entity shall—

(1) be a State, political subdivision of a State, or a local governmental entity; and

(2) submit to the Secretary an application at such time, in such manner, and containing—

(A) a plan to adopt and implement appropriate enrollment technology that includes—

(i) proposed reduction in maintenance costs of technology systems;

(ii) elimination or updating of legacy systems; and

(iii) demonstrated collaboration with other entities that may receive a grant under this section that are located in the same State, political subdivision, or locality;

(B) an assurance that the entity will share such appropriate enrollment technology in accordance with paragraph (4); and

(c) **SEC. 1572. CONFORMING AMENDMENTS.**

(a) **APPLICABILITY.**—Section 2302 of the Public Health Service Act (42 U.S.C. 300gg-21) as redesignated by section 10101(d), is amended—

(1) by striking subsection (a);

(2) in subsection (b), by striking "1 through 3" and inserting "1 and 2"; and

(3) in subsection (c), by striking "1 and 2 shall not apply to any group".

(b) **CREDIT.**—In section 2302(a), the Secretary may require.

(1) to notify States of such standards and programs, as determined by the Secretary, in consultation with the HIT Policy Committee and the HIT Standards Committee.

**SEC. 1562. CONFORMING AMENDMENTS.**

(a) **APPLICABILITY.**—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21(d)) is amended by adding at the end the following:

(1) by striking subsection (a);

(2) in subsection (b), by striking "1 through 3" and inserting "1 and 2"; and

(3) in subsection (c), by striking "1 and 2 shall not apply to any group".

(b) **SECTIONS MODIFIED.**—The sections modified by the amendment made by subsection (a) shall be sections 1121(a)(1), 1121(a)(3), 1121(a)(4), 1121(b)(1), 1121(b)(2), and 1121(b)(3).

(c) **SECTIONS CITED.**—Sections 1121(a)(1), 1121(a)(3), and 1121(a)(4) are amended by striking "1 through 3" and inserting "1 and 2".
(20) QUALIFIED HEALTH PLAN.—The term ‘qualified health plan’ has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) The term ‘Exchange’ means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—The amendments to such sections by this part shall be treated as a technical and conforming amendment to such sections as so redesignated by section 1001(3)

(i) in paragraph (1), by striking ‘‘health insurance issuer offering group or individual health insurance coverage’’ and inserting ‘‘health insurance issuer offering individual health insurance coverage’’;

(ii) in paragraph (2), by striking ‘‘health insurance coverage offered in connection with such a plan’’ each place that such term appears and inserting ‘‘or a health insurance issuer offering group or individual health insurance coverage’’;

(iii) in section 2727 (42 U.S.C. 300gg-6), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(iv) in section 2729 (42 U.S.C. 300gg-9), as so redesignated by section 1001(2), by striking ‘‘(4)(B)(iii)’’ and inserting ‘‘(4)(B)(iv)’’;

(v) in section 2731 (42 U.S.C. 300gg-11), as so redesignated by section 1001(2), by striking ‘‘(4)(B)(iii)’’ and inserting ‘‘(4)(B)(iv)’’;

(vi) in section 2733 (42 U.S.C. 300gg-13), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(i)’’ and inserting ‘‘(2)(B)(iv)’’;

(vii) in section 2735 (42 U.S.C. 300gg-15), as so redesignated by section 1001(2), by striking ‘‘(E)(iii)’’ and inserting ‘‘(E)(iv)’’;

(viii) in section 2737 (42 U.S.C. 300gg-17), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(ix) in section 2738 (42 U.S.C. 300gg-18), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(x) in section 2739 (42 U.S.C. 300gg-19), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xi) in section 2740 (42 U.S.C. 300gg-20), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xii) in section 2741 (42 U.S.C. 300gg-21), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xiii) in section 2742 (42 U.S.C. 300gg-22), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xiv) in section 2743 (42 U.S.C. 300gg-23), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xv) in section 2744 (42 U.S.C. 300gg-24), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xvi) in section 2745 (42 U.S.C. 300gg-25), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xvii) in section 2746 (42 U.S.C. 300gg-26), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xviii) in section 2747 (42 U.S.C. 300gg-27), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xix) in section 2748 (42 U.S.C. 300gg-28), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(xx) in section 2749 (42 U.S.C. 300gg-29), as so redesignated by section 1001(2), by striking ‘‘(2)(B)(iii)’’ and inserting ‘‘(2)(B)(iv)’’;

(22) EXCHANGE.—The term ‘Exchange’ means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.
“SEC. 715. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b), (1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage with group health plans, as if included in this subpart; and
(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.

(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

(i) Technical Amendment to the Internal Revenue Code of 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 9815. ADDITIONAL MARKET REFORMS.

(a) GENERAL RULE.—Except as provided in subsection (b), (1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.
(2) CLARIFICATION.—To the extent that any provision of part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subchapter, and
(c) Application of Part A Provisions.—(1) General.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.
(2) Clarification.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply.
(3) Technical Amendment to the Internal Revenue Code of 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"(A) 100 PERCENT FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (vii) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point described in clause (i) for the quarter and the State.
(2) PROVISION OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—

"(i) In General.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

"(B) CONFORMING AMENDMENT.—

"(C) T ECHNICAL AMENDMENT TO THE EMPLOYER RETIREMENT INCOME SECURITY ACT OF 1974.—

"(D) TECHNICAL AMENDMENT TO THE EMPLOYER RETIREMENT INCOME SECURITY ACT OF 1974.—

"(E) TECHNICAL AMENDMENT TO THE EMPLOYER RETIREMENT INCOME SECURITY ACT OF 1974.—

"(F) TECHNICAL AMENDMENT TO THE EMPLOYER RETIREMENT INCOME SECURITY ACT OF 1974.—

"(G) TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—

"(H) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

"(I) AMOUNT OF INCREASE.—

"(J) APPLICABLE PERCENTAGE POINT INCREASE.—

"(K) IN GENERAL.—

"(L) APPLICABLE PERCENTAGE POINT INCREASE.—

"(M) IN GENERAL.—

"(N) IN GENERAL.—

"(O) IN GENERAL.—

"(P) IN GENERAL.—

"(Q) IN GENERAL.—

"(R) IN GENERAL.—

"(S) IN GENERAL.—

"(T) IN GENERAL.—

"(U) IN GENERAL.—

"(V) IN GENERAL.—

"(W) IN GENERAL.—

"(X) IN GENERAL.—

"(Y) IN GENERAL.—

"(Z) IN GENERAL.—
“(II) EXPANSION STATE DEFINED.—For pur-
poses of the table in subclause (I), a State is an
expansion State if, on the date of the en-
actment of the Patient Protection and Af-
fordable Care Act, the State offers health
benefits coverage statewide to parents and
nonpregnant, childless adults whose income is
at least 100 percent of the poverty line,
that is not dependent on access to employer
coverage, employer contribution, or employ-
ment and is not limited to premium assist-
ance, hospital-only benefits, a high deduct-
ible health plan, or alternative benefits
under a demonstration program authorized
under section 1905. A State that offers health
benefits coverage to only parents or only
nonpregnant childless adults described in the
preceding sentence shall not be considered to
be an expansion State.

“(C) 2019 AND SUCCEEDING YEARS.—Begin-
ning January 1, 2019, notwithstanding sub-
section (D), the Federal medical assistance percentage determined for a State that is one of the 50
States or the District of Columbia for each
fiscal year quarter occurring during that pe-
riod with respect to amounts expended for
medical assistance for newly eligible individ-
uals described in subclause (VIII) of section
1902(a)(10)(A)(i), shall be increased by 23.2
percentage points.

“(D) LIMITATION.—The Federal medical as-
sistance percentage determined for a State
under subparagraph (B) or (C) shall in no case
be more than 85 percent.

“(2) DEFINITIONS.—In this subsection:

“(A) NEWLY ELIGIBLE.—The term ‘newly el-
igible’, means, with respect to an individual
described in subclause (VIII) of section
1902(a)(10)(A)(i), an individual who is not
under 19 years of age (or such higher age as
the State may have elected) and who, on the
date the State elects to offer coverage under
the State plan or under a waiver of such
plan, is eligible for medical assistance under
section (a)(10)(A) or section 1931 in the same
manner as the State provides for such a per-
iod under this section or section 1920A, sub-
ject to such guidance as the Secretary shall
establish.

“(B) FULL BENEFITS.—The term ‘full ben-
efits’ means, with respect to any individual,
medical assistance for all services covered
under the State plan under this title that is
not less in amount, duration, or scope, or is
determined by the Secretary to be substan-
tially equivalent, to the medical assistance
available for an individual described in sec-

“(C) STATES TO OFFER COVERAGE EAR-
LIER AND PRESUMPTIVE ELIGIBILITY; CHILD-
REN REQUIRED TO HAVE COVERAGE FOR PARENTS
TO BE ELIGIBLE.—

“(1) IN GENERAL.—Subsection (k) of section
1902 of the Social Security Act (as added by
paragraph (2)), is amended by inserting after
paragraph (1) the following:

“‘(2) The first day of any fiscal
year quarter that begins on or after Jan-
uary 1, 2011, and before January 1, 2014, a
State may elect through a State plan amend-
ment to provide medical assistance to indi-
viduals who would be described in subclause
(VIII) of section 1902(a)(10)(A)(i) if that sub-
clause were effective before January 1, 2014.
A State may elect to phase-in the extension of
eligibility for medical assistance to such
individuals based on income, so long as the
State does not extend such eligibility to in-
dividuals described in such subclause with
higher income before making individuals de-
scribed in such subclause with lower income
eligible for medical assistance.

“(3) If an individual in subclause (VIII) of sec-
tion (a)(10)(A)(i)(VIII) is the parent of a
child who is under 19 years of age (or such
higher age as the State may have elec-
ted) who is eligible for medical assistance
under the State plan or under a waiver of
such plan (under that subclause or under a
State plan amendment under paragraph (2),
the individual may not be enrolled under the
State plan unless the individual’s child is en-
rolled under the State plan or under a waiver
of the plan or is enrolled in other health in-
surance coverage. For purposes of the pre-
ceding sentence, the term ‘parent’ includes
an individual treated as a caretaker relative
for purposes of carrying out section 1931.

“(B) PRESUMPTIVE ELIGIBILITY.—Section 1902
of the Social Security Act (42 U.S.C. 1396e–1)
is amended by adding at the end the fol-
lowing:

“(e)(1) If the State has elected the option to
provide a presumptive eligibility period
under this section or section 1920A, the State
may elect to provide a presumptive eligi-
bility period (as defined in subsection (b)(1))
for individuals who are eligible for medical
assistance under clause (VIII) of sub-
tion (a)(10)(A) or section 1931 in the same
manner as the State provides for such a pe-
riod under this section or section 1920A, sub-
ject to such guidance as the Secretary shall
establish.

“(2) CONFORMING AMENDMENTS.—

“(A) Section 1902(a)(10) of such Act (42
U.S.C. 1396a(l)(2)(C)) is amended by striking
paragraph (A)(i)(VIII) and inserting
‘and (XV) the medical assistance made
available to an individual described in sub-
clause (VIII) of subsection (a)(10)(A)(i) shall
be increased by 32.3 percentage points.

“(B) Section 1902(l)(2)(C) of such Act (42
U.S.C. 1396b(f)(4)) is amended by inserting
‘and (XV) the medical assistance made
available to an individual described in sub-
clause (VIII) of subsection (a)(10)(A)(i)
shall be increased by 32.3 percentage points.

“(C) Section 1920 of such Act (42 U.S.C. 1396a)
is amended in the matter preceding
paragraph (73) and inserting ‘; and’; and

“(D) Section 1937(a)(1)(B) of such Act (42
U.S.C. 1396r–1) is amended by adding—

“(1) in subsection (a) (42 U.S.C. 1396r–1(a))—

“(B) by striking the period at the end of
paragraph (73); and

“(C) by inserting after paragraph (73) the
following new paragraph:

“(74) provide for maintenance of effort under
the State plan or under any waiver of the
plan in accordance with subsection (gg)’; and

“(2) in subsection (b)(1)(A)(i) (42 U.S.C. 1396r–
1(b)(1)(A)(i))—

“(A) by striking ‘and’ at the end of para-
graph (1); and

“(B) by inserting ‘and’ at the end of
paragraph (1).
in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures that are less restrictive than the eligibility standards, methodologies, or procedures in effect under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan or under a waiver of the plan with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subsection (d), shall not be considered to have in effect eligibility standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended—

(1) in paragraph (3), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each of the following:

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each of the following:

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (iii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services.

"(C) in subparagraph (B)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(iii) by adding at the end the following new paragraphs:

"(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a Medicaid managed care organization and that provides both medical and surgical benefits and mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in subsection (a) who is enrolled under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic and preventive services defined in section 1905(r) and provided in accordance with section 1902(a)(4)), shall be deemed to satisfy the requirements of subparagraph (A).

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "; and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit to the Secretary that contains—

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories as the Secretary determines appropriate for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.

(2) REPORTS TO CONGRESS.—Beginning April 1, 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year, lagged by at least one calendar year, including the number of individuals described in such subclause with household income that are not less than the Federal poverty line.

(3) EFFECTIVE DATE.—The Secretary shall by rule establish a transition period of no less than six months beginning with the enactment of this Act and ending on September 30, 2017, for the purposes of paragraphs (1) and (2).
this title and title XXI as are necessary to
ensure that States establish income and eli-
gibility determination systems that protect
beneficiaries."

(2) INCOME OR EXPENSE DISREGARDS.—No
type of expense, block, or other income
disregard shall be applied by a State to de-
termine income eligibility for medical as-
sistance under the State plan or under any
waiver of such plan or for any other purpose
applicable under the plan or waiver for
which a determination of income is required.

(3) NO ASSET TEST.—A State shall not
apply any assets or resources test for pur-
poses of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(4) EXCEPTIONS.—

(i) INDIVIDUALS ELIGIBLE BECAUSE OF
OTHER GOVERNMENTAL PROGRAM.—Elderly
individuals, medically needy individuals, and
individuals eligible for medicare cost-sharing
subsidies under and in accord-
ance with the Medicare program; or
(ii) EXPRESS LANE AGENCY FINDINGS.—In
the case of the State electing the Express
Lane option under paragraph (3), with-
standing subparagraphs (A), (B), and (C), the
State may rely on a finding made by an Ex-
press Lane agency as required by sub-
paragraph (A) and in accordance with that
paragraph relating to the income of an indi-
vidual for purposes of determining the indi-
vidual’s eligibility for medical assistance under the State plan or under a waiver of the plan.

(5) MEDICARE PRESCRIPTION DRUG SUB-
SIDIES DETERMINATIONS.—Subparagraphs
(A), (B), and (C) shall not apply to de-
terminations of eligibility for premium and
cost-sharing subsidies under and in accord-
ance with section 1915(b)(3) made by the State
pursuant to section 1931(a)(2).

(6) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1902(a)(10)(A)(i)
of the Social Security Act (42 U.S.C. 1396a), as
amended by section 101(a)(1), is amended—

(B) by striking “option for children” and
inserting “option for children”;

(C) effective date.—The amendments made
by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER
FOSTER CARE CHILDREN.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)
of the Social Security Act (42 U.S.C. 1396a), as
amended by section 101(a)(1), is amended—

(B) by striking “option for children” and
inserting “option for children”;

(C) effective date.—The amendments made
by this section take effect on January 1, 2014.

(b) OPTION TO PROVIDE PRESUMPTIVE ELIGI-
BILITY DETERMINATION.—Each State shall, in
accordance with the requirements of this
paragraph, provide presumptive eligibility
determinations for a child in foster care
for medical assistance on the basis of section
1915(h)(2)(B) under the State plan or under a waiver of the plan.

(2) Waiver.—Each State shall, in accordance with the requirements of this paragraph, provide presumptive eligibility determinations for a child in foster care for medical assistance on the basis of section 1915(h)(2)(B) under the State plan or under a waiver of the plan or under a waiver of the plan.

(3) Timeframe.—Each State shall submit to the Sec-
retary for the Secretary's approval the in-
come eligibility thresholds proposed to be
established using modified gross income and
household income, the methodologies and pro-
cedures to be used to determine income eligi-
bility using modified gross income and
household income in, and as of the date on which the indi-
vidual’s next regularly scheduled deter-
mination of eligibility is to occur, whichever is
later.

(4) Transition Planning and Oversight.—Each State shall submit to the Sec-
retary for the Secretary’s approval the in-
come eligibility thresholds proposed to be
established using modified gross income and
household income, the methodologies and pro-
cedures to be used to determine income eligi-
bility using modified gross income and
household income, and, if applicable, a State
plan amendment establishing an optional
eligibility category under subsection
(a)(10)(A)(ii)(XX). To the extent practicable,
the Secretary shall en-
sure that the eligibility thresholds proposed to be established using modified gross income and household income, includ-
ing the eligibility category established under subsection (a)(10)(A)(ii)(XX), and the
methodologies and procedures proposed to be
used to determine income eligibility, will not result in children who would have been eligible for medical assistance under the State plan or under a waiver of the plan on the date of enactment of the Patient Protec-
tion and Affordable Care Act no longer being eligible for such assistance.

(5) Limitation on Secretarial Authority.—The Secretary shall not waive compli-
ance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title
XVIII and individuals who require the level of care provided in a hospital, a nursing fa-
cility, or a State or State-approved care facility for the mentally retarded.

(6) Definitions of Modified Gross In-
come and Household Income.—In this para-
graph, the terms ‘modified gross income’ and
‘household income’ have the meanings given
to such terms in section 36B(b)(3) of the Inter-

(b) Conforming Amendments.—

(1) in subsection (a)—

(i) by striking “option for children” and
inserting “option for children”;

(ii) by striking “clause (i)(IX)”.

(2) in paragraph (1)—

(i) by striking “or” at the end of subclause
(VII);

(ii) by adding “or” at the end of subclause
(VIII);

(iii) in subparagraph (B), by striking “and
inserting “and”;

(iv) in subsection (b), by striking “under age
19” each place it appears.

(c) Conforming Amendments.—

(1) in section 1902(a)(5)(D), as amended by section
2001(a)(5)(D), is amended by inserting “(1), (2),
and (3)”, and

(2) in section 1902(a)(2)(A)(ii), as amended by
section 2001(a)(2)(A)(ii), is amended by inserting “(1),
and (3)”; and

(d) Effective Date.—The amendments made
by this section take effect on January 1, 2014.

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) Increase in Limit on Payments.—Sec-
tion 1108(g) of the Social Security Act (42 U.S.C. 1396n) is amend-
ed by inserting in paragraph (2), in the matter
preceeding subparagraph (A), by striking “par-
agraph (3)” and inserting “paragraphs (3) and
(4)”, and

(by striking “(4)” and
inserting “(3), and (4)”; and

(by striking paragraphs (3) and
(4)”.
(3) by adding at the end the following paragraph: "(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this section for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011, (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 50 percent.

(b) DISABILITY PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1106(g)(4) of such Act (42 U.S.C. 1396d(b)(4)) is amended by striking "(A) fiscal years beginning" and inserting "(A) fiscal years beginning;"

"(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible individuals under section 1905(y)(2) nonprofit childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(a)(10)(A)(i)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under such plan and the waiver describing the waiver; or (B) fiscal years beginning with the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), which is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection;"

"(2) In this subsection, the term 'disaster-recovery FMAP adjustment State' means a State that is one of the 50 States or the District of Columbia, for which, at any time during the fiscal year for which the President has declared a major disaster under section 1003 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act and determined as a result of such disaster that every county or parish in the State warrant individual and public assistance or public assistance from the Federal Government under such Act and for which;

"(A) in the case of the fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the State for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the State for the preceding fiscal year after the application of only subsection (a) of section 5001 of Public Law 111–5, by (c) of section 5001 of Public Law 111–5, and subsections (c) and (f) of this subsection to such commonwealth or territory for such fiscal year.

"(c) INCREASED FMAP.—(1) IN GENERAL.—The first sentence of section 1906(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking "shall be 55 percent" and inserting "shall be 55 percent".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DE-TERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1906 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3) and 2001(b)(2), is amended—

"(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended—

"(1) by striking "$150,000,000" and inserting "$0".

"(2) by striking the period at the end and inserting "; and"; and

"(b) MAINTENANCE OF EFFORT.—(1) IN GENERAL.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

"(2) By striking and (c) of section 5001 of Public Law 111–5, by (c) of section 5001 of Public Law 111–5, and subsections (c) and (f) of this subsection to such commonwealth or territory for such fiscal year.

SEC. 2007. MEDICAID IMPROVEMENT FUND RE-SCISSION.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 1397ee–1) for any fiscal years 2014 through 2018 that are available for expenditure under such Act shall be rescinded.

(b) CONFORMING AMENDMENT TO TITLE XXI MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding after the period "; and" except as required under section 1902(e)(14)".

(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(ii)) is amended by inserting "or any children enrolled after or before October 1, 2013" before the period.

(d) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 1905(b)(1) of the Social Security Act (42 U.S.C. 1397e(b)(1)) is amended by adding at the end the following:

"Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 25 percentage points, but in no case shall the enhanced FMAP under the preceding sentence not apply with respect to determining the payment to a State under subsection (y)(1) for fiscal years after 1906(g)(4) of such Act (42 U.S.C. 1396d(b)(4)) is amended by striking "(A) fiscal years beginning;" and inserting "(A) fiscal years beginning.

"(B) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 1902(a)(10)(A)(i)) of such Act (42 U.S.C. 1396a), to the extent that such standards, methodologies, or procedures, respectively, under such plan or waiver as in effect on the date of enactment of such Act.

The preceding sentence shall not be construed as preventing a State during such period from—

"(A) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

"(ii) imposing a limitation described in section 1212(b)(7) for a fiscal year in order to limit expenditures under the State child health plan to those for which Federal financial participation is available under this section for the fiscal year.

"(B) ASSURANCE OF EXCHANGE COVERAGE FOR TARGETED LOW-INCOME CHILDREN UNABLE TO ACCESS COVERED CHILDREN'S HEALTH PLAN AS A RESULT OF FUNDING SHORTFALLS.—In the event that allotments provided under section 2104 are insufficient to provide coverage to any child who is targeted low-income children under the State child health plan under this title, a State shall establish procedures to ensure that such children are provided coverage through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act.

"(C) CONFORMING AMENDMENT TO TITLE XXI MAINTENANCE OF EFFORT.—Section 2105(d)(1) of the Social Security Act (42 U.S.C. 1397ee(d)(1)) is amended by adding after the period "; and" except as required under section 1902(e)(14)".

"(C) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(ii)) is amended by inserting "or any children enrolled after or before October 1, 2013" before the period.

"(D) INCOME ELIGIBILITY DETERMINED USING MODIFIED GROSS INCOME.—

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

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 1905(b)(1) of the Social Security Act (42 U.S.C. 1397e(b)(1)) is amended by adding at the end the following:
(C) by adding at the end the following:

"(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 56B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 11653(a)."

(2) CONFORMING AMENDMENT.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended—

(A) by striking paragraphs (L) through (P) from (M), respectively; and

(B) by inserting after subparagraph (D), the following:

"(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income)."

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

"(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency);"

(f) ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of any disregard (based on expenses or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 1902(a)(5)(B)(ii) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as "CHIPRA"),—

(1) Section 2104(m) of the Social Security Act, as added by title 2 of CHIPRA, is amended—

(A) in the heading, by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

"(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have been paid by the State under the Federal Medical Assistance Percentage (FMAP) rate rather than the Federal medical assistance percentage matching rate for such population.

(2) Subsection 605 of CHIPRA is amended by striking "legal resident" and insert "lawfully residing in the United States".

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1397aa(a)(3)(I)), as added by section 104 of CHIPRA, are each amended by striking "and" and inserting "or".

(b) CHIPRA.—Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397aa(a)(3)(E)(ii)), as added by section 101 of CHIPRA, is amended by striking "exclusive of" and inserting "exclusive of and".

(c) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State plan under title XXI, are screened for eligibility for enrollment in qualified health plans offered through such an Exchange and, if applicable, advance payment of such assistance for a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance for the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, if the Exchange is required to reduce cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange;

(d) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the "State Medicaid agency"), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the "State CHIP agency") and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act utilize an electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance, child health assistance, or coverage obtained through the Exchange and, for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(9)(B) (relating to early and periodic screening, diagnostic (EPSD) services defined in section 1905(r) and provided in accordance with the requirements of section 1902(a)(43); and

(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance for the Patient Protection and Affordable Care Act), so long as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe that are necessary to reduce the like-lihood of eligibility errors and disruptions in coverage.
“(3) STREAMLINED ENROLLMENT SYSTEM.—The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1140 of the Patient Protection and Affordable Care Act (relating to streamlined procedures for enrollment through an Exchange, Medicaid, and CHIP).

“(4) PROVIDER REQUIREMENTS.—The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, a process that is linked to any website of an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act and to the State CHIP Exchange that allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or waiver with the benefits, premiums, and cost-sharing available to the individual under the qualified health plan offered through such an Exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided for the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

“(5) CONTINUED NEED FOR ASSESSMENT FOR HOME AND COMMUNITY-BASED SERVICES.—Nothing in paragraph (1) shall limit or modify the authority under section 1915(i) of the Social Security Act (as amended by title XIX of the Omnibus Budget Reconciliation Act of 2001) to continue the assessment of the need for home and community-based services under the State plan or under any waiver of such plan for an individual described in subsection (a)(10)(A)(i)(II)."

SEC. 2202. PERMITTING HOSPITALS TO MAKE PREMATURE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking “at the option of the State”;

(2) in subsection (b), by inserting “and” after the semicolon;

(3) in subsection (c)(1), by striking “or for” and inserting “for”;

(4) by adding after each place where it appears “and”; and

(5) by adding the following new paragraph:

“(28) freestanding birth center services (as defined in section 2001(e), as amended by section 2001(d), is amended by adding at the end the following new subparagraph:

“(B) freestanding birth center services that are offered by a freestanding birth center (as defined in subsection (b)(3)(A)) and other ambulatory services that are included in the plan; and”;

(b) CONFORMING AMENDMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(d), is amended by adding at the end the following:

“XXII who are described in subsection (i)(v) of section 1115(b) (relating to individual who is pregnant)."

(c) EFFECTIVE DATE.—The amendments made by this section shall be applied as if they had been made before January 1, 2014, with respect to services furnished on or after that date.

Title D—Improvements to Medicaid Services

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking “and” and inserting “or” at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (29) the following new paragraph:

“(28) freestanding birth center services (as defined in subsection (b)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (b)(3)(B)) and that are otherwise included in the plan, and;”

(2) in subsection (b), by adding at the end the following new paragraph:

“(3)(A) The term ‘freestanding birth center services’ means services furnished to an individual described in subsection (b)(3)(B) during a presumptive eligibility period resulting from a determination of eligibility for services under this subsection, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2302. CONCURRENT CARE FOR CHILDREN.

(a) IN GENERAL.—Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (C)”;

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

“(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided, or to have payment made under this title for services that are for treatment of the child’s condition for which a diagnosis of terminal illness has been made.”;

(b) APPLICATION TO CHIP.—Section 2110(a)(7)(B) of the Social Security Act (42 U.S.C. 1396p(a)(7)(B)) is amended by inserting “and” after “subtitle D—Improvements to Medicaid Services”.

(c) EFFECTIVE DATE.—The amendments made by this section shall be applied as if they had been made before January 1, 2014, with respect to services furnished on or after that date.

SEC. 2303. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2001(e), is amended—

(A) in subclause (XIX), by striking “or” at the end; and

(B) in subclause (XX), by adding “or” at the end; and

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

“(XXII) who are described in subsection (ii) of section 1115(b) (relating to individual who is pregnant) and who is pregnant.”

(b) CONFORMING AMENDMENT.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 2001(d), is amended by adding at the end the following new subsection:

“(A) whose income does not exceed an income eligibility level established under the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

“(B) who are not pregnant.”

(c) EFFECTIVE DATE.—Except as provided in paragraph (2), the amendments made by this section shall be effective on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—If, prior to the date of the enactment of this Act, a State legislature enacts or approves legislation amending the State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires the State to make payments (whether from State or federal legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 2304. LIMITATION ON BENEFITS.

(a) IN GENERAL.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—
S11656

CONGRESSIONAL RECORD — SENATE

November 19, 2009

U.S.C. 1396a(a)(10), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking "and (XV)" and inserting "(XV)"; and

(B) by inserting "(XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting before the semicolon.

(4) CONFORMING AMENDMENTS.—

(A) Section 1906(a) of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 2001(e)(2)(A), is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking "or" at the end;

(ii) in clause (xv), by adding "or" at the end; and

(iii) by inserting after clause (xv) the following—

"(xvi) individuals described in section 1902(11)."

(B) Section 1905(e)(2) of such Act (42 U.S.C. 1396d(a)), as amended by section 2001(e)(2)(B), is amended by inserting "1905(a)(4)(C)" after "1905(a)(4)(B),".

(5) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2904. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting "or the care and services themselves, or" before "(if provided in or after".

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

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

"(X) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDED SERVICES AND SUPPORTS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, beginning October 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 1902(a)(30)(B)) or, if greater, the income level appropriate for an individual who is determined to have income below the poverty level that is necessarily incurred in order to prevent fraud and abuse.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(7) of the Social Security Act (42 U.S.C. 1396a(a)(7)), as amended by section 2202(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: "and any services that are prescribed in order to prevent fraud and abuse.";

(ii) by striking "and only if the individual chooses to receive such services after the date of the enactment of the Social Security Act (as defined in section 1902(a)(30)(B)) and inserting "and only if the individual chooses to receive such services after the date of the enactment of the Social Security Act (as defined in section 1902(a)(30)(B)) or, if greater, the income level appropriate for an individual who is determined to have income below the poverty level that is necessarily incurred in order to prevent fraud and abuse.";

(B) Section 1904(b) of such Act (42 U.S.C. 1396a(b)), as amended by section 2202(b), is amended by striking "or the care and services themselves, or" before "(if provided in or after".
“(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and achievement of life goals; and

“(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports during emergencies;

“(iii) voluntary training on how to select, manage, and dismiss attendants.

(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to paragraph (D), the home and community-based attendant services and supports made available do not include—

“(i) room and board costs for the individual;

“(ii) special education and related services provided under the Individuals with Disabilities Education Improvement Act of 1997 and the Individuals with Disabilities Education Act of 1975, or other models to provide home and community-based attendant services and supports under a State plan amendment to be approved under this subsection during a fiscal year for which such services and supports are provided;

“(iii) health-related tasks that increase independence or support an individual to participate in the community.''

“Subject to subparagraph (D), the home and community-based attendant services and supports may include—

“(i) expenditures for transition costs such as: relocation costs, fees for the first month’s rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility or institutional placement for medical care, or other models to provide home and community-based attendant services and supports, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

“(ii) expenditures relating to a need identified in an individual’s person-centered plan of service that increases independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

“(B) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year, the Federal medical assistance percentage applicable to the State under section 1902(a)(10) shall be increased by 6 percentage points.

“(C) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection the State shall—

“(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and representatives and consults and collaborates with such individuals;

“(B) consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual’s needs, and without regard to the individual’s age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

“(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical assistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

“(D) establish and maintain a comprehensive, continuous quality assurance system that includes—

“(i) an oversight and assessment of the Administration of Home and Community-Based Services.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

“(i) The number of individuals who are entitled to receive home and community-based attendant services and supports under this subsection during the fiscal year.

“(ii) The number of individuals that receive such services and supports during the preceding fiscal year.

“(A) the specific number of individuals served by type of disability, age, gender, education level, and employment status.

“(B) the number of individuals that have been previously served under any other home and community-based attendant services program under the State plan or under a waiver.

“(B) CONSUMER CONTROLLED.—The term ‘consumer controlled’ means a method of selecting and providing services and supports whereby, in an appropriate, the individual’s representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

“(C) DELIVERY MODELS.—The term ‘agency-provider model’ means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract with the individual, or where appropriate, a home and community-based services provider for the provision of such services and supports.

“(D) HEALTH-RELATED TASKS.—The term ‘health-related tasks’ means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

“(E) INDIVIDUAL’S REPRESENTATIVE.—The term ‘individual’s representative’ means a parent, family member, guardian, advocate, or other authorized representative of an individual.

“(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ‘instrumental activities of daily living’ includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.”
(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and support, such services and supports that are provided under programs other the State Medicaid program, and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed to meet the needs and priorities of such services and supports that are provided under programs other the State Medicaid program, and that provides strategies for beneficiaries receiving such services to maximize their independence, including through the use of client-employed providers;

(3) improve coordination among, and the regulation of, all providers of such services under Federal and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a quality assurance system, a quality improvement system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(iii) the ability of a sufficient number of qualified direct care workers to provide self-directed personal assistant services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(d) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

"(1) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for such individuals under section 1915(d) of the Social Security Act (42 U.S.C. 1396n(i)) as amended by subsection (a), is amended—

(A) in subsection (XXI), by striking ''or'' at the end; and

(B) in subsection (XXII), by adding ''or'' at the end;

and

(C) by inserting after subclause (XXI), the following new subclause: "(XXIII) a beneficiary in need of such services to maximize their independence, including through the use of client-employed providers;

(3) PHASE-IN OF SERVICES AND ELIGIBILITY PERIOD.—State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such individuals are provided with services under such an election, before the end of the initial 5-year period.

(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection for providing services under such an election; and

(ii) met the State’s objectives with respect to quality improvement and beneficiary outcomes.

(d) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended by striking ''2011'' and inserting ''2016''.

(e) EFFECTIVE DATE.—The amendments made by this subsection take effect—

(A) on January 1, 2014, for such services to such individuals that are otherwise eligible for such services after the effective date of the modification to which such services were subject; and

(B) on January 1, 2016, for such services to such individuals that are otherwise eligible for such services after the effective date of the modification to which such services were subject before April 1, 2014.

SEC. 2403. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(c) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking "fiscal year 2011'' and inserting "each of fiscal years 2011 through 2016''; and

(B) in paragraph (2), by striking "2011'' and inserting "2016''.

(2) EVALUATION.—Paragraphs (2) and (3) of section 6071(g) of such Act are amended to read—

"(2) IN GENERAL.—The Secretary shall, in accordance with this subsection, review—

(A) the impact of the demonstration on participant outcomes and on costs of services; and

(B) the extent to which the demonstration improves access to and quality of care.

(3) REPORT.—The Secretary shall submit to Congress a report on the review conducted under this subsection not later than January 1, 2016.

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 1915(n) of such Act (42 U.S.C. 1396n) is amended—

(A) in subparagraph (A)(i), by striking ''2011'' and inserting ''2016''; and

(B) by striking the following:

"in the case of an individual who—

(i) is not a resident of an intermediate care facility for individuals with Intellectual and Developmental Disabilities, as defined in section 1919(n)(8); and

(ii) resides in an intermediate care facility for individuals who are not residents of an intermediate care facility for individuals with Intellectual and Developmental Disabilities, as defined in such section, for a period of not less than 90 consecutive days, except that in the case of a resident of a State that is a participating State under section 1919(n)(8) at the time of enactment of this Act, such period may be less than 90 consecutive days.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall be effective on the date of enactment of this Act.
5(b)(1)(A)) shall be applied as though “is eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or which is eligible for medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)” were substituted in such section for “(at the option of the State) is described in section 1902(a)(10)(A)(i)(VI).”

SEC. 2405. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 302).

SEC. 2406. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) Findings.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also known as the “Pepper Commission”, released its “Call for Action” blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and Olmstead decision, the long-term care provided to our Nation’s elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) Sense of the Senate.—It is the sense of the Senate that:

(1) during the 111th session of Congress, Congress incorporates long-term care spending and supports in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) Medicare by design and supports should be made available in the community in addition to institutions.

Subtitle F—Medicaid Prescription Drug Coverage

SEC. 2501. PRESCRIPTION DRUG REBATES.

(a) Increase in Minimum Rebate Percentage for Single Source Drugs and Innovator Multiple Source Drugs.—

(1) in general.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(A) in clause (i)—

(i) in subclause (A), by striking “and the Secretary” and inserting “and”; and

(ii) by striking the period at the end and inserting “; and”; and

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

“(i) MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.—

“(A) In general.—In the case of a single source drug or an innovator multiple source drug described in the clauses specified in clause (ii)(VI) of subsection (c), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

“(B) Drug described.—For purposes of subclause (A), a single source drug or an innovator multiple source drug described in this subsection is any of the following drugs:

“(aa) A clotting factor for which a separate payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

“(bb) A drug approved by the Food and Drug Administration exclusively for pediatric indications.”.

(2) Rebate of Total Savings Due to Increase.—Section 1927(b)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended by adding at the end the following new subparagraph:

“(C) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—

“(1) In general.—In addition to the amounts applied as a reduction under subparagraph (B), for rebate periods beginning after the or any quarter in a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—

“(A) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and

“(B) the amount received by the State under such subparagraph that are attributable (as estimated by the Secretary based on utilization and other data) to the increase in the minimum rebate percentage effected by the amendments made by subsections (a)(1), (b), and (d) of section 2561 of the Patient Protection and Affordable Care Act, taking into account the additional drugs included under the amendments made by subsection (c) of section 2561 of such Act.

“(2) The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

“(ii) Manner of Payment Reduction.—The amount of the payment reduction under clause (i) shall be prorated for each quarter of the rebate period to the extent that the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was greater or less than the amount of payment reduction that should have been made.

“(C) Treatment of New Formulations.—

“(1) in paragraph (1)(A), in the first sentence, by inserting “including such drugs for which payment was made under the Federal Medicare program” before the period; and

“(2) by inserting “diabetes” after “and diabetes” before the period; and

“(3) by inserting “or” after “such drugs” before the period; and

“(4) by adding a period at the end.

(b) Increase in Rebate for Other Drugs.—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

(1) in clause (i), by striking “and” at the end;

(2) in clause (ii)—

(A) by inserting “and before January 1, 2010,” after “December 31, 1993,”; and

(B) by striking the period at the end and inserting “; and”;

(3) by adding at the end the following new clause:

“(ii) in paragraph (2)(A), by inserting “and” at the end;

“(3) by striking the period at the end and inserting “; and”;

“(4) by adding at the end the following new clause:

“(xiii) such contract provides that (I) covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled in the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.”.

(2) Conforming Amendments.—Section 1927 (42 U.S.C. 1396r–8) of such Act is amended—

(A) in subsection (b)—

(i) in paragraph (1)(A), in the first sentence, by inserting “including such drugs for which payment was made under the Federal Medicare program” after “for which payment was made under the Federal Medicare program”;

(ii) in paragraph (2)(A), by inserting “including such information reported by each medicare managed care organization,” after “which for which payment was made under the Federal Medicare program”;

(B) in subsection (j), by striking paragraph (1) and inserting the following:

“(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

“(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

“(B) subject to discounts under section 360B of the Public Health Service Act.”.

(3) Technical and Conforming Amendments.—Section 1927 (42 U.S.C. 1396r–8) of such Act is amended—

(A) in subsection (a)(2)(A), by striking “and otherwise under section 1903” and inserting “and otherwise under section 1903 or 1903(m)”;

(B) by adding a period at the end of the following new subparagraph:

“(x) Treatment of new formulations.—

“(1) in the fifth sentence, by inserting “including such drugs” before the period; and

“(2) by inserting a period at the end.”
(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1397f–8(e)) is amended—

(A) in paragraph (4), by striking “or, effective January 1, 2007, two or more”;

and

(B) by striking paragraph (5) and inserting the following:

“(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the average manufacturer price, and if greater, not less than the rebate amount (calculated as a percentage of average manufacturer price) under this section for any multiple source drug, or, if greater, the product of—

(I) the highest additional rebate (calculated at a single source drug or an innovator multiple source drug;

(II) the total number of units of each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug for a rebate period beginning after December 31, 2009, and excluding such amounts as are paid for by a State after December 31, 2009.

(ii) NO APPLICATION TO NEW FORMULATIONS—

(A) agents when used to promote smoking cessation; (B) agents when used in smoking cessation; (C) benzodiazepines; (D) agents when used in treating conditions related to drug and alcohol abuse; (E) agents when used in treating conditions related to drug and alcohol abuse; (F) agents when used in treating conditions related to drug and alcohol abuse; (G) agents when used in treating conditions related to drug and alcohol abuse; (H) agents when used in treating conditions related to drug and alcohol abuse; (I) agents when used in treating conditions related to drug and alcohol abuse; (J) agents when used in treating conditions related to drug and alcohol abuse; (K) agents when used in treating conditions related to drug and alcohol abuse; (L) agents when used in treating conditions related to drug and alcohol abuse; (M) agents when used in treating conditions related to drug and alcohol abuse; (N) agents when used in treating conditions related to drug and alcohol abuse; (O) agents when used in treating conditions related to drug and alcohol abuse; (P) agents when used in treating conditions related to drug and alcohol abuse; (Q) agents when used in treating conditions related to drug and alcohol abuse; (R) agents when used in treating conditions related to drug and alcohol abuse; (S) agents when used in treating conditions related to drug and alcohol abuse; (T) agents when used in treating conditions related to drug and alcohol abuse; (U) agents when used in treating conditions related to drug and alcohol abuse; (V) agents when used in treating conditions related to drug and alcohol abuse; (W) agents when used in treating conditions related to drug and alcohol abuse; (X) agents when used in treating conditions related to drug and alcohol abuse; (Y) agents when used in treating conditions related to drug and alcohol abuse; (Z) agents when used in treating conditions related to drug and alcohol abuse.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(k)(3) of such Act (42 U.S.C. 1397f–8(k)(3)) is amended—

(1) by redesignating subparagraph (A) as subparagraph (B); and

(2) by inserting at the end the following:

“(C) RATES.—The rates and methodologies described in clause (i) shall be the rates and methodologies described in clause (ii) and this paragraph with respect to each dosage form and strength of the single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.”.

(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1397f–8(k)(1)) is amended—

(1) in subparagraph (A), by striking “retail pharmacies” and inserting “retail community pharmacies”;

(2) in subparagraph (B), by striking “reimbursement by manufacturers for the distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements” and inserting “the average price for each covered outpatient drug”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act, regardless to whether or not final regulations to carry out such amendments have been promulgated by such date.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1397f–8(k)(7)) is amended—

(A) in subparagraph (A)(i), by striking “no less than the rebate amount (calculated as a percentage of average manufacturer price) under this section for any multiple source drug” and inserting “the average manufacturer price for a covered outpatient drug”; and

(B) in subparagraph (C), by striking “(i)” and inserting “(ii)”.
Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.
(a) In General.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—
(1) in paragraph (1), by striking “and (3)” and inserting “(2), (3), and (4)”;
(2) in paragraph (3)(A), by striking “paragraphs (6) and (7)”;
(3) by redesignating paragraph (7) as paragraph (8); and
(4) by inserting after paragraph (6) the following new paragraph:

“(7) REDUCTION IN STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to—

(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined by the Secretary in accordance with this paragraph for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year 2013 or any succeeding fiscal year less than the amount equal to 25 percent of the DSH allotment determined for this State for fiscal year 2012 under this subparagraph (and after the application of this paragraph, if applicable). increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

(P) UNCOVERED INDIVIDUALS.—In this paragraph, the term ‘uncovered individuals’ means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).”.

(b) EFFECTIVE DATE.—The amendments made by this subsection take effect on October 1, 2011.

Subtitle H—Improved Coordination for Dual Eligible Beneficiaries

SEC. 2001. 5-YEAR PERIOD FOR DEMONSTRATION PROJECT.
(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting “(i)” after “(h)”; (2) by inserting “, or a waiver described in paragraph (2)” after “(i)”;

and

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

“(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled) may be approved for dual eligible individuals) may be approved for a period of 5 years and, upon the request of the State, may be extended for an additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

(B) In this paragraph, the term ‘dual eligible individual’ means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under title XIX of such title.

(c) G OALS.—The goals of the Federal Coordinated Health Care Office are as follows:

(1) I N GENERAL .—Not later than March 1, 2011, the Administrator of the Centers for Medicare & Medicaid Services shall establish a Federal Coordinated Health Care Office.

(d) S PECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals’ understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(9) Specific Responsibilities.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section 1395w–28(b)(4) of the Social Security Act (42 U.S.C. 1395w–28(b)(4))), physicians and other relevant entities or individuals with the education and tools necessary for development programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.
(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To establish and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396j) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1935(o)(6) of the Social Security Act) and to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(b) REQUIREMENTS.—In the case of a fiscal year for which there is appropriated for each of fiscal years 2011 through 2013 for each State not less than $250,000 for the purposes of this section, the Secretary shall:

(1) establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for the development, testing, validation, and dissemination of adult health quality measures shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A).

(2) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning in the fiscal year in which the Secretary establishes the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial set of core adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the retraction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1315a et seq.) as amended by section 401 of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by inserting after section 1159A the following new section:

SEC. 1159B. ADULT HEALTH QUALITY MEASURES.

(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENEFITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1159A, including with respect to the development of the core measures.

(b) PUBLICATION.—Not later than January 1, 2012, the Secretary shall publish and make publicly available the information collected through external quality reviews of managed care organizations under section 1933 and benchmark plans under section 1932.

(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the retraction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

SEC. 1945. STATE OPTION TO PROVIDE CO-ORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended by sections 2201 and 2305, is amended by adding at the end the following new section:

SEC. 2702. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the “Secretary”) shall identify current State practices that prohibit payment for health care-acquired conditions and shall incorporate the practices identified, or elements of such practices, which the Secretary determines are appropriate for application to the Medicaid program in regulations.

Such regulations shall be effective as of July 1, 2011, and shall prohibit payments to States under title XIX of the Social Security Act for any amounts expended for providing medical assistance for health care-acquired conditions specified in the regulations.

The regulations shall ensure that the prohibition on payment for health care-acquired conditions shall not result in a loss of access to care or services for Medicaid beneficiaries.
section 1902(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be at least 90 percent.

(2) METHODOLOGY.—

(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology and procedures for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals operating with such a provider, or a health team, as well as the severity or number of each such individual's chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1902(a)(30)(A).

(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month methodology or any methodology proposed by the State and approved by the Secretary for alternate models of payment.

(3) PLANNING GRANTS.—

(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) STATE CONTRIBUTION.—A State awarding a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 1905(b)(2)(D) and without regard to section 1131 of the Public Law 111-148, as added by subsection (g)), or such fiscal year for which the grant is awarded.

(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

(D) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek or require treatment in a hospital emergency department to designated providers.

(4) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

(5) MONITORING.—A State shall include in the State plan amendment—

(i) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

(ii) a proposal for use of health information technology in providing health home services on this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and access to electronic medical records and patient adherence to recommendations made by their provider).

(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider under this section shall comply with the following:

(1) have the systems and infrastructure in place to begin to collect all required quality measures; and

(2) satisfy the quality standards established by the Secretary under subsection (b).
Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project will be required to perform the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on consortia where there is evidence of an opportunity for the delivery of services and providers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs and to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional costs associated with care that had been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided to such beneficiaries under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall, in cooperation with the Centers for Medicare and Medicaid Services, under section 1115(a) of the Social Security Act, as added by section 3021 of this Act, establish the Medicaid Global Payment System Demonstration Project to authorize a participating State to adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capped payment model.

(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall begin on January 1, 2012, and shall end on December 31, 2016.

(c) REQUIREMENTS.—(1) Performance Guidelines.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) Minimum Participation Period.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(3) Annual Minimal Savings Level.—The Secretary shall establish an annual cap on incentive payments for an accountable care organization.

(4) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

(b) PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.—(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish the Pediatric Accountable Care Organization Demonstration Project in order for such individuals.

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(3) APPLICABILITY.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—(1) Performance Guidelines.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) Savings Requirement.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services for the fiscal year the demonstration project is in effect, and such savings shall be calculated by subtracting the costs of the demonstration project from the costs that would have been incurred by the State Medicaid program for the fiscal year the demonstration project is in effect, and such savings shall be based on the amount of such excess savings. The Secretary shall require the Secretary to report to Congress on the results of the demonstration project.

(d) Authorization of Appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.
(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(R) The Secretary shall submit to Congress and make available to the public a report on the findings of the evaluation under paragraph (f).

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are eligible for the demonstration project under this section) only to extent necessary to carry out the demonstration project under this section. The Secretary shall seek to achieve an appropriate balance in the geographic distribution of such projects.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(f) EVALUATION AND REPORT TO CONGRESS.—

(S) The Secretary shall submit to Congress an evaluation of the demonstration project prepared under this section not later than December 31, 2013, and expanded on a national basis.

A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(A) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(E) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(F) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(G) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(H) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.

(I) A recommendation regarding whether the demonstration project should be continued after December 31, 2013, and expanded on a national basis.
Making any recommendations regarding Medicaid beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MACPAC.

"(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Commission (in this paragraph referred to as "MedPAC") that was established under section 1901(b)(1) of the Social Security Act (42 U.S.C. 1395b–3) in carrying out its duties under section 1805(b) of the Social Security Act (42 U.S.C. 1395f–1) and the Indian Health Care Improvement Act (25 U.S.C. 1654) to the extent feasible.

"(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

"(C) CONSULTATION WITH STATES.—MACPAC shall consult with States in carrying out its duties under this section, including with respect to developing processes to carry out such duties, and ensure that input from States is taken into account and represented in MACPAC’s recommendations and reports.

"(D) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC’s authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary’s authority to carry out Federal responsibilities with respect to Medicaid and CHIP."

"(1) In the subsection heading, by inserting "—".

"(2) In subsection (a), by inserting "and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations" before the period.

"(3) In subsection (b), by inserting "and State" after "Federal";

"(4) In subsection (e)(1), in the first sentence, by inserting condition for receiving payments under sections 1903(a) and 2106(a), from any State agency responsible for administering Medicaid or CHIP, after "and";

"(5) In subsection (f), by inserting "and State" after "Federal";

"(6) In subsection (g), by inserting "other than for fiscal year 2010" before "in the same manner"; and

"(7) In subsection (h), by adding at the end the following:

"(3) FUNDING FOR FISCAL YEAR 2010.—(A) IN GENERAL.—MACPAC may, by inserting "other than for fiscal year 2010" before "in the same manner"; and

"(B) availability.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

"(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred and made available to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

"(C) IN GENERAL.—The membership of MACPAC shall include (but not be limited to) representatives of health care professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of Federal, State, or local law to the contrary.

"(D) PAYER OF LAST RESORT.—Health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (as those terms are defined in section 108A of the Indian Health Care Improvement Act (25 U.S.C. 1654)) shall be the payer of last resort for services provided by such service, tribes, or organizations to individuals who receive services through such programs, notwithstanding any Federal, State, or local law to the contrary.

"(E) FACILITATING ENROLLMENT OF INDIGENOUS POPULATIONS.—MACPAC may, by inserting "—"."
"(1) In general.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 205(3) of the Child Abuse Prevention and Treatment Act for the fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

(A) communities with concentrations of—

(i) premature birth, low-birth weight infants, and infant mortality, including infant deaths attributable to or linked to at-risk prenatal, maternal, newborn, or child health;

(ii) poverty;

(iii) crime;

(iv) domestic violence;

(v) high rates of high-school drop-outs;

(vi) substance abuse;

(vii) unemployment; or

(viii) child maltreatment;

(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

(ii) the extent to which such programs or initiatives are meeting the needs of eligible families identified under subsection (k) of section 505;

(C) the State’s capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

(2) Coordination with other assessments.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the Secretary, including the needs assessment conducted under subsection (k) of section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 606(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused activities to prevent child abuse and neglect, and other family resource sources operating in the State required under paragraph (3) of the Child Abuse Prevention and Treatment Act.

(3) Submission to the Secretary.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

(A) the results of the statewide needs assessment required under paragraph (1); and

(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include, applying for and securing grants to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, and the socio-economic status of such families, and reductions in child abuse, neglect, and injuries.

(2) Authority to use initial grant funds for planning or implementation.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds received to make a grant to a subrecipient to conduct a needs assessment under subsection (d) of this section.

(3) Grant duration.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

(4) Technical assistance.—The Secretary shall provide—

(A) a report to the entity that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds;

(B) requirements.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

(1) Quantifiable, measurable improvements in benchmark areas.—

(A) In general.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements in the eligible families participating in the program in each of the following areas:

(i) Improved maternal and newborn health.

(ii) Improved child outcomes, including—

(aa) reduced rates of emergency department visits;

(bb) reduced rates of emergency and urgent care visits;

(cc) reduced or eliminated need for inpatient hospitalization;

(dd) increased or sustained positive outcomes, as described in paragraph (B) that the eligible entity identifies and any indicators of emergency department visits.

(iii) Crime.

(iv) Domestic violence.

(v) State’s capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

(iv) Improvements in family economic self-sufficiency.

(v) Improvements in the coordination and referrals for other community resources and supports.

(B) Demonstration of improvements after 3 years.—

(i) Report to the Secretary.—Not later than 30 days after the end of the 3rd year in which the eligible entity conducts the program, the entity submits to the Secretary a report on program quality improvement, and in each of the areas specified in subparagraph (A).

(ii) Corrective action plan.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement an improvement plan in each of the areas specified in subparagraph (A).

(iii) Evaluation of the improvement plan.—The Secretary shall determine whether the improvement plan is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II).

(iv) Admissibility to the Secretary of the results of the improvement plan and conduct of oversight of the program, including through submission by the eligible entity, of the program evaluation results.

(iii) Technical assistance.—

(I) In general.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

(II) Advisory panel.—The Secretary shall establish an advisory panel for pur- poses of providing technical assistance regarding the technical assistance provided to entities in accordance with subclause (I).

(IV) No improvement or failure to submit report to the Secretary.—If the Secretary determines, on the basis of a report required under clause (i), that the eligible entity has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity identified in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family,

(2) Authority to use initial grant funds for evidence-based models.—An eligible entity...
shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in subsection (d)(3)(A).

"(iii) Criteria for evidence of effectiveness of models.—The Secretary shall establish criteria for evidence of effectiveness of the models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

"(B) Additional requirements.—

"(i) The program addresses to a clear, consistent model that satisfies the requirements of paragraph (a) in empirical knowledge related to home visiting and linked to the benchmarks areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B) related to the purposes of the program.

"(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, educators, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

"(iii) The program maintains high quality supervision to establish home visitor competence.

"(iv) The program demonstrates strong organizational capacity to implement the activities involved.

"(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

"(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

"(vii) Priority for serving high-risk populations.—The eligible entity gives priority to providing services under the program to the following:

"(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

"(B) Low-income eligible families.

"(C) Eligible families who are pregnant women who have not attained age 21.

"(D) Eligible families that have a history of child maltreatment or have had interactions with child welfare services.

"(E) Eligible families that have a history of substance abuse or need substance abuse treatment.

"(F) Eligible families that have users of tobacco products in the home.

"(G) Eligible families that are or have children with low student achievement.

"(H) Eligible families with children with developmental delays or disabilities.

"(I) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside the United States.

"(e) Application requirements.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

"(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

"(2) An assurance that the entity will give priority to serving low-income eligible families and eligible families who reside in at-risk communities, as defined in the statewide needs assessment required under subsection (b)(1)(A).

"(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

"(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations will align with the results of the statewide needs assessment conducted under subsection (b).

"(5) The quantifiable, measurable benchmarks described in paragraph (a) estimated to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

"(B) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

"(7) Assurances that the entity will establish procedures to ensure that—

"(A) the participation of each eligible family in the program is voluntary; and

"(B) services are provided to an eligible family in accordance with the individual assessment for that family.

"(8) Assurances that the entity will—

"(A) submit reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

"(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (h)(3)(B) and other research and evaluation activities carried out under subsection (h)(3).

"(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 622(c), programs funded under title IV, part D of the Child Abuse Prevention and Treatment Act (relating to community-based grants for the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

"(10) Other information as required by the Secretary.

"(11) Maintenance of effort.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

"(e) Evaluation.—

"(1) Independent, expert advisory panel.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and social work.

"(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

"(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

"(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

"(2) Authority to conduct evaluation.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (c) and the evaluations made under subsections (c) and (h)(3)(B).

"(3) The evaluation shall include—

"(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

"(B) an assessment of—

"(i) the effect of early childhood home visitation programs on child and parent outcomes and conduct and research, and such programs on different populations, including the extent to which the ability of programs to improve parent and child outcomes varies across programs and populations; and

"(ii) the potential for the activities conducted under such programs, if scaled broadly, to improve health, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

"(f) Other provisions.—

"(1) Intra-agency collaboration.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to carrying out this section, including with respect to—

"(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants required under this section, the establishment of the advisory panels required under subsections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

"(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development, the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

"(2) Grants to eligible entities that are not States.—

"(A) Indian tribes, tribal organizations, or urban Indian organizations.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortia of Indian Tribes), Tribal Organizations, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

"(i) conduct a needs assessment similar to the assessment required for all States under subsection (b), and report the results; and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

"(B) Nonprofit organizations.—If, as of the beginning of fiscal year 2012, a State has not approved or been applied for a grant under this section, the Secretary may use funds made available under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection.
to make a grant to an eligible entity that is a nonprofit organization described in subsection (b)(1)(B) to conduct an early childhood home visitation program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with requirements applicable to eligible entities that are States and shall require the organization to—

(1) carry out the program based on the needs assessment conducted by the State under subsection (b); and

(2) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

(B) REQUIREMENTS.—The Secretary shall ensure that—

(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

(ii) research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

(1) a description of the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A); and

(2) information regarding any technical assistance provided under subsection (d)(1)(B)(i)(I), including the type of such assistance provided; and

(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

(5) APPLICATION OF OTHER PROVISIONS OF TITLE.—

(A) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

(B) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

(1) Section 504(b)(6) (relating to prohibitions on payments to excluded individuals and entities).

(2) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(3) Section 507 (relating to penalties for false statements).

(F) Section 508 (relating to nondiscrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(H) APPROPRIATIONS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

(A) $300,00,000 for fiscal year 2010; $250,000,000 for fiscal year 2011; $350,000,000 for fiscal year 2012; $400,000,000 for fiscal year 2013; and $450,000,000 for fiscal year 2014.

(B) SECTION 509—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(i) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations (or a consortium of such organizations); and

(ii) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(ii), (g), and (h). (3) AVAILABLE.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be redirected to another nonprofit organization under subsection (h)(2)(B).

(6) DEFINITIONS.—In this section:

(A) ELIGIBLE ENTITY.—The term 'eligible entity' means—

(i) a State, an Indian Tribe, Tribal Organization, Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

(B) NONPROFIT ORGANIZATION.—Only for purposes of awarding grants under subsection (a), the term 'nonprofit organization' includes a nonprofit organization with an established record of providing early childhood home visitation programs or initiatives in a State for at least 3 years.

(C) ELIGIBLE FAMILY.—The term 'eligible family' means—

(i) a woman who is pregnant, and the father of the child if the father is available; or

(ii) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as a primary caregiver from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical and emotional care.

(D) INDIAN TRIBE; TRIBAL ORGANIZATION.—The term 'Indian Tribe' and 'Tribal Organization' includes 'urban Indian organization' and 'Urban Indian Organization' as defined in subsection (g) of section 502 of the Indian Self-Determination and Education Assistance Act (42 U.S.C. 670ff-1). The term does not include a group or association of Indian Tribes (or a consortium of Indian Tribes) or an organization, or Urban Indian Organization, or Tribal Organization, or Urban Indian Organization, or Tribal Organization, that is not an eligible entity under this Title.

(E) ELIGIBLE PROGRAM.—The term 'eligible program' includes—

(i) projects for the establishment, expansion, and improvement of early childhood home visitation programs in the State; and

(ii) activities under such a national campaign to increase awareness and knowledge of postpartum conditions, to promote earlier diagnosis and treatment; and

(F) THE MINIMUM AMOUNT.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(i) 2 percent of such amount for purposes of making grants to eligible entities that are Tribes, Tribal Organizations, or Urban Indian Organizations (or a consortium of such organizations); and

(ii) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations (or a consortium of such organizations); and

(iii) 3 percent of such amount for purposes of making grants to eligible entities that are States.

(G) SECTION 509—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(i) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations (or a consortium of such organizations); and

(ii) 3 percent of such amount for purposes of making grants to eligible entities that are States.

(H) PROGRAMS.—Each grant made under this section shall include conducting and sharing research and allowing the findings of the study to be used for any purpose

(i) to improve the conditions of postpartum conditions in the State;

(ii) to improve the conditions of postpartum conditions in the State;

(iii) to improve the conditions of postpartum conditions in the State;

(iv) to improve the conditions of postpartum conditions in the State;

(v) to improve the conditions of postpartum conditions in the State;

(vi) to improve the conditions of postpartum conditions in the State;

(vii) to improve the conditions of postpartum conditions in the State;

(viii) to improve the conditions of postpartum conditions in the State;

(ix) to improve the conditions of postpartum conditions in the State;

(x) to improve the conditions of postpartum conditions in the State;

(xi) to improve the conditions of postpartum conditions in the State;

(xii) to improve the conditions of postpartum conditions in the State;

(xiii) to improve the conditions of postpartum conditions in the State;

(xiv) to improve the conditions of postpartum conditions in the State;

(xv) to improve the conditions of postpartum conditions in the State;

(xvi) to improve the conditions of postpartum conditions in the State;

(xvii) to improve the conditions of postpartum conditions in the State;

(xviii) to improve the conditions of postpartum conditions in the State;

(xix) to improve the conditions of postpartum conditions in the State;

(xx) to improve the conditions of postpartum conditions in the State;

(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(i) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations (or a consortium of such organizations); and

(ii) 3 percent of such amount for purposes of making grants to eligible entities that are States.
attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance.

(4) Providing education about postpartum complications and newborn depression and treatment. Such education may include—

(A) providing complete information on postpartum conditions, symptoms, methods of recognizing the illness, and treatment resources; and

(B) in the case of a grantee that is a State, hospital, or birthing facility—

(i) ensuring that newborns and newborn mothers receive education on postpartum conditions and treatment resources; and

(ii) ensuring that training programs regarding such education are carried out at the health facility.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION. Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended at the end of the following:

SEC. 2951. PERSONAL RESPONSIBILITY EDUCATION.

(1) AMOUNT. —

(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

(ii) the State youth population percentage determined under paragraph (2).

(B) MINIMUM AMOUNT.—

(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

(i) IN GENERAL.—A State shall not be paid an allotment under this paragraph (1)(A)(i) or 2953(c) for fiscal year 2010 unless the State, at a minimum, submits an application for the fiscal year and the Secretary approves the application before the end of the fiscal year.

(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The application required under clause (i) shall be made to a State from the allotment of States that submit applications under this subparagraph in a fiscal year.

(iii) APPLICATION AND REPORT.—The Secretary shall establish requirements for the content and format of the application and shall include the following information for the State's plan for the fiscal year:

(A) description of the State's youth population for which the State is eligible to receive funds;

(B) description of the State's youth population for which the State has not been awarded funds;

(C) description of the State's youth population that is eligible for funding under this paragraph; and

(D) description of the State's youth population for which the State has not been awarded funds.

(iv) SUBMISSION OF APPLICATION.—Each State shall submit an application to the Secretary for fiscal year 2010 and each fiscal year thereafter for which the Secretary determines the State is eligible to receive funds under this paragraph.

(2) REPORT BY THE SECRETARY.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION. Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended at the end of the following:

SEC. 2951. PERSONAL RESPONSIBILITY EDUCATION.

(1) AMOUNT. —

(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

(ii) the State youth population percentage determined under paragraph (2).

(B) MINIMUM AMOUNT.—

(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

(i) IN GENERAL.—A State shall not be paid an allotment under this paragraph (1)(A)(i) or 2953(c) for fiscal year 2010 unless the State, at a minimum, submits an application for the fiscal year and the Secretary approves the application before the end of the fiscal year.

(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The application required under clause (i) shall be made to a State from the allotment of States that submit applications under this subparagraph in a fiscal year.

(iii) APPLICATION AND REPORT.—The Secretary shall establish requirements for the content and format of the application and shall include the following information for the State's plan for the fiscal year:

(A) description of the State's youth population for which the State is eligible to receive funds;

(B) description of the State's youth population for which the State has not been awarded funds;

(C) description of the State's youth population that is eligible for funding under this paragraph; and

(D) description of the State's youth population for which the State has not been awarded funds.

(iv) SUBMISSION OF APPLICATION.—Each State shall submit an application to the Secretary for fiscal year 2010 and each fiscal year thereafter for which the Secretary determines the State is eligible to receive funds under this paragraph.

(2) REPORT BY THE SECRETARY.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION. Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 2951 and 2952(c), is amended at the end of the following:

SEC. 2951. PERSONAL RESPONSIBILITY EDUCATION.

(1) AMOUNT. —

(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

(ii) the State youth population percentage determined under paragraph (2).

(B) MINIMUM AMOUNT.—

(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

(i) IN GENERAL.—A State shall not be paid an allotment under this paragraph (1)(A)(i) or 2953(c) for fiscal year 2010 unless the State, at a minimum, submits an application for the fiscal year and the Secretary approves the application before the end of the fiscal year.

(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The application required under clause (i) shall be made to a State from the allotment of States that submit applications under this subparagraph in a fiscal year.

(iii) APPLICATION AND REPORT.—The Secretary shall establish requirements for the content and format of the application and shall include the following information for the State's plan for the fiscal year:

(A) description of the State's youth population for which the State is eligible to receive funds;

(B) description of the State's youth population for which the State has not been awarded funds;

(C) description of the State's youth population that is eligible for funding under this paragraph; and

(D) description of the State's youth population for which the State has not been awarded funds.

(iv) SUBMISSION OF APPLICATION.—Each State shall submit an application to the Secretary for fiscal year 2010 and each fiscal year thereafter for which the Secretary determines the State is eligible to receive funds under this paragraph.

(2) REPORT BY THE SECRETARY.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the results of such study.
made under subsection (a)(4)(B), to enable a local organization or entity to carry out personalized responsibility education programs consistent with this subsection.

FINANCING RESPONSIBILITY EDUCATION PROGRAMS.—

(A) IN GENERAL.—In this section, the term ‘personal responsibility education program’ means a program that is designed to educate adolescents on—

(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

(ii) the 3rd of the adulthood preparation subjects described in subparagraph (C).

(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

(i) The program incorporates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

(ii) The program is medically-accurate and complete.

(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

(v) The program provides age-appropriate information and activities.

(vi) The information and activities carried out by the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

(C) ADULTHOOD PREPARATION SUBJECTS.—

The adulthood preparation subjects described in this subparagraph are the following:

(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

(ii) Personal development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other topics.

(iii) Financial literacy.

(iv) Parent-child communication.

(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

(C) RESERVATIONS OF FUNDS.—

(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and tailored services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in high birth rate communities.

An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

(B) SECRETARIAL RESPONSIBILITIES.—The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the activities described in clauses (ii) and (iii).

(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, research, training, and technical assistance, including dissemination of research and information regarding effective and promising practices, providing consultation and resources on a broad array of teen pregnancy prevention strategies, including abstinence and contraception, and developing resources and materials to support the activities of recipients of grants and other States, territorial organizations working to reduce teen pregnancy.

Carrying out such functions, the Secretary shall collaborate with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(iii) EVALUATION.—The Secretary shall evaluate the programs and activities carried out with funds provided through allotments or grants made under this section.

(D) ADMINISTRATION.—

(i) IN GENERAL.—The Secretary shall administer this section through the Assistant Secretary for Administration for Children and Families within the Department of Health and Human Services.

(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, and in consultation with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(iii) EVALUATION.—The Secretary shall provide, directly or through a competitive grant process, and in consultation with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(iv) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, and in consultation with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(E) ADMINISTRATION.—

(i) IN GENERAL.—The Secretary shall administer this section through the Assistant Secretary for Administration for Children and Families within the Department of Health and Human Services.

(ii) PROGRAM SUPPORT.—The Secretary shall provide, directly or through a competitive grant process, and in consultation with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(iii) EVALUATION.—The Secretary shall provide, directly or through a competitive grant process, and in consultation with a variety of entities that have expertise in the prevention of teen pregnancy, HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility education programs.

(F) RESERVATIONS OF FUNDS.—The Secretary shall reserve 10 percent of such remainder for purposes of awarding grants to entities that are qualified under section 412 of the Health Resources and Services Administration Act (42 U.S.C. 290bb–3), the Secretary determines appropriate for grants to Indian tribes or tribal organizations.

SEC. 2954. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking ‘fiscal year 1998 and each subsequent fiscal year’ and inserting ‘each of fiscal years 2010 through 2014’; and

(2) in subsection (d)–

(A) in the first sentence, by striking ‘1998 through 2003’ and inserting ‘2010 through 2014’; and

(b) in the second sentence, by inserting ‘except that such appropriation shall be available for obligation only if the Secretary certifies that the State or local organization to which the grant is awarded has designated another individual to make health care decisions on behalf of the child if the child is unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law’ after ‘an annual amount of $50,000’; and

(c) in subsection (e), by striking ‘2008’ and inserting ‘through 2014’; and

(d) in subsection (f), by striking ‘2008’ and inserting ‘through 2014’; and

(e) in subsection (g), by striking the first sentence and inserting ‘States subject to the requirement under section 412 of the Health Resources and Services Administration Act (42 U.S.C. 290bb–3)’.

SEC. 2955. INCLUSION OF INFORMATION ABOUT A HEALTH CARE POWER OF ATTORNEY FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) TRANSITION PLANNING.—Section 477(b)(3) of the Social Security Act (42 U.S.C. 677(b)(3)) is amended by adding ‘includes information about the importance of designating another individual to make health care decisions on behalf of the child if the child is unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law’ after ‘employment services.’

(b) INDEPENDENT LIVING EDUCATION.—Section 471(b)(3) of such Act (42 U.S.C. 671(b)(3)) is amended by adding at the end the following:—

‘(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section is provided with education about the importance of designating another individual to make health care decisions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law, after ‘employment services.’

SEC. 2956. RESERVATION OF FUNDS FOR IMPROVEMENT ACT.

Amounts appropriated under this subsection shall remain available until expended."
(c) Health Oversight and Coordination Plan.—Section 422(b)(15)(A) of such Act (42 U.S.C. 1322(b)(15)(A)) is amended—

(i) in clause (v), by striking “and” at the end; and

(ii) by adding at the end the following:

“(vii) steps to ensure that the components of the transition plan development process required under section 475(h)(2) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, health information about a health care power of attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute are met; and

(d) Effective Date.—The amendments made by this section take effect on October 1, 2010.

Title III—Improving the Quality and Efficiency of Health Care

Subtitle A—Transforming the Health Care Delivery System

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

Sec. 3001. Hospital Value-Based Purchasing Program.

(a) Program.—(1) In General.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 452(a) of theHITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

“(o) Hospital Value-Based Purchasing Program.—

“(1) Establishment.—

“(A) In General.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’).

(B) Program to Begin in Fiscal Year 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

(C) Applicability of Program to Hospitals.—

“(i) In General.—For purposes of this subsection, subject to clause (ii), the term ‘hospital’ means a hospital (as defined in subsection (d)(1)(B)).

“(ii) Exclusions.—The term ‘hospital’ shall not include, with respect to a fiscal year,–

“(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

“(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

“(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year;

“(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year;

“(V) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients; and

“(VI) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year;

“(VII) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

“(VIII) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year;

“(IX) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

“(X) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year;

“(XI) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

“(XII) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year;

“(XIII) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients; and

“(XIV) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year.

“(B) Program Requirements.—

“(1) For Fiscal Year 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall—

“(I) Conditions or Procedures.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:—

“(aa) Acute myocardial infarction (AMI).

“(bb) Heart failure.

“(cc) Pneumonia.

“(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as ‘Surgical Infection Prevention’ for discharges occurring before July 2006).

“(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

“(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

“(III) Inclusion of Efficiency Measures.—

“For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of ‘Medicare spending per beneficiary’. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

“(C) Limitations.—

“(i) Time Requirement for Prior Reporting and Notice.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period until such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Web site for at least 1 year prior to the beginning of such performance period.

“(ii) Measure Not Applicable Unless Hospital Furnishes Services Appropriate to the Measure.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services that are appropriate to the measure.

“(D) Replacing Measures.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

“(E) Performance Standards.—

“(A) Establishment.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

“(B) Achievement of Improvement.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

“(C) Timing of Announcement.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

“(D) Considerations in Establishing Standards.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

“(i) practical experience with the measures in question, including the fact that a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

“(ii) historical performance standards;

“(iii) improvement rates; and

“(iv) the opportunity for continued improvement.

“(F) Performance Period.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

“(G) Hospital Performance Score.—

“(A) In General.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the ‘hospital performance score’) for each hospital for each performance period.

“(B) Application.—

“(i) Appropriate Distribution.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in a distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals with the highest hospital performance scores receiving the largest value-based incentive payments.

“(ii) Higher of Achievement or Improvement.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

“(iii) Weights.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

“(iv) No Minimum Performance Standard.—The Secretary shall set a minimum performance standard in determining the hospital performance score for any hospital.

“(E) Reflection of Measures Applicable to the Hospital.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

“(F) Calculation of Value-Based Incentive Payments.—

“(i) In General.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year that is the value-based incentive payment amount.

“(ii) Value-Based Incentive Payment Amount.—The value-based incentive payment amount for each hospital in a fiscal year shall be equal to the product of—

“(I) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses any of the performance standards under paragraph (3) for the performance period for such fiscal year.
"(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGES.—

(1) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

(ii) No effect on other payments.—Payments described in items (aa) and (bb) of subparagraph (A)(iv), (A)(v), (A)(vi), (A)(vii), (B), (F), and (12) of subsection (d) and (aa) and (bb) of subparagraph (C)(vii) apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

(2) Public reporting.—

(A) Hospital specific information.—(i) In general.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

(1) the performance of the hospital with respect to each condition or procedure; and

(2) the performance of the hospital with respect to each measure that applies to the hospital.

(ii) Opportunity to review and submit corrections.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

(iii) Warnings.—If the information shall be posted on the Hospital Compare Internet website in an easily understandable format.

(B) Aggregate information.—The Secretary shall post the Hospital Compare Internet website aggregate information on the Program, including—

(1) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

(2) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

(3) Appeals.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital’s performance assessment score under paragraph (3) based on the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides a timely resolution of such appeals.

(B) Limitation on review.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1899, section 1876, or otherwise of the following:

(1) The methodology used to determine the amount of value-based incentive payments under paragraph (6) and the determination of such amount.

(2) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B).

(3) The establishment of the performance standards under paragraph (5) and the performance period under paragraph (4).

(4) The methodology used to determine the measures under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

(5) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

(6) The validation methodology specified in subsection (b)(9).

(C) Consultation with small hospitals.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

(12) Promulgation of regulations.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6)."


(A) in subsection (B), by striking "beginning with fiscal year 2008" and inserting "for fiscal years 2008 through 2012"; and

(C) in subsection (VII), in the first sentence, by striking "data submitted" and inserting "information regarding measures submitted"; and

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

(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

(9) Subject to section 1899(a). The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under paragraph (6)."
clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as added by section 1020(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

‘‘(x) The Secretary shall develop standard Internet website reports tailored to reflect the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in developing the type of information that is useful and the formats that best facilitate the use of the information.

(ii) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.’’.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include analysis of the impact of such program on—

(i) the quality of care furnished to Medicare patients; and

(ii) the appropriateness of the Medicare program in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(5) HHS STUDY AND REPORT—

(A) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM.—

(I) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(1) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this sense, the ‘‘Secretary’’) shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))).

(ii) A PPlicable Hospital Defined.—For the purposes of this paragraph, a critical access hospital means a hospital described in section 1861(mm) (42 U.S.C. 1395x(mm))), as added by subsection (a)(1).

(B) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program under this paragraph.

(6) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(7) Sites.—The Secretary shall conduct the demonstration program under this paragraph at hospitals in at least 3 states that are part of a permanent value-based purchasing program under the Medicare program for applicable hospitals.

(B) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) Budget Neutral Requirement.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(ii) in clause (i), by striking ‘‘and’’ at the end;

(iii) in clause (ii), by striking the period at the end and inserting a semicolon; and

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

‘‘(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.’’;

(2) in paragraph (3)(A) (in the matter preceding clause (i), by striking ‘‘2010’’ and inserting ‘‘2014’’); and

(B) in subparagraph (B), by striking ‘‘and’’ at the end.

2. Improvements to the Physician Quality Reporting System.

(a) Extension.—Section 1880c(e) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ‘‘2010’’ and inserting ‘‘2014’’; and

(B) in subparagraph (B), in clause (i), by striking ‘‘and’’ at the end;

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

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

‘‘(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.’’;

(2) in paragraph (3) (A), in the matter preceding clause (i), by inserting ‘‘(or, for purposes of subsection (a)(8), for the quality reporting period for the year)’’ after ‘‘reporting period’’; and

(B) in subparagraph (C) (i), by inserting ‘‘, or, for purposes of subsection (a)(8), for a quality reporting period for the year after’’ after ‘‘(a)(5)’’, (for a reporting period for a year);’’.

(3) in paragraph (5)(E)(iv), by striking ‘‘subsection (a)(5)(A)’’ and inserting ‘‘paragraphs (5)(A) and (5)(A) of subsection (a);’’.

(4) in paragraph (6)(C) (A) (in clause (i)II), by striking ‘‘2009, 2010, and 2011’’ and inserting ‘‘and subsections’’.

(B) in clause (ii),

(i) by inserting ‘‘(a)’’ after ‘‘(a)5’’; and

S11674

CONGRESSIONAL RECORD — SENATE
November 19, 2009
(ii) by striking "under subparagraph (D)(iii) of such subsection" and inserting "under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(5)(D)(iii), respectively".

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by inserting at the end the following new paragraph:

"(8) INCENTIVES FOR QUALITY REPORTING.—

"(A) ELIGIBILITY.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3), (i), (ii), or (9), but without regard to this paragraph):

"(i) APPLICABLE PERCENT.—For purposes of clause (i), the term ‘applicable percent’ means—

"(I) for 2015, 98.5 percent; and

"(II) for 2016 and each subsequent year, 98 percent.

(c) APPLICABLE PERIOD.—

"(1) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of such subsection.

"(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(1)(B)(iii) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

(d) DEFINITIONS.—For purposes of this paragraph:

"(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms ‘eligible professional’ and ‘covered professional services’ have the meanings given such terms in subsection (k)(3).

"(ii) PHYSICIAN REPORTING SYSTEM.—The term ‘physician reporting system’ means the system established under subsection (k).

"(iii) QUALITY REPORTING PERIOD.—The term ‘quality reporting period’ means, with respect to a year, a period specified by the Secretary.

(e) MAINTENANCE OF CERTIFICATION PROGRAMS.—

"(1) IN GENERAL.—Section 1868(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by inserting ‘‘or through a Maintenance of Certification program operated by a specialty body of the American Board of Medicine that meets the criteria for such a registry’’ after ‘‘Database’’.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2010.

(f) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1868(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

"(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the use of electronic health records. Such integration shall consist of the following:

"(A) The selection of measures, the reporting of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(B) Such other activities as specified by the Secretary.

"(C) Definitions.—For purposes of this paragraph:

"(D) DEVELOPMENT OF EPISODE GROUPLER.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

"(E) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

"(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

"(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1909(a).

"(b) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(c) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as techniques to attribute episodes of care, in whole or in part, to physicians;

"(i) identify appropriate physicians for purposes of comparison under subparagraph (B); and

"(ii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

"(d) FEEDBACK.—Prior to preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments for

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(f) DEFINITION OF PHYSICIAN.—In this paragraph:

"(1) IN GENERAL.—The term ‘physician’ has the meaning given that term in section 1861(r)(1).

"(2) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the establishment of the methodology under subsection (C), including the determination of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(D) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(E) PUBLIC AVAILABILITY.—The Secretary shall make available to the public:

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) DEFINITION OF PHYSICIAN.—In this paragraph:

"(1) IN GENERAL.—The term ‘physician’ has the meaning given that term in section 1861(r)(1).

"(2) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the establishment of the methodology under subsection (C), including the determination of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(D) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(E) PUBLIC AVAILABILITY.—The Secretary shall make available to the public:

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) DEFINITION OF PHYSICIAN.—In this paragraph:

"(1) IN GENERAL.—The term ‘physician’ has the meaning given that term in section 1861(r)(1).

"(2) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the establishment of the methodology under subsection (C), including the determination of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(D) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(E) PUBLIC AVAILABILITY.—The Secretary shall make available to the public:

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) DEFINITION OF PHYSICIAN.—In this paragraph:

"(1) IN GENERAL.—The term ‘physician’ has the meaning given that term in section 1861(r)(1).

"(2) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the establishment of the methodology under subsection (C), including the determination of which would both demonstrate—

"(i) meaningful use of an electronic health record for purposes of subsection (o); and

"(ii) quality of care furnished to an individual.

"(D) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

"(E) PUBLIC AVAILABILITY.—The Secretary shall make available to the public:

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.
(a) **LONG-TERM CARE HOSPITALS.**—Section 1886(m) of the Social Security Act (42 U.S.C. 1395w(m)), as amended by section 340(c), is amended by adding at the end the following new paragraph:

"(5) QUALITY REPORTING.—

(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase factor described in paragraph (3)(C), the Secretary shall reduce such increase factor for payments for discharges occurring during such fiscal year by 2 percentage points.

(ii) SPECIAL RULE.—The application of this subparagraph may result in payment rates under the system described in paragraph (1) for a subsequent rate year, and after application of paragraph (3), shall be reduced by 2 percentage points.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved.

(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(D) QUALITY MEASURES.—

(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.

(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by a consensus organization identified by the Secretary, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

(iii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.

(F) QUALITY REPORTING.—For purposes of fiscal year 2014 and each subsequent fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.

(2) by inserting after paragraph (1)(C)(i), with respect to the fiscal year, the Secretary shall reduce such market basket percentage increase by 2 percentage points.
each hospital described in such section shall submit to the Secretary the data on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and in a format determined by the Secretary for purposes of this subparagraph.

"(3) QUALITY MEASURES.—

(A) IN GENERAL.—Subject to subparagraph (B), each hospital described in such section shall submit data to the Secretary under this paragraph that will be endorsed by the Secretary under section 1890(a).

(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the Secretary under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

"(D) METHODS FOR THE PUBLIC DISCLOSURE OF INFORMATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties; and

"(E) OTHER ISSUES DETERMINED APPROPRIATE.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties; and

"(F) IMPLEMENTATION.—In developing the plan under paragraph (1), the Secretary shall provide for purposes of this subparagraph.

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(A) SKILLED NURSING FACILITIES.—

(I) IN GENERAL.—The Secretary of Health and Human Services shall develop a plan to implement a value-based purchasing program for payments under the Medicare program for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(II) QUALITY.—

(A) The ongoing development, selection, and modification process for measures (including under section 1890(c) of the Social Security Act (42 U.S.C. 1395aa) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) ANY OTHER ISSUES DETERMINED APPROPRIATE.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties; and

(F) IMPLEMENTATION.—In developing the plan under paragraph (1), the Secretary shall provide for purposes of this subparagraph.

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1489 of the Social Security Act (42 U.S.C. 1395s) is amended to the following:

(1) in subsection (b)(1), by inserting "subject to subsection (p)," after "1998,"; and

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

"(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

(I) IN GENERAL.—The Secretary shall establish a payment modifier that provides for the value-based modifier.

(II) QUALITY.—

(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be as determined by the Secretary.

(B) MEASURES.—

(I) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be as determined by the Secretary.

(II) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

(III) Costs.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socioeconomic and demographic characteristics, etc.) and the impact on other individuals (such as to recognize that less healthy individuals may require more intensive interventions and other factors) as determined appropriate by the Secretary.

(IV) IMPLEMENTATION.—

(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

(I) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

(II) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

(III) THE INITIAL PERFORMANCE PERIOD (AS SPECIFIED UNDER SUBPARAGRAPH (B) SUBPARAGRAPH (B)).

(B) DEADLINES FOR IMPLEMENTATION.—

(I) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under subsection (a), and in accordance with section 1897(c), the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(II) IMPLEMENTATION.—The Secretary shall establish a payment modifier that provides for the value-based modifier.

(III) BUDGET NEUTRALITY.—The payment modifier shall be budget neutral.

(IV) IN GENERAL.—The Secretary shall establish a payment modifier that provides for the value-based modifier.

(V) EFFECTIVE DATE.—The Secretary shall establish a payment modifier that provides for the value-based modifier.

(VI) MEASURES.—

(A) IN GENERAL.—Time frame.

(B) QUALITY.—

(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be as determined by the Secretary.
"(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

"(6) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under section 1869, and the Secretary determines appropriate, other similar provisions of this title.

"(7) REPORTING TO HOSPITALS.—Prior to fiscal year 2017, the Secretary shall provide confidential reports to applicable hospitals with respect to the applicable hospital acquired conditions of the applicable hospital during the applicable period.

SEC. 3011. NATIONAL STRATEGY.

(a) ESTABLISHMENT OF NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

(b) REQUIREMENTS.—The Secretary shall establish a national strategy for quality improvement in the delivery of health care services that has the potential for rapid improvement in the quality and efficiency of patient care.

(c) ROLE OF THE SECRETARY.—The Secretary shall address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques.

(d) IMPROVEMENTS.—The Secretary shall improve Federal payment policy to emphasize quality and efficiency.

(e) Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

(f) Improve the health care provided to patients with high-cost chronic diseases.

(g) Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections.

(h) Address gaps in quality, efficiency, and outcomes.

(i) Improve health care access for patients with health care disparities, including children and vulnerable populations.

(2) IDENTIFICATION OF PRIORITIES.—(A) IN GENERAL.—In order to provide an index for reducing hospital acquired conditions of each applicable hospital.

(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall make the information available to the applicable hospital, hospital or hospital system, and shall provide the opportunity to review and submit corrections for the information.

(3) REPORTING TO HOSPITALS.—Prior to fiscal year 2017, the Secretary shall provide confidential reports to applicable hospitals with respect to the hospital acquired conditions of the applicable hospital during the applicable period.

(4) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1899z-3, section 1878, or otherwise of—

(A) the establishment of the value-based payment modifier under this subsection;

(B) the evaluation of quality of care under paragraph (2)(A); and

(C) the determination of costs under paragraphs (3)(B) and (5)(B).

(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2017, the Secretary shall provide confidential reports to applicable hospitals with respect to the hospital acquired conditions of the applicable hospital during the applicable period.

(6) HOSPITAL ACQUIRED CONDITIONS.—(A) IN GENERAL.—The Secretary shall establish a national strategy for quality improvement in the delivery of health care services that has the potential for rapid improvement in the quality and efficiency of patient care.

(B) REQUIREMENTS.—The Secretary shall establish a national strategy for quality improvement in the delivery of health care services that has the potential for rapid improvement in the quality and efficiency of patient care.

(C) ROLE OF THE SECRETARY.—The Secretary shall address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques.

(D) IMPROVEMENTS.—The Secretary shall improve Federal payment policy to emphasize quality and efficiency.

(E) Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

(F) Improve the health care provided to patients with high-cost chronic diseases.

(G) Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections.

(H) Address gaps in quality, efficiency, and outcomes.

(I) Improve health care access for patients with health care disparities, including children and vulnerable populations.

(II) Improve the health care provided to patients with high-cost chronic diseases.

(III) Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections.

(IV) Improve health care access for patients with health care disparities, including children and vulnerable populations.

(2) IDENTIFICATION OF PRIORITIES.—(A) IN GENERAL.—The Secretary shall address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques.

(B) REQUIREMENTS.—The Secretary shall establish a national strategy for quality improvement in the delivery of health care services that has the potential for rapid improvement in the quality and efficiency of patient care.

(C) ROLE OF THE SECRETARY.—The Secretary shall address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques.

(D) IMPROVEMENTS.—The Secretary shall improve Federal payment policy to emphasize quality and efficiency.

(E) Enhance the use of health care data to improve quality, efficiency, transparency, and outcomes.

(F) Improve the health care provided to patients with high-cost chronic diseases.

(G) Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections.

(H) Address gaps in quality, efficiency, and outcomes.

(I) Improve health care access for patients with health care disparities, including children and vulnerable populations.

(II) Improve the health care provided to patients with high-cost chronic diseases.

(III) Improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections.

(IV) Improve health care access for patients with health care disparities, including children and vulnerable populations.

(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations of the National Committee for Health Care in a particular area and the Secretary shall, as appropriate, apply the payment modifier established under this section in a manner that promotes systems-based care.
(D) Coordination with State agencies.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children’s Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, and timetables that are consistent with the national priorities identified under paragraph (A).

(b) Strategic Plan.—

(1) General.—The strategic plan shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

(2) Requirements.—The strategic plan shall include provisions for addressing, at a minimum, the following:

(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures identified by the Secretary under section 1139A or 1139B of the Social Security Act or endorsed under section 1890 of such Act.

(B) Agency-specific strategic plans to achieve national priorities.

(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

(E) Strategies to align public and private payers with regard to quality and patient safety efforts.

(F) Incorporating quality improvement and related improvement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

(c) Implementation of National Strategy.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

(d) Submission and Availability of National Strategy and Updates.—

(1) Deadline for initial submission of national strategy.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

(2) Periodic update of national strategy.—(A) In general.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1) and the process used to make such identification.

(B) Information submitted.—Each update submitted under subparagraph (A) shall include—

(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

(ii) an analysis of the progress, or lack of progress, of each goal and any barriers to such progress;

(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

(iv) in the case of an update required to be submitted on or after January 1, 2014, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

(c) Grants or Contracts for Quality Improvement.

(1) In general.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for the purpose of developing, improving, updating, or expanding quality measures identified under subsection (b).

(2) Prioritization in the development of quality measures.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow for the assessment of—

(A) health outcomes and functional status of patients;

(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to

(e) Health Care Quality Internet Website.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

(i) the national priorities for health care quality improvement established under subsection (a)(2); and

(ii) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B) and

(3) other information, as the Secretary determines to be appropriate.

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

(a) In general.—The President shall convene a working group known as the Interagency Working Group on Health Care Quality (referred to in this section as the “Working Group”).

(b) Goals.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 399HH(a)(2).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, wherever practicable, and a streamlined process for quality reporting and compliance requirements.

(3) Assessment of quality efforts in the public sector with private sector initiatives.

(c) Composition.—

(1) In general.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

(B) the Centers for Medicare and Medicaid Services;

(C) the National Institutes of Health;

(D) the Centers for Disease Control and Prevention;

(E) the Food and Drug Administration;

(F) the Health Resources and Services Administration;

(G) the Agency for Healthcare Research and Quality;

(H) the Office of the National Coordinator for Health Information Technology;

(I) the Substance Abuse and Mental Health Services Administration;

(J) the Administration for Children and Families;

(K) the Department of Commerce;

(L) the Office of Management and Budget;

(M) the United States Coast Guard;

(N) the Federal Bureau of Prisons;

(O) the Federal Highway Traffic Safety Administration;

(P) the Federal Trade Commission;

(Q) the Social Security Administration;

(R) the Department of Labor;

(S) the United States Office of Personnel Management;

(T) the Department of Defense;

(U) the Department of Education;

(V) the Department of Veterans Affairs;

(W) the Veterans Health Administration; and

(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) Chair.—(A) Chair.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) Vice-Chair.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) Report to Congress.—Not later than December 31, 2010, and annually thereafter, the Secretary shall convene the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. Quality Measure Development.

(a) Public Health Service Act.—Title IX of the Public Health Service Act (42 U.S.C. 300 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by redesigning sections 931 through 938 as sections 941 through 948, respectively, and in section 948(b), by striking “931” and inserting “941”; and

(4) by inserting after section 926 the following:

“PART D—Health Care Quality Improvement

Subpart I—Quality Measure Development

SEC. 931. Quality Measure Development.

(a) Quality Measure.—In this subpart, the term ‘quality measure’ means a standard or metric for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

(b) Identification of Quality Measures.—

(1) Identification.—The Secretary, in consultation with the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall identify, not less often than triennially, gaps where no quality measures exist and existing quality measures that need improvement, updating, or expansion, consistent with the national strategy under section 399HH, to the extent available, for use in Federal health care programs. In identifying such gaps and existing quality measures that need improvement, the Secretary shall take into consideration—

(A) the gaps identified by the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders;

(B) quality measures identified by the pe
diotor of the quality measure program under section 1139A of the Social Security Act; and

(C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

(2) Publication.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

(c) Grants or Contracts for Quality Measure Development.—

(1) In general.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for the purpose of developing, improving, updating, or expanding quality measures identified under subsection (b).

(2) Prioritization in the development of quality measures.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow for the assessment of—

(A) health outcomes and functional status of patients;

(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to
inform decisionmaking about treatment options, including the use of shared decision-making tools and preference sensitive care (as defined in section 306);

"(D) the meaningful use of health information technology;

"(E) the safety, effectiveness, patient-centerenedness, appropriateness, and timeliness of care;

"(F) the efficiency of care;

"(G) the equity of health services and health disparities across health disparity populations (as defined in section 483K) and geographic areas;

"(H) patient experience and satisfaction;

"(I) the use of innovative strategies and methodologies identified under section 911; and

"(J) other areas determined appropriate by the Secretary.

"(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall:

"(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

"(B) have adopted procedures to include in the quality measure development process—

"(i) patient, family, and other provider or payer whose performance will be assessed by the measure;

"(ii) reviews of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

"(C) collaborate with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

"(D) have appropriate policies regarding governance and conflicts of interest; and

"(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

"(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

"(A) Such measures support requirements required to be reported under the Social Security Act and other applicable law, and in support of gaps and existing quality measures that need improvement, as described in subsection (b)(1)(A).

"(B) Such measures support measures developed under section 1139A of the Social Security Act and the Medicaid Quality Measurement Program under section 1139B of such Act, where applicable.

"(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

"(D) Each quality measure is free of charge to users of such measure.

"(E) Each quality measure is publicly available on an Internet website.

"(5) DEVELOPMENT OF QUALITY MEASURES.—The Administrator of the Center for Medicare & Medicaid Services shall through contracts develop quality measures (as determined by the Administrator) that provide for use under this Act. In developing such measures, the Administrator shall consult with the Director of the Agency for Healthcare Research and Quality.

"(c) FUNDING.—There are authorized to be appropriated to the Secretary of Health and Human Services to carry out this section, $75,000,000 for each of fiscal years 2010 through 2014. Of the amounts appropriated under the preceding sentence in a fiscal year, not less than 50 percent of such amounts shall be reported under the preceding sentence in a fiscal year shall remain available until expended.

SEC. 3014. QUALITY MEASUREMENT.

(a) NEW DUTIES FOR CONSENSUS-BASED ENTITY;

"(1) MULTI-STAKEHOLDER GROUP INPUT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aa(b)), as amended by section 3003, is amended by adding at the end the following new paragraph:

"(4) CONSIDERATION OF MULTI-STAKEHOLDER GROUPS.—

"(A) IN GENERAL.—The entity shall convene multi-stakeholder groups to provide input on—

"(i) the selection of quality measures described in subparagraph (B), from among—

"(I) such measures that have been endorsed by the entity; and

"(II) such measures that have not been considered for endorsement by such entity but are used or proposed to be used by the Secretary for the collection or reporting of quality measures;

"(B) NATIONAL PRIO RITIES.—(I) The National Quality Forum shall, in consultation with the entity, develop multi-stakeholder consensus-based categories of priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

"(ii) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act and where targeted research may address such gaps; and

"(v) the matters described in clauses (i) and (ii) of paragraph (7)(A).

"(b) MULTI-STAKEHOLDER GROUP INPUT INTO SELECTION OF QUALITY MEASURES.—The Secretary shall establish a pre-rulemaking process under which the following steps occur with respect to the selection of quality measures described in section 1890(b)(7)(B):

"(1) INPUT.—Pursuant to section 1890(b)(7), the entity with a contract under section 1890 shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in subparagraph (B) of such paragraph.

"(2) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—The Secretary shall make available to the public a list of quality measures described in section 1890(b)(7)(B) that the Secretary is considering under this title.

"(3) TRANSMISSION OF MULTI-STAKEHOLDER GROUP INPUT.—Pursuant to section 1890(b)(8), not later than February of each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1),

"(4) CONSIDERATION OF MULTI-STAKEHOLDER GROUP INPUT.—The Secretary shall take into consideration the input from the multi-stakeholder groups described in paragraph (1) in selecting quality measures described in section 1890(b)(7)(B) that has not been endorsed by the entity with a contract under section 1890.
“(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

(a) conduct an assessment of the quality improvement measures described in section 1899(f)(7)(B); and

(b) make such assessment available to the public.

(7) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality improvement measures used by the Secretary. Such process shall include the following:

(A) The incorporation of such measures, where applicable, in workforce programs, training, or any other form of dissemination determined appropriate by the Secretary.

(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

(2) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the process described in paragraph (1).

(3) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

(A) IN GENERAL.—The Secretary shall—

(i) periodically review and determine whether to endorse existing measures described in section 1899(f)(7)(B); and

(ii) with respect to each such measure, determine whether to—

(I) maintain the use of such measure; or

(II) phase out such measure.

(B) EXISTING METHODS.—In conducting the review under paragraph (1), the Secretary shall take steps to—

(A) seek to avoid duplication of measures used; and

(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary.

(4) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using its own quality measures identified under sections 1139A and 1139B.

(c) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary may enter into agreements with the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395j) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395w), in such proportion as the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014.

(d) COORDINATION.—Where appropriate, the Secretary shall coordinate the manner in which health care providers and other groups and organizations appropriate, and may use, such information, and provide such information to health care providers, and other groups and organizations appropriate, and may use, such information, and provide such information to health care providers, and other groups and organizations as appropriate, with an opportunity to comment on, and make recommendations to, the Secretary about the use of such information.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

"SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

"(a) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation in such department or agency as may be necessary for fiscal years 2010 through 2014.

"(b) GRANTS OR CONTRACTS FOR DATA COLLECTION, ANALYSIS AND DEVELOPMENT OF PERFORMANCE INFORMATION.—

(1) DEVELOPMENT OF PERFORMANCE WEBSITES.—The Secretary shall establish a performance website for the public, through the use of a multi-stakeholder entity that coordinates development of methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary. The Secretary shall make such performance website available to the public, through standardized Internet websites.

(2) CONSISTENT DATA AGGREGATION.—The Secretary shall provide standards for the protection of the security and privacy of patient data.

(3) MATCHING FUNDS.—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 3022. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by adding after title XIX the following new title:

"TITLE XXI—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

"SUBTITLE A—CEO AUTHORITY

"SECTION 2101. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION.

"(a) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation in such department or agency as may be necessary for fiscal years 2010 through 2014."

SEC. 3023. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION.

(a) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation in such department or agency as may be necessary for fiscal years 2010 through 2014.

(b) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this Act.
(iii) an individual who meets the criteria of both clauses (i) and (ii).

(B) APPLICABLE TITLE.—The term ‘applicable title’ means title XVIII, title XIX, or both.

(b) TESTING OF MODELS (PHASE I).—

(1) In general.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (d)(1)(B)) on program expenditures and outcomes under such titles and the quality of care received by individuals receiving benefits under such title.

(2) SELECTION OF MODELS TO BE TESTED.—

(A) In general.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the models address a targeted population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected for the preceding sentence may include the models described in subparagraph (B).

(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

(i) Promoting broad payment and practice reforms that promote innovative care delivery models, such as through risk-based comprehensive payment for care or salary-based payment.

(ii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

(I) an inability to perform 2 or more activities of daily living.

(II) Cognitive impairment, including dementia.

(iii) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

(iv) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

(v) Contracting payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician’s adherence to appropriate- ness criteria developed by the Secretary or the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

(vi) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

(vii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

(viii) Establishing payment to providers of services and suppliers for using patient decision-support tools, including tools to promote and promote self-management and to coordinate care over time and across settings.

(ix) Whether the model provides for the monitoring of a closed relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and supplies on a real time basis.

(x) Whether the models rely on a team-based approach to interventions, such as comprehensive care assessments, care planning, self-management, remote monitoring systems, to coordinate care over time and across settings.

(xi) Whether under the applicable title, providers and suppliers are able to share information with patients, caregivers, and other providers of services and supplies on a real time basis.

(xii) Whether the model provides for the expansion of a closed relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and supplies on a real time basis.

(xiii) Whether the model provides for the expansion of a closed relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and supplies on a real time basis.

(xiv) Whether the model includes an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

(xv) Whether the model includes an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

B) TERMINATION OR MODIFICATION.—

The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines that the Secretary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies, after testing has begun, that the model is expected to—

(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without reducing the quality of care; or

(ii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

(c) EVALUATION.—

(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

(B) INFORMATION.—The Secretary shall include in each evaluation under this subsection a description of the model tested under this subsection and a description of the impact of the model on care delivery and care coordination, and a description of the impact of the model on program expenditures and outcomes for applicable individuals in cooperation with applicable individuals, including family members or other informal caregivers of the applicable individual, including family members or other informal caregivers of the applicable individual.

(D) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

(i) Whether the model includes an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

(ii) Whether the model includes an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

(iii) Whether the model includes an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

(iv) Whether the model includes an analysis of—

(I) the quality of care furnished under the applicable title.

(II) the changes in spending under the applicable title.

(e) EXPANSION OF MODELS (PHASE II).—

Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary if—

(i) the model has demonstrated an improvement in the quality of care or

(ii) reducing the quality of care or

(iii) reducing spending under applicable title.
“(2) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

“(d) Determination.—

“(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(2), 1927, and 1927(1)(A)(iii) as the Secretary determines necessary solely for purposes of carrying out this section with respect to testing models described in subsection (b).

“(2) DETERMINATION REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(A) the selection of models for testing or expansion;

“(B) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

“(C) determinations regarding budget neutrality under subsection (b)(3)(B).

“(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

“(f) FUNDING.—

“(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

“(A) $5,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

“(B) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019;

“(C) the amount described in subparagraph (A)(i) for activities described in subparagraph (B) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the first 10-year fiscal period beginning with fiscal year 2020).

“Amounts appropriated under the preceding sentence shall remain available until expended.

“(g) USE OF CERTAIN FUNDS.—Out of amounts appropriated under subparagraphs (B) and (C) of paragraph (1), not less than $25,000,000 shall be made available each fiscal year to design, implement, and evaluate models under subsection (b).

“(h) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to the Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). Each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of payment models.

“(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a), as amended by section 8092(b), is amended—

“(1) in paragraph (41), by striking ‘‘and’’ at the end; and

“(2) in paragraph (42), by striking the period at the end and inserting ‘‘; and’’; and

“(c) Definitions.—

“(B) an implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State determines that implementation would not be administratively feasible or appropriate to the health care delivery system of the State."

“(3) REVIEW OF QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1396c–5) are amended by striking ‘‘(5)’’ each place it appears.

“SEC. 3022. MEDICAID SHARED SAVINGS PROGRAM.

“Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

“SEC. 1899A. (a) ESTABLISHMENT.—

“(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the ‘program’) that promotes accountability for a patient population and coordinates and integrates payments among parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program:

“(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

“(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

“(C) QUALITY PERFORMANCE STANDARDS.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

“(A) ACO professionals in group practice arrangements;

“(B) Networks of individual practices of ACO professionals.

“(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

“(D) Hospitals employing ACO professionals.

“(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

“(2) REQUIREMENTS.—An ACO shall meet the following requirements:

“(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it. Under such program, the Secretary shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the ‘agreement period’).

“(B) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participate providing providers of services and suppliers.

“(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participate providing providers of services and suppliers.

“(D) The ACO shall include primary care ACO professionals that are sufficient for the number of Medicare fee-for-service beneficiaries assigned to the ACO under subsection (b)(3)(B). At a minimum, the ACO shall have at least 5,000 such beneficiaries assigned to it under subsection (c) in order to be eligible to participate in the ACO program.

“(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other report requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

“(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

“(G) The ACO shall define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

“(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary as the use of patient and caregiver assessments or the use of individualized care plans.

“(I) QUALITY AND OTHER REPORTING REQUIREMENTS.—

“(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

“(i) clinical processes and outcomes;

“(ii) patient and, where practicable, caregiver satisfaction;

“(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

“(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on the measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning, follow-up by ACO professionals, as the Secretary determines appropriate.

“QUALITY PERFORMANCE STANDARDS.—
The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

“OTHER REPORTING REQUIREMENTS.—
The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the Medicare Physician Quality Reporting Initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments.

“(D) The ACO shall improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

“(E) DETERMINATION OF ACO QUALITY PERFORMANCE STANDARDS.—

“(F) DETERMINATION OF ACO QUALITY PERFORMANCE STANDARDS.—

“(G) The ACO shall define processes to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.
under this title, or any other program or demonstration project that involves such shared savings.

"(B) The independence at home medical practice program under section 1863E.

"(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (b)(1)(A).

"(d) PAYMENTS AND TREATMENT OF SAVINGS.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2), only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall establish a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(2) PAYMENTS FOR SHARED SAVINGS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(c) PAYMENTS AND TREATMENT OF SAVINGS.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2), only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(2) PAYMENTS FOR SHARED SAVINGS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(3) PAYMENTS FOR SHARED SAVINGS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(3) PAYMENTS FOR SHARED SAVINGS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(3) PAYMENTS FOR SHARED SAVINGS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).

"(3) PAYMENTS FOR SHARED SAVINGS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii), the Secretary shall determine the appropriate payment described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available estimate of national per capita Medicare expenditures for parts A and B services, adjusted for beneficiary characteristics, as estimated by the Secretary under subsection (b)(3), if an ACO meets the requirements under subparagraph (B)(i).
of post-acute care to the applicable beneficiary.

"(2) Development of quality measures for an episode of care and for post-acute care.

"(A) In general.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and the entity with a contract under section 1860(a) of the Social Security Act, shall develop quality measures for use in the pilot program—

(i) for episodes of care; and

(ii) for post-acute care.

"(B) Site-neutral post-acute care quality measures.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

"(C) Coordination with quality measure development and endorsement procedures.—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under sections 1888 and 1890a that are applicable to all post-acute care settings.

"(d) Details.—

"(1) Duration.—

"(A) In general.—The pilot program shall be conducted for a period of 5 years.

"(B) Extension.—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the beginning of the period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in not reducing the quality of patient care and reducing spending under this title.

"(2) Participating providers of services and suppliers.—

"(A) In general.—An entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to participate in the pilot program for episodes of care for applicable individuals under this section.

"(B) Requirements.—The Secretary shall develop requirements for entities to participate in the pilot program under this section. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

"(3) Payment methodology.—

"(A) In general.—

"(i) Establishment of payment methods.—The Secretary shall develop payment methods for the pilot program for entities participating in the pilot program. Such payment methods may include bundled payments from entities for episodes of care. The Secretary shall make payments to the entity for services covered under this section.

"(ii) No additional program expenditures.—Payments under this section for applicable items and services under this title (including payment for services described in subparagraph (B)) for applicable beneficiaries for a year shall be established in a manner that does not result in spending more for such entity for such beneficiaries than the payments otherwise expended for such entity for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

"(B) Services Otherwise Credited.—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

"(C) Bundled payments.—

"(i) In general.—A bundled payment under the program shall—

"(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary); and

"(II) be made to the entity which is participating in the pilot program.

"(ii) Requirements for provision of applicable services and other appropriate services.—Applicable services and other applicable services for which payment is made under this subparagraph shall be furnished or directed by the entity which is participating in the pilot program.

"(D) Payment for post-acute care services after the episode of care.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which payment for such services shall be made.

"(3) Quality measures.—

"(A) In general.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided by entities participating in the pilot program. Such quality measures established under the preceding sentence shall include measures of the following:

"(i) Functional status improvement.

"(ii) Reducing rates of avoidable hospital readmissions.

"(iii) Rates of discharge to the community.

"(iv) Rates of admission to an emergency room after a hospitalization.

"(v) Incidence of health care acquired infections.

"(vi) Efficiency measures.

"(vii) Measures of patient-centeredness of care.

"(viii) Measures of patient perception of care.

"(ix) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

"(B) Reporting on quality measures.—

"(i) In general.—A entity shall submit data to the Secretary on quality measures established under paragraph (1) for each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

"(ii) Submission of data through electronic health record.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13))) in a manner specified by the Secretary.

"(iii) Waiver.—The Secretary may waive such provisions of this title and title XI to applicable beneficiaries (as defined in subsection (d)) to the extent that such provisions are not necessary to carry out the purpose of this section.

"(C) Independent Evaluation and Reporting Program.—

"(i) In general.—The Secretary shall conduct an independent evaluation of the pilot program, including the extent to which the pilot program has—

"(I) improved quality measures established under subsection (c)(4)(A);

"(II) improved health outcomes;

"(III) improved applicable beneficiary access to care;

"(IV) reduced spending under this title.

"(D) Final report.—Not later than 3 years after the implementation of the pilot program, the Secretary shall submit to Congress a report on the initial results of the independent evaluation conducted under paragraph (1).

"(E) Consultation.—The Secretary shall consult with representatives of small rural hospitals, including critical access hospitals (as defined in section 1861(mm)(1)), regarding their participation in the pilot program. Such consultation shall include consideration of innovative methods of implementing bundled payments in hospitals described in this section, including consideration of any difficulties in doing so as a result of the low volume of services provided by such hospitals.

"(F) Implementation Plan.—

"(i) In general.—Not later than January 1, 2016, the Secretary shall submit a plan for implementation of an expansion of the pilot program if the Secretary determines that such expansion will result in improving or not reducing the quality of patient care and reducing spending under this title.

"(ii) Administration.—Chapter 35 of title 44, United States Code, shall not apply to the selection, testing, and evaluation of models on the expansion of such models under this section..

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866D, as inserted by section 3023, the following new section:

"INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM.

"SEC. 1866D. (a) Establishment.—

"(1) In general.—The Secretary shall conduct a demonstration program in this section (referred to as the 'demonstration program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)) to the extent that such provisions are not necessary to carry out the purpose of this section.

"(2) Requirements.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

"(A) reducing preventable hospitalizations;

"(B) preventing hospital readmissions;

"(C) reducing emergency room visits;

"(D) improving health outcomes that are commensurate with the beneficiaries' stage of chronic illness;

"(E) improving the efficacy of care, such as by reducing duplicative diagnostic and laboratory tests;

"(F) reducing the cost of health care services covered under this title; and

"(G) achieving beneficiary and family caregiver satisfaction.

"(b) Independence at home medical practice defined.—In this section—

"(1) In general.—The term 'independence at home medical practice' means a legal entity that—

"(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 assistants, pharmacists, and other health and social services staff as

November 19, 2009

CONGRESSIONAL RECORD — SENATE

S11685

SEC. 3024. INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.
appropriate who have experience providing home-based primary care to applicable bene-
diciaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out and report activities that are related to the care of the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a)."

(ii) is organized at least in part for the purpose of providing physicians' services;

(iii) has documented experience in providing home-based primary care services to high-risk chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile di-
gnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group of home medical practices, individual providers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training and experience to fulfill the physician's role described in subparagraph (A)(i).

(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed as preventing a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant may, by acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the role of the physician's assistant role described in paragraph (1)(A)(i).

(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this section shall be construed as preventing a nurse practitioner or physician assistant from participating in the demonstration program if—

(A) the nurse practitioner or physician assistant is enrolled in an independence at home medical practice if—

(i) is organized at least in part for the purpose of providing physicians' services;

(ii) has documented experience in providing home-based primary care services to high-risk chronically ill beneficiaries, as determined appropriate by the Secretary;

(iii) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program;

(iv) has entered into an agreement with the Secretary;

(v) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vi) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group of home medical practices, individual providers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(2) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians' services and has the medical training and experience to fulfill the physician's role described in paragraph (1)(A)(i).

(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this section shall be construed as preventing a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant may, by acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the role of the physician's assistant role described in paragraph (1)(A)(i).

(4) PREFERENCE.—In approving an independence at home medical practice under the demonstration program for the purpose of providing physicians' services, the Secretary shall give preference to practices that—

(A) have experience providing home-based primary care services to applicable beneficiaries;

(B) have experience furnishing health care services to applicable beneficiaries in the home; and

(C) use electronic medical records, health information technology, and individualized plans of care.

(5) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

(6) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(8) EVALUATION AND MONITORING.—

(I) IN GENERAL.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program.

(II) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Program Account.

(9) REPORT TO CONGRESS.—The Secretary shall provide Congress a final report, including best practices under the demonstration program and submit to Congress a final report, including best practices under this title and incentive payments under subsection (c).

(10) REPORT TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program.

(11) REPORT TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program.
(a) In general.—Section 1866 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001 and 3008, is amended by adding at the end the following new subsection:

"(q) Hospital Readmissions Reduction Program.—

"(1) In general.—With respect to payment for discharges from an applicable hospital (as defined in paragraph (3)(A)(iv)(G)), occurring during a fiscal year beginning on or after October 1, 2012, in order to account for excess readmissions in the hospital, the Secretary shall determine a ratio that would otherwise be made to such hospital under subsection (d) (or section 1814(b)(3), as the case may be) for such a discharge by an amount equal to the product of—

"(A) the base operating DRG payment amount (as defined in paragraph (2) for the discharge; and

"(B) the adjustment factor (described in paragraph (3)(A) for the hospital for the fiscal year.

"(2) Base operating DRG payment amount defined.—

"(A) In general.—Except as provided in subparagraph (B), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

"(i) the payment amount that would otherwise be made to such hospital under subsection (d) (determined without regard to subsection (o) for a discharge if this subsection did not apply) reduced by

"(I) any portion of such payment amount that is attributable to payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

"(B) Special rules for certain hospitals.—

"(i) Sole community hospitals and Medicare-dependent, small rural hospitals.—In the case of a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal years 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(ii), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

"(ii) Hospitals paid under section 184.—

"In the case of a hospital that is paid under section 184(a) (as defined in paragraph (4)(A)), the Secretary may exempt such hospitals provided that States paid under such section submit an annual report to the Secretary describing how a similar program is implemented for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established herein with respect to such section.

"(3) Adjustment factor.—

"(A) In general.—For purposes of paragraphs (1) and (2), the adjustment factor under this paragraph (as defined in paragraph (3)(D)) for a fiscal year is equal to the greater of—

"(i) the ratio described in subparagraph (B) for the hospital for the applicable period (as defined in paragraph (3)(D)) for such fiscal year; or

"(ii) the floor adjustment factor specified in paragraph (C).

"(B) The floor adjustment factor.—

"(i) Aggregate payments for all discharges that occur in a fiscal year are equal to the product of—

"(A) the aggregate payments for all discharges (as defined in paragraph (4)(B)) with respect to such applicable hospital for such applicable period;

"(B) the adjustment factor specified in this subparagraph for—

"(I) fiscal year 2013 is 0.99; or

"(ii) fiscal year 2014 is 0.98; or

"(iii) fiscal year 2015 and subsequent fiscal years is 0.97.

"(C) Aggregate payments, excess readmission ratio defined.—For purposes of this subsection:

"(A) Aggregate payments for excess readmissions.—The term ‘aggregate payments for excess readmissions’ means, for a hospital for an applicable period, the sum, for each applicable condition, of the product of—

"(i) the base operating DRG payment amount for such hospital for such applicable period for such condition;

"(ii) the number of admissions for such condition for such hospital for such applicable period; and

"(iii) the excess readmissions ratio (as defined in paragraph (C)) for such hospital for such applicable period minus 1.

"(D) Aggregate payments for all discharges.—The term ‘aggregate payments for all discharges’ means, for a hospital for an applicable period, the sum of the base operating DRG payment amount for all discharges for all conditions from such hospital for such applicable period.

"(E) Excess readmissions ratio.—

"(i) In general.—Subject to clause (ii), the term ‘excess readmissions ratio’ means, with respect to an applicable condition for a hospital for an applicable period, the ratio (but not less than 1.0) of—

"(I) the risk adjusted readmissions based on actual readmissions, as determined consistent with a readmission measure methodology that has been endorsed under paragraph (5)(A)(ii)(I), for an applicable hospital for such condition with respect to such applicable period; to

"(II) the risk adjusted expected readmissions (as determined consistent with such a methodology) for such hospital for such condition with respect to such applicable period.

"(ii) Exclusion of certain readmissions.—For purposes of clause (i), in determining the applicable condition, such readmissions shall not include readmissions for an applicable condition for which there are fewer than a minimum number (as determined by the Secretary) of such readmissions for such applicable condition for the applicable period and such hospital.

"(5) Definitions.—For purposes of this subsection:

"(A) Applicable condition.—The term ‘applicable condition’ means, subject to paragraph (B), a condition or procedure selected by the Secretary among conditions and procedures for which—

"(i) readmissions (as defined in subparagraph (B)) that represent conditions or procedures that are high volume or high expenditures under this title (or other criteria specified by the Secretary); and

"(ii) measures of such readmissions—

"(I) have been endorsed by the entity with a contract under section 1890(a); and

"(II) such endorsed measures have exclusions for readmissions that are unrelated to that particular planned readmission or transfer to another applicable hospital.

"(B) Expansion of applicable conditions.—With respect to fiscal year 2015, the Secretary, to the extent practicable, expand the applicable conditions beyond the 3 conditions for which measures have been endorsed as described in subparagraph (A)(ii)(I) as of the date of the enactment of this subsection to the additional 4 conditions that have been identified by the Medicare Payment Advisory Commission in its report to Congress in June 2007 and to other conditions and procedures as determined appropriate by the Secretary. In expanding such applicable conditions, the Secretary shall seek the endorsement described in subparagraph (A)(ii)(I) but may apply such measures with respect to such an endorsement in the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible measure has been endorsed by a consensus organization identified by the Secretary.

"(C) Applicable hospital.—The term ‘applicable hospital’ means a subsection (d) hospital or a hospital that is paid under section 1814(b)(3), as the case may be.

"(D) Applicable period.—The term ‘applicable period’ means, with respect to a fiscal year, such period as the Secretary shall specify.

"(E) Readmission.—The term ‘readmission’ means, in the case of an individual who is discharged from an applicable hospital within a time period specified by the Secretary for the discharge of the individual to the same or another applicable hospital within a time period specified by the Secretary for the discharge of the individual to the same or another applicable hospital, the admission of the individual to the same or another applicable hospital within a time period specified by the Secretary.

"(F) Reporting hospital specific information.—

"(A) In general.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the program.

"(B) Opportunity to review and submit corrections.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public. Such information shall be posted on the Hospital Compare Internet website in an easily understandable format. Such information shall not be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(1) The determination of base operating DRG payment amounts.

"(2) The methodology for determining the adjustment factor under paragraph (3), including excess readmissions ratios.

"(3) The measures of readmissions as described in paragraph (A)(ii)(I).

"(4) Readmission rates for all patients.

"(B) Calculation of readmission.—The Secretary shall calculate readmission rates for all patients (as defined in paragraph (D)) for a specified hospital (as defined in subparagraph (D)(ii)) for an applicable period as the percentage of applicable conditions and other conditions deemed appropriate by the Secretary for an applicable period (as defined in paragraph (3)(D)) in the same manner as specified under section 1886 for hospitals with respect to this title and posted on the CMS Hospital Compare website.
(B) POSTING OF HOSPITAL SPECIFIC ALL PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.—(1) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, on a quarterly basis and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

D. Definitions.—For purposes of this paragraph:

(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

(ii) The term ‘specified hospital’ means a hospital that has a high rate of risk adjusted readmissions as determined by the Secretary.

(3) MEDI-CARE BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395x(ee)) or enrolled under part C of such title, but not enrolled under part B of such title.

(4) PROGRAM.—The term ‘program’ means the program conducted under this section.

(5) READMISSION.—The term ‘readmission’ means the readmission of a Medicare beneficiary to the hospital to improve readmission rates calculated under subparagraph (A).

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

(7) REQUIREMENTS.—(A) In general.—The Secretary shall give priority to eligible entities that:

(1) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions within multiple hospitals or hospital systems;

(2) provide services to medically underserved populations, small communities, and rural areas;

(3) demonstrate an ability to reduce hospital readmissions through the use of patient care transition services offered by a program administered by the Administration on Aging to provide concurrent care transitions interventions within multiple hospitals or hospital systems;

(4) conduct comprehensive medication reconciliation activities and medication therapy management activities;

(5) provide information to beneficiaries about the availability of other concurrent care transitions services;

(6) develop and implement concurrent care transitions interventions related to preventive care, chronic disease management, and disease self-management;

(7) provide lessees with services to care for high-risk Medicare beneficiaries and provide services described in subsection (d)(2)(B)(i) and which are sufficient to support concurrent care transitions interventions that are specific to the beneficiary’s condition.

(8) LIMITATION.—A concurrent care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that:

(a) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions within multiple hospitals or hospital systems;

(b) provide services to medically underserved populations, small communities, and rural areas;

(c) demonstrate an ability to reduce hospital readmissions through the use of patient care transition services offered by a program administered by the Administration on Aging to provide concurrent care transitions interventions within multiple hospitals or hospital systems;

(d) provide information to beneficiaries about the availability of other concurrent care transitions services; and

(e) develop and implement concurrent care transitions interventions related to preventive care, chronic disease management, and disease self-management.

(4) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of

$500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the provisions of this section shall remain available until expended.

SEC. 3026. COMMUNITY-BASED CARE TRANSITION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) ELIGIBILITY.—For purposes of this section:

(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means the following:

(A) A subrecipient (d) hospital (as defined in section 1866d(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as a hospital participating in a program conducted for a 5-year period, beginning January 1, 2011.

(B) A hospital that has a high rate of risk adjusted readmissions as determined by the Secretary.

(C) A hospital that—

(i) is medically underserved; and

(ii) participates in a program conducted for a 5-year period, beginning January 1, 2011.

(D) A hospital that has a high rate of risk adjusted readmissions as determined by the Secretary.

(E) A hospital that—

(i) is medically underserved; and

(ii) participates in a program conducted for a 5-year period, beginning January 1, 2011.

(F) A hospital that has a high rate of risk adjusted readmissions as determined by the Secretary.

(G) A hospital that—

(i) is medically underserved; and

(ii) participates in a program conducted for a 5-year period, beginning January 1, 2011.

H. Definitions.—For purposes of this paragraph:

(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

(ii) The term ‘specified hospital’ means a hospital that has a high rate of risk adjusted readmissions as determined by the Secretary.

(3) MEDI-CARE BENEFICIARY.—The term ‘Medicare beneficiary’ means an individual entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395x(ee)) or enrolled under part C of such title, but not enrolled under part B of such title.

(4) PROGRAM.—The term ‘program’ means the program conducted under this section.

(5) READMISSION.—The term ‘readmission’ means the readmission of a Medicare beneficiary to the hospital to improve readmission rates calculated under subparagraph (A).

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

(7) REQUIREMENTS.—(A) In general.—The Secretary shall give priority to eligible entities that:

(1) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions within multiple hospitals or hospital systems;

(2) provide services to medically underserved populations, small communities, and rural areas;

(3) demonstrate an ability to reduce hospital readmissions through the use of patient care transition services offered by a program administered by the Administration on Aging to provide concurrent care transitions interventions within multiple hospitals or hospital systems;

(4) provide information to beneficiaries about the availability of other concurrent care transitions services; and

(5) develop and implement concurrent care transitions interventions related to preventive care, chronic disease management, and disease self-management.

(b) FUNDING.—(1) IN GENERAL.—Subsection (d)(3) of such section is amended by inserting ‘‘and for fiscal years 2011 through 2015. Amounts transferred under the provisions of this section shall remain available until expended.’’ after ‘‘March 31, 2013’’.

(2) AVAILABLE.—Subsection (f)(2) of such section is amended by striking ‘‘2010’’ and inserting ‘‘2014 or until expended’’.

(3) REPORTS.—(A) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(4) of such section is amended by striking ‘‘May 1, 2010’’ and inserting ‘‘March 31, 2015’’.
PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.
Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by deleting at the end the following new paragraph:

``(18) UPDATE FOR 2010.—(A) IN GENERAL.—Subject to paragraphs (7)(B), (13)(A), and (16)(B), in lieu of the update a to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 2.1 percent.

(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE PHYSICIAN FEE SCHEDULE.

(a) EXTENSION OF WORK GPIC FLOOR.—Section 1848(a)(1) of the Social Security Act (42 U.S.C. 1395w–4(a)(1)) is amended by striking “before January 1, 2010” and inserting “before January 1, 2011”.

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1)(C) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(C)) is amended—

(1) in subparagraph (A), by striking “and (G)” and inserting “(G), (H), and (I)”;

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

```````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````````
years, 3 fiscal years, or other yearly period specified by the Secretary.

"(II) The pharmacy has been enrolled under section 1866(b) as a supplier of durable medical equipment, prosthetics, orthotics, supplies, and home health services, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 1848(b)(2)(B) of title 18, United States Code, as added by section 223 of the Social Security Act (42 U.S.C. 1395w-3))."

"(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subclauses (I) and (II).

"(B) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary shall implement the amendments made by subsection (a) by program instruction or otherwise.

[RULE OF CONSTRUCTION.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies qualifying for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w-3).]"

"SEC. 3110. PART D SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

"(1)(I) In the case of any individual who is a covered beneficiary (as defined in section 102(5) of title 10, United States Code) at the time of enactment of this Act, the Secretary shall notify the individual that an enrollment period is being established under subsection (a) of this section, which enrollment period shall commence on the first day of the month following the date the individual is notified of enrollment under such section.

"(1)(II) The Secretary shall ensure that the pharmacy meets the criteria described in subclauses (I) and (II), and related instructions made by subsection (a) by program instruction or otherwise.

"(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICAL PROGRESS.—

"(1) IN GENERAL.—The Institute of Medical Progress shall conduct a demonstration project, the Secretary shall establish appropriate follow up pursuant to any notification provided under the preceding sentence.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

"(c) PAYMENT.—

"(1) IN GENERAL.—Section 1839 of the Social Security Act (42 U.S.C. 1395w-4) is amended by striking "(section 1837(1)(4)" and inserting "(section 1837(1)(4) and 1837(4)"

"SEC. 3111. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

"(1) In general.—Section 1848 of the Social Security Act (42 U.S.C. 1395l(b)) is amended by striking "(section 1837(1)(4)" and inserting "section 1837(1)(4)"

"(b) Rule of Construction.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies requiring for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w-3).


Section 1988(b)(1)(A) of the Social Security Act (42 U.S.C. 1395li) is amended by striking "$22,290,000,000" and inserting "$30,000,000,000".

SEC. 3113. Treatment of Certain Complex Diagnostic Laboratory Tests.

(a) Demonstration Project.—

"(1) In General.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a demonstration project under part B title XVIII of the Social Security Act under which separate payments are made under such part for complex diagnostic laboratory tests provided to individuals under such part. Under the demonstration project, the Secretary shall establish appropriate payment rates for such tests.

"(2) Covered Complex Diagnostic Laboratory Test Defined.—In this section, the term "covered complex diagnostic laboratory test" means a diagnostic laboratory test—

"(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

"(B) that is determined by a beneficiary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics; and

"(C) that is billed using a Health Care Procedure Coding System (HCPCS) code other than a not otherwise classified code under such Coding System;

"(D) for which the Secretary is required to provide such individuals with notification prior to, or within 2 weeks after, the test is performed.

"(b) Administration.—Notwithstanding any other provision of law, the Secretary shall implement the amendments made by subsection (a) by program instruction or otherwise.

"(c) Rule of Construction.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies requiring for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w-3).


"(1) IN GENERAL.—The Social Security Disability Insurance program shall provide benefits for individuals who are determined to be disabled through December 31, 2030, and whose application is filed on or after the date of the enactment of this Act.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to applications filed on or after the date of enactment of this Act.
Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account for transfer to the Medicare and Medicaid Trust Funds under section 1805 of the Social Security Act (42 U.S.C. 1395d) for the fiscal years 2011 and 2012.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE AND ACCEPTABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITALIZED PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395t–2), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395t–2b) and section 107 of title III of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395t–2c), is amended by adding at the end the following new subsection:

"(g) One-Year Extension of Demonstration Program.—

(1) In general.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period (the '1-year extension period') beginning October 1, 2010, and ending October 1, 2011.

(2) Expansion of demonstration states.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 5-year period.

(3) In the case of a rural community hospital that is participating in the demonstration program during the 1-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may prescribe, to discontinue participation for 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A after '700 discharges', and by adding at the end the following new subparagraph:

"(D) Temporary applicable percentage increase.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year'.

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) Removal of Limitation on Number of Eligible Counties.—Section 410A of Division C of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 1395ww note) is amended by striking ''through fiscal year 2011'' and inserting 'through fiscal year 2012'.

Sec. 3127. MEDIcA PAYMENT FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) Study.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas.

(b) Report.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

Sec. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) In General.—Subsections (g)(2)(A) and (i)(8) of section 1834 of the Social Security Act...
Act (42 U.S.C. 1395m) are each amended by inserting “101 percent of” before “the reasonable costs”.

(b) Effective Date.—The amendments made by section (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 320).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDI CARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) Authorization.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395j–4(j)) is amended—

(1) by striking “2010, and for” and inserting “2010, for”;

(2) by inserting “and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended before the period at the end.

(b) Use of Funds.—Section 1820(c) of the Social Security Act (42 U.S.C. 1395j–4(g)(5)) is amended—

(3) by striking “101 percent of” before “the reasonable costs”.

(c) Effective Date.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT MODIFICATIONS FOR HOME HEALTH CARE.

(a) Revising Home Health Prospective Payment Amount.—

(1) In general.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395ff(b)(3)(A)) is amended—

(A) by striking “prospective” and inserting “subject to clause (ii),”;

(B) by striking “and” and inserting “(I)”; and

(C) by striking “and” and inserting “(I),”;

(2) In subsection (a)—

(A) by striking “, and episodes” and inserting “, and episodes of or services provided during such an episode,”;

(B) by striking “and” and inserting “(I)”, and inserting “(I)”,

(c) Effective Date.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.

(1) In General.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing on- and off-site services and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395ff) to more accurately reflect the costs related to patient severity of illness or to improving beneficiary access to care, including—

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be implemented to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and financial incentives in delivering provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for the implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) Considerations.—In conducting the study under paragraph (1), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes; and

(D) the poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) Report.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—
(A) stakeholders representing home health agencies;
(B) groups representing Medicare beneficiaries;
(C) the Medicare Payment Advisory Commission;
(D) the Inspector General of the Department of Health and Human Services; and
(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(I) IN GENERAL.—Subtitle A of the Social Security Act (42 U.S.C. 1395f, as amended by section 305(c), is amended—

(A) by redesignating paragraph (6) as paragraph (5); and

(B) by inserting after paragraph (5) the following new paragraph:

“(6)(A) The Secretary shall collect additional data and information as the Secretary determines appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect such data by not later than January 1, 2011.

“(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

“(i) charges and payments;

“(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A; and

“(iii) with respect to each type of service included in hospice care, the amount of the payment for the type of service;

“(iv) charitable contributions and other revenue of the hospice program;

“(v) the number of hospice visits;

“(vi) the type of practitioner providing the visit; and

“(vii) the length of the visit and other basic information with respect to the visit.

“(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

“(D)(i) Notwithstanding the preceding paragraphs of this subsection, not earlier than October 1, 2010, the Secretary, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care pursuant to this paragraph, as determined by the Secretary, based on data from the Census Bureau or other sources the Secretary determines to be appropriate.

“(ii) Revisions in payment implemented pursuant to clause (i) shall result in the same estimated amount of aggregate expenditures for hospice care furnished in the fiscal year in which such revisions in payment are implemented as would have been made under this title for such care in such fiscal year if such revisions had not been implemented.

“(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).

(b) ADOPTION OF MEDPAC HOSPICE PROGRAM EQUITY RECERTIFICATION REQUIREMENTS.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented)” and inserting “(before the first fiscal year in which the payment revisions described in paragraph (6)(D) are implemented), subject to clause (iv),”;

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

“(iv) With respect to routine home care and other services included in hospice care furnished during fiscal years subsequent to the first fiscal year in which payment revisions described in paragraph (6)(D) are implemented, the payment rates for such care and services shall be the payment rates in effect under this clause during the preceding fiscal year increased by, subject to clause (iv), the market basket percentage increase (as defined in section 1886(b)(3)(B)(iii)) for the fiscal year.”;

(c) ADJUSTMENTS TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww, as amended by sections 301, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking “For” and inserting “Subject to subsection (r),”;

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

“(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

“(I) EMPICALLY JUSTIFIED DSH PAYMENTS.—For each fiscal year, other than fiscal year 2010, the Secretary shall—

“(a) periodically identify services as being potentially misvalued under subsection (k) or (l) of section 1886 of the Social Security Act (42 U.S.C. 1395ww); and

“(b) in each fiscal year, the Secretary shall pay to subsection (d) hospitals an additional amount equal to the product of the following factors:

“(i) the aggregate amount of payments that would otherwise be made to subsection (d) hospitals under paragraphs (1) and (2) of section 1886(c)(2), subject to clause (ii), and

“(ii) the aggregate amount of payments that would otherwise be made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

“(K) POTENTIALLY MISVALUED CODES.—

“(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

“(II) review and make appropriate adjustments to the relative values established under paragraph (a) of this subsection for services identified as being potentially misvalued under clause (I).

“(O) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the most recent estimates available from the Census Bureau or other sources the Secretary determines to be appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services; and

“(P) FISCAL YEARS 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of such individuals—

“(I) who are uninsured in the most recent period for which data is available (as so calculated); and

“(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

“(Q) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

“(I) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on alternative data)); and

“(II) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

“(R) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1809, section 1878, or otherwise of the following:

“(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

“(B) Any period selected by the Secretary for such purposes.”.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.—

Section 1886 of the Social Security Act (42 U.S.C. 1395ww, as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking “For” and inserting “Subject to subsection (r),”;

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

“(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

“(I) EMPICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2010, and each subsequent fiscal year, the Secretary shall—

“(a) periodically identify services as being potentially misvalued under subsection (k) or (l) of section 1886 of the Social Security Act (42 U.S.C. 1395ww); and

“(b) in each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

“(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to a subsection (d) hospital an additional amount equal to the product of the following factors:

“(A) FACTOR ONE.—A factor equal to the difference between—

“(i) the aggregate amount of payments that would otherwise be made to subsection (d) hospitals under paragraphs (1) and (2) of section 1886(c)(2), and

“(ii) the aggregate amount of payments that would otherwise be made to subsection (d) hospitals under paragraph (1) for such fiscal year (as so estimated).

“(B) FACTOR TWO.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

“(I) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on alternative data)); and

“(II) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

“(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

“(I) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by the Secretary, based on alternative data)); and

“(II) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

“(D) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1809, section 1878, or otherwise of the following:

“(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

“(B) Any period selected by the Secretary for such purposes.”.

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN CLAIM FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

“(K) POTENTIALLY MISVALUED CODES.—

“(I) IN GENERAL.—The Secretary shall—

“(A) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

“(B) review and make appropriate adjustments to the relative values established under this subsection for services identified as being potentially misvalued under clause (I).
(II) Identification of potentially misvalued codes.—For purposes of identifying potentially misvalued services pursuant to clause (i)(1), the Secretary shall examine (and if determined to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; services with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the Relative Values (RVs) (the ‘Harvard-valued codes’); and such other codes determined to be appropriate by the Secretary.

(iii) Review and Adjustments.—

(1) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(i).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other evaluations of the services described in clause (i)(ii) to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(i).

(iii) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(i), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(ii).

(iv) The Secretary may coordinate the review and adjustment described in clause (i)(ii) with the periodic review described in subparagraph (B).

(iv) Provision of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units under subsection (B)(ii)(II) in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(i) In general.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (B)(ii)(II).

(ii) Components and elements of work.—The process described in clause (i) may include validation of work elements (such as time, work, and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

(iii) Scope of codes.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

(iv) Methods.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

(v) The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

(II) Utilization of certain advanced diagnostic imaging services for 2011 and subsequent years.—Effective for fee schedules established for services furnished after December 31, 2010, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(iii) instead of the presumed rate of utilization of such equipment of 50 percent.

(V) Change in presumed utilization level of certain advanced diagnostic imaging services for 2011 and subsequent years.—For services furnished after December 31, 2010, the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(ii) shall not apply to payment for items and services furnished pursuant to contracts

SEC. 3315. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) Adjustment of practice expense to reflect higher presumed utilization.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ‘‘subparagraph (A)’’ and inserting ‘‘this paragraph’’;

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

(III) CHANGE IN PRESUMED UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.—Not later than January 1, 2013, the Secretary may use analytic methodologies to establish the highest reimbursement rates for services furnished after December 31, 2010, that are presumed to be appropriate to reflect the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(ii) instead of the presumed rate of utilization of such equipment of 50 percent.

(b) Adjustment in practice expense to reflect higher presumed utilization.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

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

(IV) CHANGE IN PRESUMED UTILIZATION LEVEL OF CERTAIN ADVANCED DIAGNOSTIC IMAGING SERVICES FOR 2011 AND SUBSEQUENT YEARS.—Effective for fee schedules established for services furnished after December 31, 2010, reduced expenditures attributable to the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(ii) shall not apply to payment for items and services furnished after December 31, 2010, that are presumed to be appropriate to reflect the presumed rate of utilization of imaging equipment of 75 percent under subsection (b)(4)(C)(ii) instead of the presumed rate of utilization of such equipment of 50 percent.

The amendments made by subsection (a) shall not apply to payment made for items and services furnished before such date.
entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w-3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATION PROVISIONS—


(2) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(b) RECOMMENDING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Payment Advisory Commission June 2007 report entitled “Report to Congress: Promoting Greater Efficiency in Medicare”, including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(c) INDICATORS OF DETERMINING RERCLASSIFICATIONS.—Notwithstanding any other provision of law, in making decisions on applications for reclassification of hospitals, such decisions shall be made in paragraphs (1)(B) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for the purposes described in paragraph (18)(D) of such section 4410 and paragraph (4) of title 42, Code of Federal Regulations, in the case of such hospitals during fiscal year 2011 and each subsequent fiscal year (until the first fiscal year beginning on or after the date that is 1 year after the Secretary of Health and Human Services submits the report to Congress under subsection (b), the Geographic Classification Review Board established under paragraph (18)(D) of such section 4410 shall use the average hourly wage comparison criteria used in making such decisions as of September 30, 2008. The preceding sentence shall be effected in a budget neutral manner.

SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395f(t)) is amended by adding at the end the following new paragraph:

“(B) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

(1) GENERAL.—The Secretary shall conduct a study to determine if, under the system described in this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary). In conducting the study under this subparagraph, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals;

(2) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by other hospitals furnishing services under this subsection, the Secretary may authorize a hospital wage index adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395wwa) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking “or” at the end; and

(ii) in subparagraph (B), by striking the period at the end and inserting “; and”;

(2) in subparagraph (C), by—

(A) the average sales price as determined under paragraph (2) of section 1395wwa(f) for the reference biological product (as defined in section 1395wwa(c)(6)(H)), the amount determined under paragraph (8)(B); and

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

“(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in paragraph (7)(B) for a biosimilar biological product described in paragraph (1)(C) is the sum of—

(A) the average sales price as determined using the method described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

(B) 6 percent of the amount determined under paragraph (4) for the biological product (as defined in subsection (c)(6)(L)); and

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

“(B) BIOSIMILAR BIOLOGICAL PRODUCT.—The term ‘biosimilar biological product’ means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

(D) REFERENCING BIOLOGICAL PRODUCT.—The term ‘reference biological product’ means the biological product licensed under such section 351 that is referred to in the application for a license of a biosimilar biological product.”;

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries and their families, during the hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(b) CONTENTS.—The Secretary shall select not more than 15 hospice programs at which the demonstration program under this section shall not be conducted. Selected hospice programs shall be located in urban and rural areas.

(c) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(d) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPICE WAGE INDEX.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. IHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395w). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals in parish or county that have more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)); and

(B) whether payments to Medicare-dependent, small rural hospitals under subsection

November 19, 2009 CONGRESSIONAL RECORD — SENATE S11695
(d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) **Urban Medicare-dependent hospital defined.**—For purposes of this section, the term "urban Medicare-dependent hospital" means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1841(d) of such Act, payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary determines appropriate.

**Subtitle C—Provisions Relating to Part C**

SEC. 2201. **Medicare Advantage payment.**

(a) MA **BENCHMARK BASED ON PLAN’S COMPARATIVE BID.**—

(I) **In general.**—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)) is amended—

(A) by striking "AMOUNTS.—For purposes” and inserting "AMOUNTS.—‘‘(AA) 1⁄3 of the quotient of—

(1) **Computation of MA competitive benchmark amount.**—In no case shall the MA competitive benchmark amount for an area for a month be greater than the applicable amount determined by the Secretary.

(B) **Weighting rules.**—

(1) **Single plan rule.**—In the case of an MA plan area in which only a single MA plan is being offered, the amount under subparagraph (A) shall be equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1856(d)(1)), or, in applying such definition for purposes of this paragraph, to compute the MA competitive benchmark amount under section 1853(j)(2) shall be substituted for ‘‘to compute the percentage specified in subparagraph (A) and other relevant percentages under this part”.

(2) **Establishment of actuarial guidelines.**—

(A) **Section 1854(b) of the Social Security Act.**—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by inserting "(or 100 percent in the case of plan years beginning on or after January 1, 2014)" after "percentage points.”

(B) **Bidding rules.**—

(1) **Requirements for information submittal.**—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)) is amended by inserting "(as determined in the flush matter following clause (v), by adding at the end the following sentence: ‘‘Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under this paragraph’’.)

(2) **Establishment of actuarial guidelines.**—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(A) in clause (i), by striking ‘‘(iii) and (iv)’’ and inserting ‘‘(iii), (iv), and (v)’’; and

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

‘‘(v) **Establishment of actuarial guidelines.**—

(I) **In general.**—In order to establish fair MA competitive benchmark amounts under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the ‘‘Chief Actuary’’), shall establish—

(aa) actuarial guidelines for the submission of bid information under this paragraph; and

(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

(II) **Denial of bid amounts.**—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet the actuarial guidelines and rules established under subclause (i). In the case of plan years beginning on or after January 1, 2014, the Secretary may refuse to accept any bid amounts that do not meet the actuarial guidelines and rules established under subparagraph (A) that do not adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall determine that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling.

(III) **Effective date.**—The amendments made by this subsection shall apply to bid
amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1833(d) of the Social Security Act (42 U.S.C. 1395w–23(d)(1)) is amended—

(A) in the subsection heading, by striking “MA REGION” and inserting “MA REGION; MA LOCAL PLAN SERVICE AREA”;

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

“(A) with respect to an MA local plan—

(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and

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

“(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

(A) URBAN AREAS.—

(i) In general.—Subject to clause (ii) and subparagraphs (B) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a ‘CBSA’) or, if applicable, any similar alternative classification, as defined by the Director of the Office of Management and Budget.

(ii) CBSA covering more than one state.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization for MA local plans and managed care plans described in this paragraph, the Secretary may adopt more refined or rural area in each State as follows:

(A) URBAN AREAS.—

(i) In general.—Subject to clause (ii) and subparagraphs (B) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a ‘CBSA’) or, if applicable, any similar alternative classification, as defined by the Director of the Office of Management and Budget.

(ii) CBSA covering more than one state.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization for MA local plans and managed care plans described in this paragraph, the Secretary may adopt more refined or rural area in each State as follows:

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)) is amended by striking "(b)(1)) and inserting "(B)(1)) of such Act (42 U.S.C. 1395w–21(b)(1)) that is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to—

(1) in the case of a plan that achieves a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

(I) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for individuals enrolled under the original Medicare fee-for-service program for the year; and

(ii) such other system established by the Secretary.

(ii) such other system established by the Secretary.

(iii) such other system established by the Secretary.

(iv) such other system established by the Secretary.

(iv) such other system established by the Secretary.

(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year, subject to subparagraph (C).

(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage organization offering the Medicare Advantage contract or MA plan level; or

(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (iv).

(D) DATA USED IN DETERMINING SCORE.—

(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to each performance measure shall be based on the most recent data available.

(ii) Such other care management and coordination programs as the Secretary determines appropriate.

(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus under this paragraph. The Secretary shall monitor auditing activities conducted under this subparagraph.

(F) QUALITY PERFORMANCE BONUSES.—

(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

I (C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

(i) Care management programs that—

(II) reduce declines in health status; and

(ii) transitional care interventions that—

(III) facilitate improved care by using advanced technologies, including clinical decision support, and other tools to facilitate data collection and ensure patient-centered, appropriate care.

(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

(iv) Patient safety programs, including programs for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

(v) Policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

(vii) Medication therapy management programs that are more extensive than is required under section 1899(c)(6) (as determined by the Secretary).

(viii) Health information technology programs, including clinical decision support tools to improve patient selection and ensure patient-centered, appropriate care.

(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (iv).
“(1) Application of Performance Bonuses to MA Regional Plans.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and risk adjustment) in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year + 75 percent of the adjusted average per capita cost for the year involved, deemed determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1844(b), 1886(d), and 1886(h).

“(2) Election to Provide Rebates to Grandfathered Enrollees.—

“(A) General.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

“(B) Application.—For purposes of this section, the term ‘applicable amount’ means—

“(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

“(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

“(3) Special Rules for Plans in Identified Areas.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

“(A) Payments.—The amount of the monthly payment under this section to the Medicare Advantage organization with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

“(i) for 2012 and 2013, the sum of—

“(I) the bid amount under section 1854(a) for the MA local plan; and

“(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

“(ii) for 2014 and subsequent years, the sum of—

“(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to reflect the average amount of such rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

“(II) the applicable amount (as so defined) for the MA local plan for the year.

“(B) Requirement to Submit Bids Under Competitive Bidding.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan and the Secretary shall identify MA local areas in which, with respect to 2012, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1844(b), 1886(d), and 1886(h).

“(C) Nonapplication of Bonus Payments and Any Other Rebates.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under section 1854(b)(1)(C) (as so defined under this subsection) with respect to grandfathered enrollees.

“(D) Nonapplication of Uniform Bid and Payment Amounts to Grandfathered Enrollees.—Section 1854(c) shall not apply with respect to the MA local plan.

“(E) Nonapplication of Limitation on Application of Part B Premium.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such subsection (n) (as so defined under this subsection) with respect to grandfathered enrollees.

“(F) Risk Adjustment.—The Secretary shall risk adjust rebates to grandfathered enrollees in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

“(G) Definition of Grandfathered Enrollment.—In this subsection, the term ‘grandfathered enrollee’ means an individual who is enrolled (effective as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).

“(H) Transitional Extra Benefits.—

“(i) General.—For years beginning with 2012, the Secretary shall provide transitional extra benefits under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraphs (1) and (2).

“(ii) Enrollees Described.—An enrollee described in this paragraph is an individual who—

“(A) enrolls in an MA local plan in an applicable area; and

“(B) experiences a significant reduction in extra benefits described in clause (i) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

“(J) Applicable Areas.—In this subsection, the term ‘applicable area’ means the following:

“(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

“(B) A county where—

“(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011; and

“(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2011 is greater than 30 percent (as determined by the Secretary); and

“(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for...
the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to enrollees under sections 1848(b), 1886(n), and 1886(h).

"(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

"(D) In the case of a county described in subparagraph (A) or (B), subsection (g) of section 1851(c) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(B)) is amended—

"(1) in clause (i), by inserting ''after ''and''; and

"(2) by redesigning clauses (ii) and (iv) as clauses (i) and (iii), respectively.

"(E) In the case of a county described in subparagraph (A) or (B), subsection (g) of section 1851(c) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(B)) is amended—

"(1) by striking ''and'' and inserting ''or''; and

"(2) by adding at the end the following new clause:

"(F) In the case of a county described in subparagraph (A) or (B), subsection (g) of section 1851(c) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(B)) is amended—

"(1) by striking ''and'' and inserting ''or''; and

"(2) by adding at the end the following new clause:

"(G) In the case of a county described in subparagraph (A) or (B), subsection (g) of section 1851(c) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(B)) is amended—

"(1) by striking ''and'' and inserting ''or''; and

"(2) by adding at the end the following new clause:

"(H) In the case of a county described in subparagraph (A) or (B), subsection (g) of section 1851(c) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(B)) is amended—

"(1) by striking ''and'' and inserting ''or''; and

"(2) by adding at the end the following new clause:

"(I) In the case of a county described in subparagraph (A) or (B), subsection (g) of section 1851(c) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(B)) is amended—

"(1) by striking ''and'' and inserting ''or''; and

"(2) by adding at the end the following new clause:
S11700

CONGRESSIONAL RECORD — SENATE
November 19, 2009

and Providers Act of 2008 (Public Law 110–275), is amended by striking “2011” and inserting “2014”.

(b) Authority To Apply Frailty Adjustment

The Secretary may apply the payment rules under section 1876(h)(5)(B) of the Social Security Act (42 U.S.C. 1395w–28(f)) as amended by adding at the end the following new subparagraph:

“(I) TIMELINE FOR INITIAL TRANSITION.—

The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals described in subsection (b)(6)(B) who are no longer eligible for medical assistance under title XIX.

(d) Temporary Extension of Authority To Operate but Not Service Area Expansion

For Dual Special Needs Plans That Do Not Meet Certain Requirements.

Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking “December 31, 2010” and inserting “December 31, 2012.”

(e) Authority To Require Special Needs Plans Be NCQA Approved.

Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsections (a) and (c), is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

“(C) If applicable, the plan meets the requirement described in paragraph (7);”;

(2) in paragraph (3), by adding at the end the following new subparagraph:

“(D) If applicable, the plan meets the requirement described in paragraph (7);”;

(3) in paragraph (5), by adding at the end the following new subparagraph:

“(E) If applicable, the plan meets the requirement described in paragraph (7);”;

and

(4) adding at the end the following new paragraph:

“(F) Authority To Require Special Needs Plans Be NCQA Approved.—For 2012 and subsequent plan years, in the case of a plan described in subparagraph (B), the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).”;

(f) Authority To Approve Special Needs Plans.

Section 1859(f)(2) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

“(C) If applicable, the plan meets the requirement described in paragraph (7);”;

and

(g) Extension of Reasonable Cost Contracts.

Section 1876(h)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)(C)) is amended, in the matter preceding subparagraph (A), by striking “and (B)” and inserting “. . . and (B)”.

(i) Authority To Deny Bids That Propose Significant Increases in Cost Sharing.

The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits. The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under such plan.

(j) Effective Date.

The amendment made by this section shall take effect on January 1, 2010, and apply to plan years beginning on or after such date.

SEC. 3208. MAKING SENIOR HOUSING FACILITY PAYMENT RULES PERMANENT.

(a) In General.—Section 1809 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:


(c) Technical Correction.


SEC. 3207. TECHNICAL CORRECTION TO MA PRIMARY FEE-FOR-SERVICE PLANS.

For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the Medicare Advantage policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services’ memorandum with the subject ‘‘2008 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans’’) to Medicare Advantage senior housing facility plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage senior housing facility plan provider under section 1857(h)(2) of the Social Security Act (42 U.S.C. 1395w–27(h)(2)) and that had enrollment as of October 1, 2008.

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

(a) In General.—Section 1859(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end the following new paragraph:

“(C) If applicable, the plan meets the requirement described in paragraph (7);”;

and

(b) Effective Date.—The amendment made by this section shall take effect on January 1, 2010, and apply to plan years beginning on or after such date.
Section 3301. Medicare Coverage Gap Discount Program—Part D—Under Part D—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w-101 et seq.), is amended by adding at the end the following new section:

"(a) Condition for Coverage of Drugs Under Part D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w-101 et seq.) is amended by striking "(1) for drugs covered under part B. Such revisions shall be based on evidence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the ‘1991 NAIC Model Regulation’ deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to ‘date of enactment of this subsection’ deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act and the rules applicable under subsection (p)(1)(E) with the reference to the ‘1991 NAIC Model Regulation’ deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to ‘date of enactment of this subsection’ deemed a reference to the date of enactment of the Patient Protection and Affordable Care Act.

(b) Medicare Coverage Gap Discount Program.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w-101) is amended by inserting after section 1860D-14 the following:

"(1) THE SECRETARY.—The Secretary shall establish a Medicare coverage gap discount program in this section to be in effect under this section with respect to the period beginning on January 1, 2010, and ending on December 31, 2010, and as of January 1, 2011, for purposes of administering the program, including—

(i) the establishment of procedures to provide such discounts as soon as practicable after the point-of-sale of a applicable drug; (ii) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the period of time that the drug is reimbursed for an amount equal to the difference between—

(A) the negotiated price of the applicable drug; and

(B) the discounted price of the applicable drug under this section is applied before the effective date of the termination.

(2) EFFECTIVE DATE.—This section shall take effect on the date of its enactment.

(3) AUTHORIZING COVERAGE OF DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

(A) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

(B) the Secretary determines that in the period beginning on January 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

(4) DEFINITION OF MANUFACTURER.—In this section, the term ‘manufacturer’ has the meaning given such term in section 1860D-14A(g)(5)."
(A) In General.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiary discounts for applicable drugs of the manufacturer that fail to meet each agreement for the amount for each such failure in an amount the Secretary determines is commensurate with the sum of—

(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement, which will then be used to pay the discounts which the manufacturer would have provided; and

(ii) 25 percent of such amount.

(B) Application.—The provisions of section 1128A(a), and subsections (a) and (b) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under such section.

(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary to ensure the implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

(4) THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program.

(5) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

(e) Enforcement.—(1) AUDITS.—Each manufacturer with an agreement under this section shall be subject to periodic audit by the Secretary.

(2) CIVIL MONEY PENALTY.—
(iii) by striking the period at the end and inserting ‘‘, and’’; and

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SUBSIDY ELIGIBLE INDIVIDUALS AND WIDOWS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Section 1860D–1(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

‘‘(ii) for fiscal year 2009, of $5,000,000; and

‘‘(iii) for the period of fiscal years 2010 through 2012, of $10,000,000.’’.

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to plan years beginning on or after January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS AND WIDOWS REGARDING ELIGIBILITY FOR LOW-INCOME PROGRAMS.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

‘‘(ii) for fiscal year 2009, of $5,000,000; and

‘‘(iii) for the period of fiscal years 2010 through 2012, of $15,000,000.’’.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3306. FORMULARY MANAGEMENT.

(a) IN GENERAL.—Section 1860D–14(c)(2)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1395w–114(c)(2)(C)(i)(VI)) is amended by inserting ‘‘, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1901D–1A’’ before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to months beginning on or after January 1, 2011.

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

‘‘(ii) for fiscal year 2009, of $5,000,000; and

‘‘(iii) for the period of fiscal years 2010 through 2012, of $15,000,000.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3308. VOLUNTARY DE MINIMIS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS AND WIDOWS REGARDING ELIGIBILITY FOR LOW-INCOME PROGRAMS.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

‘‘(ii) for fiscal year 2009, of $5,000,000; and

‘‘(iii) for the period of fiscal years 2010 through 2012, of $10,000,000.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3309. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR AREA AGING RESOURCES.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–114(a)(4)) is amended—

(1) by redesignating subsection (a) as subsection (b); and

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

‘‘(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.’’.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395w–23(f)) is amended by inserting ‘‘, and all that follow through the period at the end and inserting ‘‘(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account’’ before the period at the end.

(c) EFFECTIVE DATE.—The amendment made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(d) CONFORMING AMENDMENT TO DEFINITION OF BEST PRICE UNDER MEDICARE.—Section 1927(c)(1)(C)(i)(VI) of the Social Security Act (42 U.S.C. 1395w–114(c)(1)(C)(i)(VI)) is amended by striking ‘‘, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1901D–1A’’ before the period at the end.

(e) SECRETORIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Section 1853(n) of the Public Health Service Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging—

(1) for fiscal year 2009, of $5,000,000; and

(2) for the period of fiscal years 2010 through 2012, of $5,000,000.

(f) BUDGETARY TREATMENT.—Amounts appropriated under this subsection shall remain available until expended.’’. 
following categories and classes of drugs shall be identified under clause (ii)(I):

- "(I) Anticonvulsants.
- "(II) Antidepressants.
- "(III) Antipsychotics.
- "(IV) Antiretrovirals.
- "(V) Immunosuppressants for the treatment of organ transplants.

(b) **Effective Date.**—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

### SEC. 3308. **REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.**

(a) **INCOME-RELATED INCREASE IN PART D PREMIUM.**

(I) **IN GENERAL.**—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

"(7) **INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.**

"(A) **IN GENERAL.**—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December of such year shall be increased by the monthly adjustment amount specified in subparagraph (B).

"(B) **MONTHLY ADJUSTMENT AMOUNT.**—The monthly adjustment amount specified in this subparagraph for an individual for a month after December of the year beginning with 2010, the Secretary shall determine the monthly adjustment amount specified in subparagraph (B) by adding at the end the following new paragraph:

"(7) **INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.**

"(A) **IN GENERAL.**—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December of such year shall be increased by the monthly adjustment amount specified in subparagraph (B).

"(B) **MONTHLY ADJUSTMENT AMOUNT.**—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of:

- "(i) the quotient obtained by dividing—
  - "(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year in question, by 100 percent; and
  - "(II) 25.5 percent; and
- "(ii) the base beneficiary premium (as computed under paragraph (2)).

"(C) **MODIFIED ADJUSTED GROSS INCOME.**

For purposes of this paragraph, the term ‘modified adjusted gross income’ has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

(D) **EXEMPTION BY COMMISSIONER OF SOCIAL SECURITY.**—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

(E) **PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.**

"(1) **DISCLOSURE OF BASE BENEFICIARY PREMIUM.**—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

"(2) **ADDITIONAL DISCLOSURE.**—Not later than March 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year:

- "(I) the modified adjusted gross income threshold amount under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).
- "(II) the applicable percentage determined under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section).

(b) **CONFORMING AMENDMENTS.**

(1) **MEDICARE.**—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

- "(A) by redesignating subparagraph (F) as subparagraph (G);
- "(B) in subparagraph (G), as redesignated by subparagraph (A), by striking ‘‘(D) and ‘(E)’’ and inserting ‘‘(D), (E), and ‘(F)’’; and
- "(C) by inserting after subparagraph (G) the following new subparagraph:

"‘‘(F) **INCREMENT BASED ON INCOME.**—The monthly beneficiary premium shall be increased pursuant toclause (i).’’

(2) **INTERNAL REVENUE CODE.**—Section 6103(k)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to officers and employees of the Social Security Administration) is amended by inserting ‘‘or, effective on a date specified by the Secretary (in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (i) of section 1903(m) or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicare managed care organization with a contract under section 1903(m) or under section 1932 after ‘‘1902(q)(1)(B).’’

### SEC. 3310. **REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES**

(a) **IN GENERAL.**—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–114(c)) is amended by adding at the end the following new paragraph:

"(3) **REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA-PD PLANS.**

(b) **Effective Date.**—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.
SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) In General.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and MA–PD plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1852 of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate intervention and enforcement based on substantial complaints and to guide quality improvement.

(b) Model Electronic Complaint Form.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) Secretary.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) Definitions.—In this section:

(1) MA–PD PLAN.—The term ‘‘MA–PD plan’’ has the meaning given such term in section 1860D–2(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(2) PRESCRIPTION DRUG PLAN.—The term ‘‘prescription drug plan’’ has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(3) SECRETARY.—The term ‘‘Secretary’’ means the Secretary of Health and Human Services.

(4) SYSTEM.—The term ‘‘system’’ means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) In General.—Section 1860D–2(b)(3)(A) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

‘‘(C) by striking ‘‘the amounts necessary to carry out the comparison under subparagraph (A)’’ and inserting ‘‘such costs shall be treated as incurred only if’’; and

‘‘(D) by striking the period at the end and inserting ‘‘such costs shall be treated as incurred only if’’.’’

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals made by a plan under such subsection for costs incurred on or after January 1, 2011.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES.—The Inspector General of the Department of Health and Human Services shall conduct, and the Secretary shall ensure the extent to which the Medicare formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6)).

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—(1) STUDY.—(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare Prescription Drug Program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A model form for use under such process (as the Inspector General determines feasible, a single, uniform model form for use under such process) that the Secretary determines appropriate.

(ii) A study and report on prescription drug prices under Medicare Part D and Medicaid.

(B) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to prescription drug prices under Medicare Part D and Medicaid.

(2) REPORT.—(A) IN GENERAL.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—(1) STUDY.—(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall carry out the comparison under subparagraph (A)(1) with such recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to prescription drug prices under Medicare Part D and Medicaid.

(c) ANNUAL REPORTS BY THE SECRETARY.—(1) IN GENERAL.—The Secretary shall conduct a study of the extent to which MA–PD plans; and

(II) the prices paid for covered outpatient drugs by a Medicare Advantage plan under title XIX.

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government;

(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan (as defined in section 1902(a)(10));

(III) the impact of such differences on Medicare Advantage organizations offering MA–PD plans; and

(IV) the impact of such differences on MA–PD plans.

(2) REPORT.—(A) IN GENERAL.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with such recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—Notwithstanding any other provision of law, the Inspector General of the Department of Health and Human Services shall carry out the study and report submitted under subparagraph (A) if the Inspector General determines that such costs are treatment for such subsection, there shall be no change in the premiums, bids, or any other parameters under this part or part C; and

(C) APPLICATION.—In applying subparagraph (A) as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C; and

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term ‘‘Medicare Advantage organization’’ has the meaning given in section 1859(a)(1) of such Act (42 U.S.C. 1395w–26(a)(1)).

(E) PDP SPONSOR.—The term ‘‘PDP sponsor’’ means the Medicare Advantage organization in which the term ‘‘Medicare Advantage organization’’ has the meaning given in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term ‘‘prescription drug plan’’ has the meaning given in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

SEC. 3314. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking ‘‘and’’ at the end;

(2) in clause (i)—

(A) by striking ‘‘such costs shall be treated as incurred only if’’ and inserting ‘‘subject to clause (iii), such costs shall be treated as incurred only if’’;

(B) by striking ‘’, under section 1860D–14, or under a State Pharmaceutical Assistance Program’’; and

(C) by striking the period at the end and inserting ‘‘; and’’; and

(3) by inserting after clause (i) the following new clause:

‘‘(ii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (i) if such costs are borne or paid’’.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

SEC. 3315. IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)) is amended—

(1) in paragraph (3)(A), by striking ‘‘paragraph (4)’’ and inserting ‘‘paragraphs (4) and (7)’’; and

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

‘‘(7) DECREASE IN INITIAL COVERAGE LIMIT IN 2010.—‘‘(A) IN GENERAL.—For the plan year beginning on January 1, 2010, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by $500.

‘‘(B) APPLICABILITY.—In applying subparagraph (A) as otherwise provided in this subparagraph, there shall be no change in the premiums, bids, or any other parameters under this part or part C; and

‘‘(C) If costs that would be treated as incurred costs for purposes of applying paragraph (4) but for the application of subparagraph (B) continue to be treated as incurred costs; and

(iii) the Secretary shall establish procedures, which may include a reconciliation
process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph (A):

(iv) The Secretary shall establish procedures for the reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph (A) and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

(C) No Effect on Subsequent Years—The increase under subparagraph (A) shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2010, shall be determined as if subparagraph (A) had never applied.”.

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 1201 of the Patient Protection and Affordable Care Act (as added by section 1141 of the American Recovery and Reinvestment Act of 2009), is amended—

(1) in clause (i)(XX), by striking “clause (vii)” and inserting “clauses (vii), (ix), (xi), and (xii)”;

(2) in the first sentence of clause (viii), by inserting “of such applicable percentage increase (determined without regard to clause (ix), (x), or (xii))” after “one-quarter”;

(3) in the first sentence of clause (ix)(B), by inserting “(determined without regard to clause (viii), (xi), or (xii))” after “clause (i)” the second time it appears; and

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

“(xii) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i), the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(ii).”

(B) Skilled Nursing Facilities—Section 1886(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(5)(B)) is amended—

(1) by striking “PERCENTAGE.—” and inserting “PERCENTAGE.—”;

(2) by inserting “subject to clause (ii)” before the period at the end of the first sentence of clause (i), as added by paragraph (1); and

(3) by adding at the end the following new clause:

“(C) IN GENERAL.—For purposes of paragraph (C)(i)(II), the other adjustment described in this subparagraph is—

(i) subject to clause (ii), for each of fiscal years 2010 through 2019, 0.2 percentage point; and

(ii) subject to clause (ii), for each of fiscal years 2010 through 2019, 0.2 percentage point, if for such fiscal year—

(aa) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); and

(bb) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); and

(vi)-adjustments.—after determining the home health market basket percentage

by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’; and

(ii) the excess (if any) of—

(bb) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); and

(c) Long-Term Care Hospitals.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as added by section 1201 of the Patient Protection and Affordable Care Act (as added by section 1141 of the American Recovery and Reinvestment Act of 2009), is amended—

(1) by striking “FACTOR.—For purposes of paragraph (C)(i)(II), the other adjustment described in this subparagraph is—

(ii) subject to clause (ii), for each of fiscal years 2010 through 2019, 0.2 percentage point; and

(ii) subject to clause (ii), for each of fiscal years 2010 through 2019, 0.2 percentage point.

(ii) REDUCTION OF OTHER ADJUSTMENT.—The application of the preceding sentence may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(ii) for each of fiscal years 2010 through 2019, by the other adjustment described in subparagraph (D).

2019, by the other adjustment described in subparagraph (D).

(D) OTHER ADJUSTMENT.—For purposes of paragraph (C)(i)(II), the other adjustment described in this subparagraph is—

(i) subject to clause (ii), for each of fiscal years 2010 through 2019, 0.2 percentage point, if for such fiscal year—

(ii) the excess (if any) of—

(aa) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); and

(bb) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary);”.

(e) Home Health Agencies.—Section 1865(b)(3)(B) of the Social Security Act (42 U.S.C. 1395f(f)(3)(B)) is amended—

(1) in clause (ii)(V), by striking “clause (v)” and inserting “clauses (v) and (vi)”;

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

“(vi) Adjustments.—After determining the home health market basket percentage

by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such rate year—

(ii) the excess (if any) of—

(bb) the total percentage of the non-elderly insured population for such preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); and

(bb) the total percentage of the non-elderly insured population for such preceding rate year (estimated by the Department of Health and Human Services);”.

Securities Act of 2006.”.

11706
CONGRESSIONAL RECORD — SENATE
November 19, 2009
increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

"(i) for 2015 and each subsequent year, by the productivity adjustment described in section 1866(b)(3)(B)(x)(I)(ii); and

"(ii) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

(2) HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subclauses:

"(C) IN GENERAL.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subsequent year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(x)(I)(ii), the other adjustment described in this paragraph, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

(3) OTHER ADJUSTMENT.—

"(B) by striking ''clause (ii)'' and inserting ''subclause (II) and clause (i)''; and

"(C) by adding at the end the following new subclause:

"(II) For 2012 and each subsequent year, after applying the increase factor described in subsection (B), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(x)(I)(ii), after subtracting from such increase factor being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

(4) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

"(i) by redesigning clause (v) as clause (vi); and

"(ii) by inserting after clause (iv) the following new clause:

"(B) by striking the period at the end and inserting ''and'';

"(B) by striking the period at the end and inserting ''; and'';

"(C) by adding at the end the following new subparas:

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

(5) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in this subsection for a rate year being less than such payment rates for the preceding rate year.

(6) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395w-3(i)(2)(D)) is amended—

"(i) by inserting after clause (iv) the following new clause:

"(iv) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for such preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

"(ii) subject to clause (i), for each of 2012 through 2019, 0.2 percentage point.

(7) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

"(i) by redesigning clause (v) as clause (vi); and

"(ii) by inserting after clause (iv) the following new clause:

"(B) by striking the period at the end and inserting ''; and'';

"(B) by striking the period at the end and inserting ''; and'';

"(C) by adding at the end the following new subparas:

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

(8) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395w-3(i)(2)(D)) is amended—

"(i) by redesigning clause (v) as clause (vi); and

"(ii) by inserting after clause (iv) the following new clause:

"(B) by striking the period at the end and inserting ''; and'';

"(B) by striking the period at the end and inserting ''; and'';

"(C) by adding at the end the following new subparas:

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

(9) HOSPITALS.—

"(B) by striking ''clause (ii)'' and inserting ''subclause (II) and clause (i)''; and

"(C) by adding at the end the following new subclause:

"(II) For 2012 and each subsequent year, after applying the increase factor described in subsection (B), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(x)(I)(ii), after subtracting from such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.

"(G) OTHER ADJUSTMENT.—

"(ii) subject to clause (i), for each of 2012 through 2019, 0.2 percentage point.

(10) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

"(i) by inserting after clause (iv) the following new clause:

"(B) by striking the period at the end and inserting ''; and'';

"(B) by striking the period at the end and inserting ''; and'';

"(C) by adding at the end the following new subparas:

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

(11) HOSPITALS.—Section 1886 of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3133, is amended by adding at the end the following new clauses:

"(iv) After determining the market basket percentage increase under clause (ii)(VII) or subparagraph (A) for the preceding fiscal year, the Secretary shall reduce such percentage—

"(v) Clause (iv)(II) shall be applied with respect to any of fiscal years 2014 through 2019 by subtracting '0.0 percentage points' for '0.5 percentage point', if for such fiscal year—

"(i) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for the preceding year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

"(bb) the total percentage of the non-elderly insured population for such preceding year (as estimated by the Secretary); exceeds

"(ii) subject to clause (i), for each of 2012 through 2019, 0.2 percentage point.

(12) LABORATORY SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395w-3(i)(2)(D)) is amended—

"(i) by inserting after clause (iv) the following new clause:

"(B) by striking the period at the end and inserting ''; and'';

"(B) by striking the period at the end and inserting ''; and'';

"(C) by adding at the end the following new subparas:

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percentage point.

(13) HOSPITALS.—

"(B) by striking ''clause (ii)'' and inserting ''subclause (II) and clause (i)''; and

"(C) by adding at the end the following new subclause:

"(II) For 2012 and each subsequent year, after applying the increase factor described in subsection (B), the Secretary shall reduce such increase factor by the productivity adjustment described in section 1886(b)(3)(B)(x)(I)(ii), after subtracting from such increase factor being less than 0.0 for a year, and may result in payment rates under the payment system under this paragraph for a year being less than such payment rates for the preceding year.

The application of this subparagraph may result in the increase factor under subparagraph (C)(iv) being less than 0.0 for a year, and may result in payment rates under the system described in this subsection for a year being less than such payment rates for the preceding year.
(B) by striking ‘‘through 2013’’ and inserting ‘‘and 2016’’; and
(2) by adding at the end the following new clause:
‘‘(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—
‘‘(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1866(b)(3)(B)(xii); and
‘‘(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (I) shall result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.”.

(m) Certain Durable Medical Equipment.—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—
(1) by striking ‘‘2009’’ and inserting ‘‘2008’’;
(A) by striking ‘‘2011, 2012, and 2013.’’; and
(B) by inserting ‘‘and’’ after the semicolon at the end;
(2) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:
‘‘(L) for 2011 and each subsequent year—
‘‘(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1866(b)(3)(B)(xii); and

(iii) by adding at the end the following flush sentence:
‘‘The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates for such year being less than such payment rates for the preceding year.”.

(n) Prosthetic Devices, Orthotics, and Prosthetics.—Section 1866(b)(3)(B)(4) of the Social Security Act (42 U.S.C. 1395m(b)(4)) is amended—
(1) in subparagraph (A)—

(A) in clause (ix), by striking ‘‘and’’ at the end; and

(B) in clause (x)—

(i) by striking ‘‘a subsequent year’’ and inserting ‘‘such year’’; and

(ii) by inserting ‘‘and’’ after the semicolon at the end; and

(C) by adding at the end the following new clause:
‘‘(xx) for 2011 and each subsequent year—

(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1866(b)(3)(B)(xii); and

(iii) by adding at the end the following flush sentence:
‘‘The application of subparagraph (A)(xii)(II) may result in the applicable percentage increase in such payment rates for a year being less than such payment rates for the preceding year.’’.

(o) Other Items.—Section 1842(e)(1) of the Social Security Act (42 U.S.C. 1395u(a)(1)) is amended—
(1) in the first sentence, by striking ‘‘Subject to’’ and inserting ‘‘(A) Subject to’’;

(2) by striking the second sentence and inserting the following new subparagraph:
‘‘(B) Any fee schedule established under this paragraph for such item or service shall be updated—

(i) for years before 2011—

(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and

(II) for years before 2011 and each subsequent year—

(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1866(b)(3)(B)(xii); and

(iii) by adding at the end the following flush sentence:
‘‘The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates for any year being less than such payment rates for the preceding year.’’

(2) in paragraph (3)(A)(i), by striking ‘‘The’’ and inserting ‘‘The applicable’’;

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:
‘‘(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any provision of this section, during the period beginning on January 1, 2011, and ending on December 31, 2019—

(A) the threshold amount otherwise applicable under paragraph (2)(D) for 2010 shall be equal to such amount for 2010; and

(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.’’.

(p) Sec. 3402. Temporary Adjustment to the Calculation of Part B Premiums.

Section 1833(b)(2) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—
(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting ‘‘subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—

(ii) the productivity adjustment described in section 1866(b)(3)(B)(xii); and

(iii) by adding at the end the following flush sentence:
‘‘The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 for a year, and may result in payment rates for any year being less than such payment rates for the preceding year.’’.

(q) Board.—

(1) In general.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:
‘‘INDEPENDENT MEDICARE ADVISORY BOARD

SEC. 3403. INDEPENDENT MEDICARE ADVISORY BOARD.

(a) Board.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:
‘‘INDEPENDENT MEDICARE ADVISORY BOARD

SEC. 1861(d).—There is established an independent board to be known as the ‘‘Independent Medicare Advisory Board’’.

(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

(I) by the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as ‘‘a determination year’’), the projected Medicare per capita growth rate for the second year following the determination year (in this section referred to as ‘‘an implementation year’’);

(II) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Board to develop and submit during the first year following the determination year (in this section referred to as ‘‘a proposal year’’) a proposal containing (in this section referred to as ‘‘the proposal’’) a reduction to the Medicare per capita growth rate to the extent required by this section; and

(III) by requiring the Secretary to implement such proposals so that this Congress enacts legislation pursuant to this section.

(c) Board Proposals.—

(1) DEVELOPMENT.—

(A) IN GENERAL.—The Board shall develop and submit to Congress advisory reports on matters to which the proposal under this section may apply, regardless of whether or not the Board submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to Medicare systems for providers of services and suppliers who are not otherwise subject to the scope of the Board’s recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

(2) PROPOSALS.—

(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (7)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year that is at least equal to the applicable savings target established under paragraph (7)(B) for such implementation year. In determining whether a proposal meets the requirement of preceding sentence, ‘‘Medicare program spending’’ means Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during such period pursuant to subsection (e)(2)(A).

(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1819, 181A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would reduce payment rates for items and services furnished, prior to December 31, 2019, by providers of services (as defined in section 1861(d) of the Patient Protection and Affordable Care Act, to reduce the reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would reduce Medicare per capita growth rate to the extent required by this section.

As appropriate, the proposal shall include recommendations to reduce Medicare
payments under parts C and D, such as re-
ductions in direct subsidy payments to Medi-
care Advantage and prescription drug plans
specified under paragraph (1) and (2) of sec-
tion 1860D–2(b)(3) that are related to ad-
ministrative expenses (including profits) for
basic coverage, denying high bids or removing
high bids for prescription drug coverage from
the determinations of the national monthly
bid amount under section 1860D–13(a)(4), and
reductions in payments to Medi-
care Advantage plans under clauses (i) and (ii)
of paragraph (1) of section 1860D–2(b)(3) that
are related to administrative expenses (including
profits) and performance bonuses for Medicare Ad-
vantage plans under section 1860D–2(b)(3).
Any such recommendation shall not affect the
base beneficiary premium percentage speci-
fied under 1860D–13(a).

(3) TRANSMISSION OF BOARD PROPOSAL TO
SECRETARY.—The Board shall submit a draft
posal.

(A) IN GENERAL.—

(i) The Board shall submit a proposal under clause (i)
in a proposal year if the
(ii) a year for which the Chief Actuary of
the Centers for Medicare & Medicaid Serv-
ices makes a determination in the deter-
mation year, in any increase in the total
Medicare program spending that would have occurred
if the proposal described in clause (i) of such
paragraph does not exceed the growth
rate described in clause (ii) of such para-
graph;

(III) a year in which the Chief Actuary of
the Centers for Medicare & Medicaid Serv-
ices makes a determination in the deter-
mation year that the growth rate de-
scribed in paragraph (8) exceeds the
rate described in paragraph (6)(A)(i).

(V) other information determined appro-
riate by the Board.

(D) CONSULTATION WITH MEDPAC.—The
Board shall submit a draft copy of each pro-
posal to be submitted under this section to the
Medicare Payment Advisory Commission
established under section 1805 for its review.
The Board shall submit such draft copy
by not later than September 1 of the determina-
tion year for implementation.

(E) REVIEW AND COMMENT BY THE SEC-
RETARY.—The Board shall submit a draft
copy of each proposal to be submitted to Congress
or the Secretary during the comment period for the
Secretary’s review and comment. The
Board shall submit such draft copy by
not later than September 1 of the determi-
nation year. On March 1 of the submis-
sion year, the Secretary shall submit a re-
port to Congress on the results of such re-
view, unless the Secretary submits a pro-
posal under paragraph (5)(A) in that year.

(5) CONTINGENT SECRETARIAL DEVELOP-
MENT OF PROPOSAL.—If, with respect to a proposal
submitted by the Board under subparagraph
(A)(1) or the Secretary under paragraph (5), thePresident
shall immediately submit such proposal to
Congress.

(6) PER CAPITA GROWTH RATE PROJECTIONS
BY CENTER FOR MEDICARE SERVICES.—

(A) IN GENERAL.—Subject to subsection
(f)(3)(A), not later than April 30, 2013, and
annually thereafter, the Chief Actuary of the
Centers for Medicare & Medicaid Services
shall determine in each such year whether—

(i) the projected Medicare per capita
growth rate for the implementation year (as
defined under subparagraph (B) exceeds
the product of—

(ii) the projected Medicare per capita
rate for the implementation year. such that
the growth rate in year (if any) in the
Consumer Price Index for All Urban Consumers (all
items; United States city average) for such implemen-
tation year;

(iii) an actuarial opinion by the Chief Ac-
tuary of the Centers for Medicare & Medicaid
Services certifying that the proposal meets the
requirements of subparagraphs (A)(i) and (C) of
paragraph (2);

(II) the applicable percent for
implementation year (as
defined under subparagraph (B) exceeds
the product of—

(i) the total amount of projected Medi-
care program spending for the proposal year;

(ii) the applicable percent for the imple-
mentation year.

(C) MEDICARE PER CAPITA TARGET GROWTH
RATE.—For purposes of this section, the
Medicare per capita growth rate for an
implementation year shall be calculated as
the projected 5-year average (ending with
such year) of the growth in Medicare pro-
gram spending per unduplicated enrollee.
‘(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

(b) PER CAPITA RATE OF GROWTH IN NATION-WIDE PROGRAMS.—In the case of the nation-wide Medicare program for the termination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health care expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average rate that would result in a $484 billion increase in national health care expenditures.

(d) CONGRESSIONAL CONSIDERATION.—

(1) INTRODUCTION.—

(A) IN GENERAL.—On the day on which a proposal is submitted by the President to the Houses of Congress, or the proposal is introduced in one House, as described in subparagraph (A), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be considered (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

(B) IN THE CASE OF AN IMPLEMENTATION YEAR.—If either House is not in session on the day on which a legislative proposal is submitted, the legislative proposal shall be introduced in that House, as described in subparagraph (A), on the first day thereafter on which that House is in session.

(2) ANY MEMBER.—If the legislative proposal (described in subparagraph (A)) contains a proposal that is a revision to the Medicare program or a proposal that relates to the Medicare program, any Member of the House may introduce the legislative proposal.

(3) REFERRAL.—The legislation introduced under this paragraph shall be referred by the President of the Senate to the Committee on Finance in the Senate and to the Committee on Energy and Commerce in the House of Representatives, and the Committee on Ways and Means in the House of Representatives.

(2) COMMITTEE CONSIDERATION OF PROPOSAL.—

(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, any Member of that House may introduce the legislative proposal.

(B) CALCULATIONS.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year should be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matters not within the jurisdiction of the Standing Committees of the Senate, with respect to such matters that is relevant to a proposal contained in the bill submitted under subsection (c)(3).

(D) DISCHARGE.—If, with respect to the House, the committee has reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change the recommendations of the Board if that change would result in an increase of subparagraph (A) and (C) of subsection (c)(2).

(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change the recommendations of the Board if that change would result in a reduction of subparagraph (A) and (C) of subsection (c)(2).

(4) CONGRESSIONAL CONSIDERATION.—

(A) IN GENERAL.—The expedited procedures provided in this subsection for the consideration of any amendment to a bill introduced pursuant to paragraph (1) shall not apply to such a bill that is received by one House from the other after introduction but before disposition of such a bill in the receiving House, or the following shall apply:

(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—The question on passage shall be put on the bill of the other House as amended by the language of the receiving House.

(C) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—Any legislative proposal that originates in the receiving House shall be considered to be the vote on passage of the bill received from the other House as amended by the language of the receiving House.

(6) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, the proposal shall be considered to be the bill that originates in the receiving House.

(7) LIMITATION.—Clauses (i), (ii), and (iv) shall apply only to a bill received by one House from the other House if the bill—

(i) is related only to the program under consideration,

(ii) satisfies the requirements of subparagraphs (A)(i) and (C) of subsection (c)(2),

(iii) is related to the program under consideration of the bill that originates in the receiving House.

(8) MOTION TO FURTHER LIMIT DEBATE.—A motion to further limit debate on the bill is in order and is not debatable.

(9) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

(10) VOTING.—The motion to end debate shall be considered to be the vote on passage of the bill, and the vote on passage shall be required in the Senate to sustain an opposition thereto by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(11) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

(12) VOTING.—The motion to end debate shall be considered to be the vote on passage of the bill, and the vote on passage shall be required in the Senate to sustain an opposition thereto by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(13) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

(14) VOTING.—The motion to end debate shall be considered to be the vote on passage of the bill, and the vote on passage shall be required in the Senate to sustain an opposition thereto by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(15) MOTION OR APPEAL.—Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal.

(16) VOTING.—The motion to end debate shall be considered to be the vote on passage of the bill, and the vote on passage shall be required in the Senate to sustain an opposition thereto by the affirmative vote of three-fifths of the Members, duly chosen and sworn.
“(iii) Final disposition.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all other motions, except a quorum call, or to recommend a quorum call on demand to establish the presence of a quorum and any amendment thereto before the Senate at that time or necessary to resolve the differences between the Houses and to the exclusion of all other motions, except a quorum call or to reconsider one quorum call on demand to establish the presence of a quorum head immediately before the final vote begins.

“(iv) Limitation.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or an amendment thereto—

“(1) is related only to the program under this title; and

“(2) satisfies the requirements of subparagraphs (A)(1) and (C) of subsection (c)(2).

“(F) Vetoes.—If the President vetoes the bill, debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

“(G) Rules of the Senate and House of Representatives.—This subsection and subsection (f)(2) are enacted by Congress—

“(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, and is designed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House, in the case of the Senate, and, it supersedes other rules only to the extent that it is inconsistent with such rules; and

“(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

“(e) Implementation of Proposal.—

“(1) In general.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted.

“(2) Application.—

“(A) In general.—A recommendation described in paragraph (1) shall apply as follows:

“(i) In the case of a recommendation that is a change in the payment rate for an item or service in Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

“(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

“(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

“(B) Intraim Rulemaking.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

“(3) Exception.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the President to Congress pursuant to this section if—

“(A) prior to August 15 of the proposal year, Federal legislation is enacted that includes the following provision: ‘This Act supersedes the recommendations of the Board contained in the proposal submitted, in the year which includes the date of enactment of this Act, to Congress under section 1899A of the Social Security Act’; and

“(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution of the Congress (C)(1) is enacted not later than August 15, 2017.

“(4) No Affect on Authority to Implement Certain Provisions.—Nothing in paragraph (1) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that such recommendation is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a fiscal year), or to the extent that such recommendation is inconsistent with such rules; and

“(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

“(g) Board Membership; Terms of Office; Vacancies; Officers; Removal.—

“(1) General.—The Board shall consist of not more than 15 individuals, by and with the advice and consent of the President, to serve during his or her term in office, except as follows: nothing in paragraph (1) shall be construed to affect the authority to implement such recommendation administratively.

“(5) Limitation on Review.—There shall be no administrative or judicial review under section 1899A of the Social Security Act, or section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal submitted by the President to Congress pursuant to this section after January 16, 2018; and

“(6) Except a Motion to Reconsider.—For purposes of subparagraph (B), a joint resolution described in this paragraph means only a joint resolution—

“(A) that is introduced in 2017 by not later than February 1 of such year;

“(B) which does not have a preamble;

“(C) the title of which is as follows: ‘Joint resolution disapproving the process for consideration and automatic implementation of the annual proposal of the Independent Medicare Advisory Board under section 1899A of the Social Security Act’; and

“(D) ANOTHER HOUSE ACTS FIRST.—If, before the passage by 1 House of a joint resolution of that House described in paragraph (1), that House receives from the other House a joint resolution described in paragraph (1), then the following procedures shall apply:

“(1) Immediately following the passage by either House of a joint resolution described in paragraph (1), the other House shall not be referred to a committee.

“(ii) With respect to a joint resolution described in paragraph (1) of the House receiving the joint resolution—

“(i) the procedure in that House shall be the same as if no joint resolution had been received from the other House; but

“(ii) the vote on final passage shall be on the joint resolution of the other House.

“(E) Excluded Days.—For purposes of determining the period specified in subparagraph (D) there shall be excluded—

“(A) both days if either House of Congress is adjourned not later than 3 days during a session of Congress for any purpose other than recess;

“(B) both days if one House of Congress is adjourned not later than 3 days during a session of Congress for any purpose other than recess;

“(C) both days if one House of Congress is adjourned for more than 3 days during a session of Congress for any purpose other than recess.

“(4) Majority Required for Adoption.—A joint resolution considered under this subsection shall require an affirmative vote of three-fifths of the Members, duly chosen and sworn, for adoption.

“(5) Termination.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

“(A) the Board, including any individuals serving as ex-officio members, shall be dissolved; and

“(B) the Board shall not be reconstituted.

“(C) The Board and the Advisory Board established by section 1899C of the Social Security Act shall terminate on December 31, 2020.

“(D) Board Membership; Terms of Office; Chairperson; Vacancies; Removal.—

“(i) Membership.—The Board shall be composed of—

“(A) 15 individuals appointed by the President, by and with the advice and consent of the Senate, to serve during his or her term in office.

“(B) The Secretary, the Administrator of the Center for Medicare and Medicaid Services,
and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

(1) In general.—The appointed membership of the Board shall include individuals with national recognition for their expertise in health economics, health services research, and technology assessment; broad geographic representation; and a balance between urban and rural representatives.

(i) Inclusion.—The appointed membership of the Board shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmacoeconomics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes research, and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(ii) Compensation.—The appointed members of the Board shall be treated as officers of the United States.

(iii) Officers.—The President, the Vice-Chairperson, and the Chairperson of the Board shall be ex officio members of the Board.

(iv) Officers in general.—Each officer of the Board, including the Chairperson, shall be a voting member of the Board.

(v) vacancies.—The President shall, within 30 days of any vacancy, appoint a successor to the former Board member.

(2) Term of office.—Each appointed member shall hold office for a term of 6 years, the term of each to be designated by the President, and shall be subject to removal by the President for neglect of duty or malfeasance in office, but for no other cause.

(3) Definitions.—In this section:

(A) In general.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

(B) Term of office.—Each appointed member shall be the principal executive officer of the Board, and shall exercise all of the powers of the Board.

(C) Compensation.—The Chairperson may annually appoint a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

(D) Removal.—Any appointed member may be removed by the President for neglect of duties or malfeasance in office, but for no other cause.

(E) Quorum.—The Board shall have an official seal, of which judicial notice shall be taken.

(F) Vacancies.—The President shall appoint a successor to the former member.

(G) Compensation.—The Chairperson shall be compensated at the rate of pay prescribed for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(H) Gifts.—The President may accept, use, and dispose of gifts or donations of services or property.

(I) Meetings.—The Board shall meet at least once each year, and at other times as the Chairperson shall designate.

(J) Compensation of Members and Chairperson.—Each appointed member, other than the Chairperson, shall be compensated at the rate equal to the daily equivalent of the annual rate of basic pay prescribed for level III of the Executive Schedule under section 3135 of title 5, United States Code.

(2) Travel expenses.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(3) Staff.—Chairperson.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other executive and administrative officers and employees as may be necessary to enable the Board to perform its duties. The employment of an executive director shall be subject to confirmation by the Board.

(4) Authorization of compensation.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code. The Board may determine to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate equal to the rate of pay for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(5) Procurement of temporary and intermittent services.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of title 5, United States Code.

(K) Consumer Advisory Council.—There is established a consumer advisory council to advise the Board on the impact of payment policies under this title on consumers.

(2) Membership.—(A) Number and appointment.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

(B) Qualifications.—The membership of the council shall represent the interests of consumers and particular communities.

(3) Powers of the council.—The council may issue orders and rules and enter into contracts and take any other action as necessary to fulfill its responsibilities.

(4) Meetings.—The council shall meet at least once each year in the District of Columbia.

(5) Election of officers.—The consumer advisory council shall elect their own officers.

(6) Application of P.L.C.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the work of the council, except that section 14 of such Act shall not apply.

(C) Definitions.—In this section:

(A) Chairperson.—The terms ‘Chairperson’, ‘Vice-Chairperson’, and ‘Member’ mean the Independent Medicare Advisory Board;"
means the program established under this part A or enrolled for benefits under part B.

(3) Medicare beneficiary.—The term ‘Medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

(4) Medicare program spending.—The term ‘Medicare program spending’ means program spending under parts A, B, and D net of premiums.

(5) Funding.—There are appropriated to the Board to carry out its duties and functions—

(A) for fiscal year 2012, $15,000,000; and

(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) as of June of the previous fiscal year.

(6) From trust funds.—Sixty percent of amounts appropriated under paragraph (5), as adjusted, shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under subsection (a) of section 1899A shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1811.

(7) Lobbying cooling-off period for members of the Independent Medicare Advisory Board.—Section 207(c) of title 18, United States Code, is amended by inserting at the end of that section the following:

(8) Members of the Independent Medicare Advisory Board.—

(A) in general.—Paragraph (1) shall apply to—

(i) the member of the Independent Medicare Advisory Board under section 1899A.

(B) agencies and Congress.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Independent Medicare Advisory Board, the Department of Health and Human Services, and the relevant committees of jurisdiction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

(9) GAO study and report on determination and implementation of payment and coverage policies under the Medicare program.—

(A) Initial study and report.—

(1) study by the Comptroller General of the United States (in this section referred to as the ‘Comptroller General’): the Comptroller General shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Independent Medicare Advisory Board under section 1899A of such Act (as added by subsection (a), including an analysis of the effect of such recommendations on—

(A) Medicare beneficiary access to providers and items and services;

(B) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

(C) the potential impact of changes on other government or private-sector purchasers and payers of care; and

(D) quality of patient care, including patient experience, outcomes, and other measures of care.

(B) report.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), including legislation and administrative action as the Comptroller General determines appropriate.

(C) Conforming amendments.—Section 1865(b) of the Social Security Act (42 U.S.C. 1395b-6(b)) is amended—

(1) by redesigning paragraphs (4) through (8) as paragraphs (5) through (9), respectively;

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

(P) Review and comment on the independent medicare advisory board or secretarial proposal.—If the Independent Medicare Advisory Board (as established under subsection (a) of section 1899A) or the Secretary determines that the Commission under such section in a year, the Commission shall review the proposal and, not later than March 1 of that year, submit to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.

Subtitle F—Health Care Quality Improvements

SEC. 3501. HEALTH CARE DELIVERY SYSTEM RESEARCH, QUALITY IMPROVEMENT TECHNICAL ASSISTANCE.

Part D of title IX of the Public Health Service Act, as amended by section 3013, is further amended by adding at the end the following:

Subpart II—Health Care Quality Improvement Programs

SEC. 3531. HEALTH CARE DELIVERY SYSTEM RESEARCH.

(a) Purpose.—The purpose of this section is to—

(1) enable the Director to identify, develop, test, and disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value; and

(2) ensure that the Director is accountable for implementing a model to pursue such research in a collaborative manner with other related Federal agencies.

(b) General Functions of the Center.—

(1) the Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), or any other relevant agency or department designated by the Director, shall—

(A) develop and disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value; and

(B) that include changes in processes of care, the redesign of systems used by providers that will reliably result in intended health outcomes, improve patient safety, and reduce medical errors (such as skill degradation) and other quality problems (including team-based health care delivery and rapid cycle process improvement) and facilitate adoption of improved workflow;

(C) identify health care providers, including health care systems, single institutions, and individual providers, that—

(D) deliver consistently high-quality, efficient, and effective health care services (as determined by the Secretary); and

(E) employ best practices that are adaptable and scalable to diverse health care settings or effective in improving care across diverse settings;

(F) assess research, evidence, and knowledge about what strategies and methodologies are most effective in improving health care delivery;

(G) find ways to translate such information rapidly and effectively into practice, and maintain the sustainability of those improvements;

(H) create strategies for quality improvement through the development of tools, interventions, and other activities that can successfully reduce variations in the delivery of health care;

(I) identify, measure, and improve organizational, human, or other causative factors, including those related to the culture and system design of a health care organization, that contribute to the success and sustainability of specific quality improvement and patient safety strategies;

(J) provide for the development of best practices in the delivery of health care services;

(K) have a high likelihood of success based on structured review of empirical evidence;

(L) are specified with sufficient detail of the individual processes, steps, training, skills, and knowledge required for implementation and incorporation into workflow of health care practitioners in a variety of settings; and

(M) are designed to be readily adapted by health care providers in a variety of settings; and

(N) where applicable, assist health care providers in working with other health care providers across the continuum of care and with patients and their families in improving the care and patient health outcomes;

(O) provide for the funding of the activities of organizations with recognized expertise and excellence in improving the delivery of health care services, including children’s health care, by involving multiple disciplines, managers of health care entities, broad development and training, patients, caregivers and families, and frontline health care workers, including activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services;

(P) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentoring programs to support the delivery system improvement and the development of tools to facilitate adoption of best practices;
that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

"(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

(B) identify which evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1908(a) of the Social Security Act in the report required under section 399J;

(C) address concerns identified by health care institutions and providers and communicated through the Center pursuant to subsection (d);

(D) reduce preventable morbidity, mortality, health care costs of morbidity, and mortality by building capacity for patient safety research;

(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

(F) ensure communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

(i) the implementation of a national application of Intensive Care Unit improvement focused on the adult including geriatric, pediatric, and neonatal patient populations;

(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Enterococcus infections and other emerging infections;

(iii) practical methods for reducing preventable hospital admissions and readmissions;

(iv) expand demonstration projects for improving the quality of children's health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1138A of the Social Security Act for assessing and improving quality, where applicable;

(H) identify and mitigate hazards by—

(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

(ii) using the results of such analyses to develop scientific methods of response to such events;

(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

(3) DISSEMINATION OF RESEARCH FINDINGS.—

(A) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

(B) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research findings identified in paragraph (1) or (2) by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the National Health Information Technology Extensin program under section 302l, as well as any relevant standards, certification criteria, or implementation specifications.

(C) TECHNICAL ASSISTANCE.—The Director shall identify and regularly update a list of processes or systems on which to focus research and disseminate activities of the Center, taking into account—

(i) the cost to Federal health programs;

(ii) consumer assessment of health care experience;

(iii) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

(iv) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children and minorities;

(v) the areas of insufficient evidence identified under subsection (c)(2)(B); and

(vi) the evolution of meaningful use of health information technology, as defined in section 3000.

(D) COORDINATION.—The Center shall coordinate its activities with activities conducted by the Agency for Healthcare Research and Quality (referred to in this section as the 'Center'), including—

(i) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and suppliers with limited infrastructure and financial capacity) and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for whom disparities in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

(ii) implementation grants to eligible entities to implement the models and practices described under paragraph (1).

(E) Prioritization.—The Director shall prioritize technical assistance awards to eligible entities to implement the models and practices described under paragraph (1).

(F) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through contributions from any public or private entity and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(G) EVALUATION.—

(H) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

(i) the success of such entity in achieving the implementation, by the health care care providers and providers assisted by such entity, of the models and practices identified in the research conducted by the Center under section 933;

(ii) the perception of the health care institutions and providers assisted by such entity regarding the value of the entity; and

(iii) the impact on patient health outcomes and lower cost resulting from the assistance provided by such entity.

(I) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.

(2) GRANT OR CONTRACT.—To be eligible to receive an implementation grant or contract under subsection (a)(2), an eligible entity—

(A) may be a hospital or other health care provider or consortium of providers, as determined by the Secretary; and

(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

(3) RESEARCH REQUIREMENTS.—To be eligible to receive a research grant or contract under subsection (a)(2), an eligible entity—

(A) may be a hospital or other health care provider or consortium of providers, as determined by the Secretary; and

(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

(4) APPLICATION.—

(A) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

(i) a plan for a sustainable business model that may include a system of—

(I) charging fees to institutions and providers that receive technical support from the entity; and

(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations;

(B) such other information as the Director may require.

(5) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

(i) financial cost, staffing requirements, and timeline for implementation; and

(ii) pre- and post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

(B) such other information as the Director may require.

(6) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through contributions from any public or private entity and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(7) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.
technology regional extension centers under section 3012(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement information and reform, and best practices information.”.

SEC. 2502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) In General.—The Secretary of Health and Human Services (referred to in this section as “the Secretary” shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service area (as determined by the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitlated payments to primary care providers as determined by the Secretary.

(b) Eligible Entities.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act;

(2) demonstrate achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care navigation into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) establish that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants;

(5) provide services to eligible individuals with chronic conditions, as described in section 1945 of the Social Security Act (as added by section 2703), in accordance with the methodology established under subsection (c) of such section; and

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

(c) Requirements for Health Teams.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care providers, state and community-based resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and health promotion with whom care is provided or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary, interprofessional plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate health care providers, patients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local primary care providers to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preventive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-delivered medication management services, including medication record keeping and (F) provide coordination of the appropriate use of complementary and alternative (CAM) services through such services;

(G) promote effective strategies for treatment planning, monitoring health outcomes and resource use, sharing information, treatment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appropriate setting, including access to individuals that implement the care plans of patients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental problems such as such as the use of inofelines, health information technology, or other means as determined by the Secretary;

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that provides admission and discharge coordination, assists with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing homes or other long-term care settings;

(B) discharge planning and counseling support to providers, patients, caregivers, and authorized representatives;

(C) assure that post-discharge care plans include medication management, as appropriate;

(D) referrals for mental and behavioral health services, which may include the use of inofelines; and

(E) transitional health care needs from adolescence to adulthood;

(9) serve as a liaison to community prevention and treatment programs;

(9) demonstrate a capacity to implement and maintain health information technology that is certified EHR technology (as defined in section 3000 of the Public Health Service Act (2 U.S.C. 399j)) to facilitate coordination among members of the applicable care team and all-inclusive primary care practices; and

(10) where applicable, report to the Secretary on the following: health care services provided by the eligible entities. Grants or contracts shall be used under section 399W of the Public Health Service Act.

(d) Requirement for Primary Care Providers.—A provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration.

(e) Reporting to Secretary.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out by the entity under subsection (c).

(f) Definition of Primary Care.—In this section, the term “primary care” means the provision of integrated, accessible health care services by clinicians who are accountable for providing personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after 3501 the following:

“SEC. 935. GRANTS OR CONTRACTS TO IMPLEMENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

(a) In General.—The Secretary, acting through the Patient Safety Research Center established in section 399A of this title (referred to in this section as the ‘Center’), shall establish a program to provide grants or contracts to eligible entities to implement medication management services (referred to in this section as ‘MTM’ services provided by licensed pharmacists, as a collaborative, interdisciplinary, interprofessional approach to the treatment of chronic diseases of targeted individuals, to improve the quality of care and reduce overall cost in the treatment of chronic diseases. The Secretary shall commence the program under this section not later than May 1, 2010.

(b) Eligible Entities.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1) provide a setting appropriate for MTM services, as recommended by the experts described in subsection (e); and

(2) submit to the Secretary a plan for achieving long-term financial sustainability;

(3) where applicable, submit a plan for coordinating MTM services through local community health teams established in section 3002 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W;

(4) submit a plan for meeting the requirements under subsection (c); and

(5) submit to the Secretary such other information as the Secretary may require.

(c) MTM Services to Targeted Individuals.—The MTM services provided under section 3002 and 399W shall be provided to individuals who, with the assistance of a grant or contract awarded under subsection (a), shall be allowed by State law including applicable collaborative pharmacy practice agreements, include—

(1) performing or obtaining necessary assessments of the health and functional status of each patient receiving such MTM services;

(2) formulating a medication treatment plan according to therapeutic goals agreed

November 19, 2009 CONGRESSIONAL RECORD — SENATE S11715
upon the prescriber and the patient or caregiver or authorized representative of the patient;

(3) selecting, initiating, modifying, recommending courses to, or administering medication therapy;

(4) monitoring, which may include access to, ordering, or performing laboratory assessment of the response of the patient to therapy, including safety and effectiveness;

(5) performing an initial comprehensive medication review, with the intent to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and a drug-interaction review, a schedule developed collaboratively with the prescriber;

(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

(7) providing education and training designed to enhance the understanding and appropriate medication-related activities of the patient, caregiver, and other authorized representatives;

(8) providing information, support services, and strategies designed to enhance patient adherence with therapeutic regimens;

(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

(a) TARGETED INDIVIDUALS.—MTM services provided by licensed pharmacists under a grant or contract awarded under subsection (a) shall be offered to targeted individuals who—

(1) take 4 or more prescribed medications (including over-the-counter medications and dietary supplements);

(2) take any ‘high risk’ medications;

(3) have 2 or more chronic diseases, as identified by the Secretary; or

(4) have undergone a transition of care, or other situations, as determined by the Secretary, that are likely to create a high risk of medication-related problems.

(b) CONSULTATION WITH EXPERTS.—In designing and implementing MTM services provided under grants or contracts awarded under subsection (a), the Secretary shall consult with Federal, State, private, public, and academic entities, pharmacy and pharmacist organizations, health care organizations, consumer advocates, chronic disease and patient advocacy groups, and other stakeholders involved with the research, dissemination, and implementation of pharmacist-delivered MTM services, as the Secretary determines appropriate. The Secretary, in collaboration with such group, shall determine whether it is possible to incorporate rapid cycle process improvement concepts in use in other Federal programs that have implemented MTM services.

(1) REPORTING TO THE SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as requested by the Secretary, the activities carried out under subsection (c), including quality measures endorsed by the entity with a contract under section 1890 of the Social Security Act, as determined by the Secretary.

(2) REPORTING TO CONGRESS.—The Secretary shall submit to the relevant committees of Congress a report which shall—

(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintain inpatient hospitalizations and emergency room visits than similar patients not enrolled in the program;

(2) assess changes in overall health care resource use by targeted individuals;

(3) assess patient and prescriber satisfaction with MTM services;

(4) assess the impact of patient-cost sharing requirements on medication adherence and recommendations for modifications;

(5) identify and evaluate other factors that affect patient-reported outcomes, including demographic characteristics, clinical characteristics, and health service use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and

(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

(b) GRANTS OR CONTRACTS TO FUND DEVELOPMENT OF PERFORMANCE MEASURES.—The Secretary shall make available for development program under section 931 of the Public Health Service Act, award grants or contracts to eligible entities for the purpose of developing performance measures that assess the use and effectiveness of medication therapy management services.

SEC. 1204. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (2 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(2) in the section heading, by inserting ‘FOR TRAUMA SYSTEMS’ after ‘GRANTS’; and

(B) in subsection (a), by striking ‘Administrator of the Health Resources and Services Administration’ and inserting ‘Assistant Secretary for Preparedness and Response’;

(2) by inserting after section 1203 the following:

(SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(2) APPLICATION INFORMATION.—Each application shall include—

(A) an assurance from the eligible entity that the proposed system—

(vi) addresses pediatric concerns related to, or occurring in, an emergency medical dispatch.

(b) ELIGIBLE ENTITY: REGION.—In this section:

(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means—

(A) a State or a partnership of 1 or more States and 1 or more local governments; or

(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

(2) REGION.—The term ‘region’ means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

(3) EMERGENCY SERVICES.—The term ‘emergency services’ includes acute, prehospital, and trauma care.

(4) Pilot Projects.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot project to design, implement, and evaluate an emergency medical and trauma system that—

(1) coordinates with public health and safety services, emergency medical services, medical facilities, trauma centers, and other entities in a region to develop an approach to emergency medical and trauma system access throughout the region, including 9–1–1 Public Safety Answering Points and emergency medical dispatch;

(2) includes a mechanism, such as a regional medical direction or transport command system, that operates throughout the region to ensure that the patient is taken to the medically appropriate facility (whether an initial facility or a higher-level facility) in a timely fashion;

(3) allows for the tracking ofprehospital and hospital resources, including inpatient bed capacity, emergency department capacity, trauma center capacity, on-call specialist coverage, ambulance diversion status, and the coordination of such tracking with regional communications and hospital destination decisions; and

(4) includes a consistent region-wide prehospital, hospital, and interfacility data management system that—

(A) submits data to the National EMS Information System, the National Trauma Data Bank, and others;

(B) reports data to appropriate Federal and State databanks and registries; and

(C) contains information sufficient to evaluate key elements of prehospital care, hospital destination decisions, including initial hospital and interfacility decisions, and relevant health outcomes of hospital care.

(4) APPLICATION.—(1) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(2) APPLICATION INFORMATION.—Each application shall include—

(A) an assurance from the eligible entity that the proposed system—

(vi) addresses pediatric concerns related to, or occurring in, an emergency medical dispatch.

(SEC. 1204. COMPETITIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—An eligible entity that seeks a contract or grant described in subsection (a) shall submit to the Secretary an application at such time and in such manner as the Secretary may require.

(2) APPLICATION INFORMATION.—Each application shall include—

(A) an assurance from the eligible entity that the proposed system—

(vi) addresses pediatric concerns related to, or occurring in, an emergency medical dispatch.

(b) ELIGIBLE ENTITY: REGION.—In this section:

(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means—

(A) a State or a partnership of 1 or more States and 1 or more local governments; or

(B) an Indian tribe (as defined in section 4 of the Indian Health Care Improvement Act) or a partnership of 1 or more Indian tribes.

(2) REGION.—The term ‘region’ means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

(3) EMERGENCY SERVICES.—The term ‘emergency services’ includes acute, prehospital, and trauma care.

(4) Pilot Projects.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that proposes a pilot
equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(2) Indian tribal, and urban Indian contributions. Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and exclusions of such donations and contributions). Amounts provided by the Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(f) Priority.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a population in a medically underserved area (as defined in section 330(b)(3)).

(g) Report.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in subparagraph (f) shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

(2) the system characteristics that contribute to, or detract from, the efficiency of the program (or lack thereof);

(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system.

(4) the State and local legislation necessary to implement and to maintain the system;

(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

(6) recommendations on the utilization of available funding for future regionalization efforts.

SECTION 330. GUIDELINES.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g), and—

(3) in section 1232—

(A) in subsection (a), by striking ''appropriate'' and inserting ''appropriate $24,000,000 for each of fiscal years 2010 through 2014,''; and

(B) by inserting after subsection (c) the following:

(d) Authority.—For the purpose of carrying out parts A through C, beginning on the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall transfer authority in administering grants and related authorities under such parts to the administrator of the Health Resources and Services Administration to the Assistant Secretary for Preparedness and Response.

(B) SUPPORT FOR EMERGENCY MEDICINE RESEARCH.—Part H of title IV of the Public Health Service Act (42 U.S.C. 289 et seq.) is amended by inserting after the section 489C the following:

SEC. 489D. SUPPORT FOR EMERGENCY MEDICINE RESEARCH.

(a) EMERGENCY MEDICINE RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care systems to expand and accelerate research in emergency medical care systems and emergency medicine, including—

(1) the basic science of emergency medicine;

(2) the model of service delivery and the components of such models that contribute to patient health outcomes and efficiencies of care;

(3) the translation of basic scientific research into improved practice; and

(4) the development of timely and efficient delivery of health services.

(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical systems and pediatric emergency medicine, including—

(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

(2) the role of pediatric emergency services as an integrated component of the overall health system;

(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

(4) pediatric training in professional education; and

(5) research in pediatric emergency care, specifically on the efficacy, safety, and effectiveness of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, improvements in the coordination of coordinated emergency care systems.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for the purpose of this section such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 3650. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) Trauma Care Centers.—

(1) General requirement.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsections (a)(1) if the trauma center—

(1) to assist in defraying substantial uncompensated care costs;

(2) to further the primary missions of such trauma centers, including by addressing costs associated with patient stabilization and transfer, trauma education and outreach, coordination of care, trauma systems, electronic personnel and other fixed costs, and expenses associated with employee and non-employee physician services; and

(3) to provide emergency relief to ensure the continued and future availability of trauma care.

(b) Minimum Qualifications of Trauma Centers.—

(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTIFIED PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a)(1) if the trauma center—

(1) is located in a trauma system that substantially complies with section 1213.

(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE.—If the Secretary shall award substantial uncompensated care grants under subsection (a)(1) only to trauma centers meeting at least 1 of the criteria in the following 3 paragraphs.

(A) CATEGORY A.—The criteria for category A are as follows:

(i) At least 40 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

(B) CATEGORY B.—The criteria for category B are as follows:

(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

(C) CATEGORY C.—The criteria for category C are as follows:

(i) At least 30 percent of the visits in the emergency department were charity or self-pay patients.

(ii) At least 30 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

(4) Trauma Centers in 115 Waiver States.—Notwithstanding paragraph (3), the Secretary shall award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool Net Care Waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

(d) Designation.—The Secretary shall designate as a trauma center under subsection (a)(1) an equivalent State or local agency.

(e) Additional Requirements.—The Secretary shall not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

(A) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

(B) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.

(2) Considerations in Making Grants.—

(1) Substantial uncompensated care awards.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

(2) Percentage.—The applicable percentages are as follows:

(1) With respect to a category A trauma center, 100 percent of the uncompensated care costs.

(2) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

(3) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.
“(b) Core Mission Awards.—

“(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

“(A) reserve 25 percent of the amount allocated under paragraphs (1) through (3) of section 1241 to Level III and Level IV trauma centers; and

“(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I trauma centers.

“(2) clinical priority for trauma centers which have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding capacity.

“(3) Emergency Awards.—In awarding grants under section 1241(a)(3), the Secretary shall—

“(1) give preference to any application submitted by a trauma center that provides trauma services in the geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downsize; and

“(2) reallocate any emergency awards funds not obligated due to insufficient, or a lack of qualified, applications to the significantly decreased or will significantly decrease if the center is forced to close or downsize.

“(c) Emergency Awards.—In awarding grants under section 1241(a)(3), the Secretary shall—

“(1) make available—

“(A) 50 percent of such funds for category A trauma center grantees; and

“(B) 35 percent of such funds for category B trauma center grantees; and

“(2) provide available funds within each category in a manner proportional to the 15 percent of such funds for category C trauma center grantees.

“(d) Limitation.—

“(1) IN GENERAL.—In awarding grants under section 1241(a)(3), the Secretary will be required to—

“(a) maintain the overall financial stability of trauma centers.

“(b) TRAUMA CARE REGISTRY.—The Secretary may require a trauma center receiving a grant under section 1241(a) to maintain access to trauma services at comparable levels to the prior year during the grant period.

“(c) Trauma Care Registry.—The Secretary may require the trauma center receiving a grant under section 1241(a) to provide data to a national and centralized registry of trauma cases, in accordance with guidelines developed by the American College of Surgeons, and as the Secretary may otherwise require.

“(e) General Provisions.—

“(1) Limitation on Duration of Support.—The period during which a trauma center receives payments under a grant under section 1241(a)(3) shall be for 3 fiscal years, or such shorter period as a State determines the Secretary to be necessary to carry out support activities provided under this section.

“(2) Limitation on Amount of Grant.—Notwithstanding section 1242(a), a grant under section 1241 may not be made in an amount exceeding $2,000,000 for each fiscal year.

“(3) Eligibility.—Except as provided in section 1242(b)(1)(B)(iii), acquisition of, or eligibility for, a grant under section 1241(a)(3) shall not preclude a trauma center from being eligible for other grants described in this part.

“(4) Funding Distribution.—Of the total amount appropriated for a fiscal year under section 1245, 70 percent shall be used for substantial uncompensated care awards under section 1241(a)(1), 20 percent shall be used for core mission awards under section 1241(a)(2), and 10 percent shall be used for substantial uncompensated care awards under section 1241(a)(3).

“(f) Minimum Allowance.—Notwithstanding subsection (e), if the amount appropriated for substantial uncompensated care awards under section 1241(a)(1) is less than $25,000,000, all available funding for such fiscal year shall be used for substantial uncompensated care awards under section 1241(a)(3).

“(g) Substantial Uncompensated Care Award Distribution and Proportional Share.—Notwithstanding section 1242(a), of the amount appropriated for substantial uncompensated care grants for a fiscal year, the Secretary shall—

“(1) make available—

“(A) 50 percent of such funds for category A trauma center grantees; and

“(B) 35 percent of such funds for category B trauma center grantees; and

“(2) provide available funds within each category in a manner proportional to the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downsize.

“(h) Authorization of Appropriations.—

“(1) IN GENERAL.—A State may use not more than 20 percent of the amount available to the State under this part for a fiscal year for administrative costs associated with awarding grants and related costs.

“(i) Use of Funds.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b)

“(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers.

“(2) Establishing new trauma services in underserved areas as defined by the State.

“(3) Reducing trauma center overcrowding at specific trauma centers related to outreach of trauma patients.

“(4) Establishing new trauma services in underserved areas as defined by the State.

“(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

“(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

“(7) Enhancing trauma surge capacity at specific trauma centers.

“(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

“(9) Establishing trauma center collaboration.

“(10) Limitation.—

“(1) IN GENERAL.—A State may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

“(2) Distribution of Funds.—The following shall apply with respect to grants provided in this part:

“(a) LESS THAN $10,000,000.—If the amount of appropriations for this fiscal year in a State is less than $10,000,000, the Secretary shall not award grants to States to enable such States to award grants to eligible entities for the purposes described in this section.

“(b) AWARDING GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

“(c) Eligibility.—(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

“(A) be—

“(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b); or

“(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

“(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

“(D) submit to the Secretary an application at such time, in such manner, and containing such information as the State may require.

“(2) LIMITATION.—A State shall not use all the funds available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

“(d) Use of Funds.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b)

“(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

“(2) Providing for individual safety net trauma center fiscal stability and costs related to having security in place 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

“(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

“(4) Establishing new trauma services in underserved areas as defined by the State.

“(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

“(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

“(7) Enhancing trauma surge capacity at specific trauma centers.

“(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

“(9) Establishing trauma center collaboration.

“(10) Limitation.—

“(1) IN GENERAL.—A State may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.

“(2) Distribution of Funds.—The following shall apply with respect to grants provided in this part:

“(a) LESS THAN $10,000,000.—If the amount of appropriations for this fiscal year in a State is less than $10,000,000, the Secretary shall not award grants to States to enable such States to award grants to eligible entities for the purposes described in this section.

“(b) AWARDING GRANTS BY STATES.—Each State may award grants to eligible entities within the State for the purposes described in subparagraph (d).

“(c) Eligibility.—(1) IN GENERAL.—To be eligible to receive a grant under subsection (b) an entity shall—

“(A) be—

“(i) a public or nonprofit trauma center or consortium thereof that meets that requirements of paragraphs (1), (2), and (5) of section 1241(b); or

“(ii) a safety net public or nonprofit trauma center that meets the requirements of paragraphs (1) through (5) of section 1241(b); or

“(iii) a hospital in an underserved area (as defined by the State) that seeks to establish new trauma services; and

“(D) submit to the Secretary an application at such time, in such manner, and containing such information as the State may require.

“(2) LIMITATION.—A State shall not use all the funds available to the State under this part for a fiscal year to award grants to safety net trauma centers described in paragraph (1)(A)(ii).

“(d) Use of Funds.—The recipient of a grant under subsection (b) shall carry out 1 or more of the following activities consistent with subsection (b)

“(1) Providing trauma centers with funding to support physician compensation in trauma-related physician specialties where shortages exist in the region involved, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii).

“(2) Providing for individual safety net trauma center fiscal stability and costs related to having security in place 24 hours a day, 7 days a week, with priority provided to safety net trauma centers described in subsection (c)(1)(A)(ii) located in urban, border, and rural areas.

“(3) Reducing trauma center overcrowding at specific trauma centers related to throughput of trauma patients.

“(4) Establishing new trauma services in underserved areas as defined by the State.

“(5) Enhancing collaboration between trauma centers and other hospitals and emergency medical services personnel related to trauma service availability.

“(6) Making capital improvements to enhance access and expedite trauma care, including providing helipads and associated safety infrastructure.

“(7) Enhancing trauma surge capacity at specific trauma centers.

“(8) Ensuring expedient receipt of trauma patients transported by ground or air to the appropriate trauma center.

“(9) Establishing trauma center collaboration.

“(10) Limitation.—

“(1) IN GENERAL.—A State may not provide funding to a State under this part unless the State agrees that such funds will be used to supplement and not supplant State funding otherwise available for the activities and costs described in this part.
benefits, harms and scientific evidence for
authorized representatives regarding the
preferences of the patient, caregivers or
ical care for which the clinical evidence does
term ‘preference sensitive care’ means med-
cumstances, beliefs, and preferences.

under subparagraph (A) shall be for a period
AIDS.—
''SEC. 936. PROGRAM TO FACILITATE SHARED DE-
through 2015.''.

$100,000,000 for each of fiscal years 2010
there is authorized to be appropriated
''SEC. 1282. AUTHORIZATION OF APPROPRIA-
appropriations for this part in a fiscal year is
''(1) the determination by the Secretary
(2) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

(1) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

(3) LESS THAN $30,000,000.—If the amount of
appropriations for this part in a fiscal year is
less than $30,000,000, the Secretary shall di-
vide such funding evenly among only those
States that have, or more trauma centers eligible
for funding under section 1241(b)(3).

(4) $30,000,000 OR MORE.—If the amount of
appropriations for this part in a fiscal year is
$30,000,000 or more. The Secretary shall divide
such funding evenly among all States.

SEC. 1282. AUTHORIZATION OF APPROPRIA-
"For the purpose of carrying out this part,
there is authorized to be appropriated
$100,000,000 for each of fiscal years 2010
through 2015."

SEC. 3506. PROGRAM TO FACILITATE SHARED DE-
CISMAKING.
Part D of title IX of the Public Health
Service Act, as amended by section 3503, is
further amended by adding at the end the
following:

SEC. 936. PROGRAM TO FACILITATE SHARED DE-
CISMAKING.
"(a) PURPOSE.—The purpose of this section is to
facilitate collaborative processes be-
 tween patients, caregivers or authorized re-
presentatives, and clinicians that engages the
patient, caregiver or authorized representa-
tive in helping the patient make informed
decisions about patient care, including
the selection of an appropriate treatment
option and other health care decisions.

(1) PATIENT DECISION AID.—The term ‘pa-
tient decision aid’ means an educational
tool that helps patients, caregivers or authorized
representatives understand and commu-
nicate their health status, preferences related
to their treatment options, and to decide
with their health care provider what treat-
ments are best for them based on their treat-
ment options, and facilitates the incor-
poration of patient preferences and values
into the medical plan.

(b) DEFINITIONS.—In this section:
"(1) PATIENT DECISION AID.—The term ‘pa-
tient decision aid’ means an educational
tool that helps patients, caregivers or authorized
representatives understand and commu-
nicate their health status, preferences related
to their treatment options, and to decide
with their health care provider what treat-
ments are best for them based on their treat-
ment options, and facilitates the incor-
poration of patient preferences and values
into the medical plan.

"(ii) the dissemination of best practices

"(c) E STABLISHMENT OF INDEPENDENT
STANDARD FOR SCIENTIFIC EVIDENCE
FOR PREFERENCE SENSITIVE CARE.—
"(1) CONTRACT WITH ENTITY TO ESTABLISH
STANDARDS AND CERTIFY PATIENT DECISION
AIDS.—
"(A) DEVELOP AND IDENTIFY STANDARDS FOR
PATIENT DECISION AIDS.—The entity shall syn-
thetize evidence and convene a broad range of
experts and key stakeholders to develop
and identify standards to evaluate patient decision aids for preference
sensitive care.

"(B) ENDORSE PATIENT DECISION AIDS.—The
entity shall endorse patient decision aids and
develop a certification process whether pa-
tient decision aids meet the standards devel-
oped and identified under subparagraph (A).

"(d) PROGRAM TO DEVELOP, UPDATE AND
PATIENT DECISION AIDS TO SUPPORT
HEALTH CARE PROVIDERS AND PATIENTS.—
"(1) IN GENERAL.—The Secretary, acting
through the Director, and in coordination
with heads of other relevant agencies, such as
the Director of the Centers for Disease
Control and Prevention and the Director of
the National Institutes of Health, shall es-
 tablish a program to award grants or con-
 tracts—

"(A) to develop, update, and produce pa-
tient decision aids for preference sensitive
conditions. The Secretary shall consider in edu-
cating patients, caregivers, and authorized
representatives concerning the relative safe-
tity, relative effectiveness (including possible
health consequences on functional status
and quality of life), and relative cost of treat-
ment or, where appropriate, palliative care
options;

"(B) to test such materials to ensure such
materials are balanced and evidence based in
aiding health care providers and patients,
caregivers, and authorized representatives
to make informed decisions about patient care
and can be readily incorporated into a broad
array of practice settings; and

"(C) to educate providers on the use of
such materials, including through academic
curricula.

"(2) REQUIREMENTS FOR PATIENT DECISION
AIDS.—Patient decision aids developed and
produced pursuant to a grant or contract
under paragraph (1)—

"(A) shall be designed to engage patients,
caregivers, and authorized representatives in
informing decisionmaking with health care
providers;

"(B) shall present up-to-date clinical evi-
dence about the risks and benefits of treat-
ment options in a form and manner that is
designed to be accessible and age-appropriate
for patients, caregivers, and authorized
representatives from a variety of cultural and
educational backgrounds to reflect the var-
ing needs of consumers and diverse levels of
health literacy;

"(C) shall, where appropriate, explain why
there is a lack of evidence to support one

(2) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

(b) REVIEW AND CONSULTATION.—In making
the determination under subsection (a), the
Secretary shall review all available sci-
cific evidence about the use of, and the effects
of, decisionmaking and social and cognitive
psychology and consult with drug manufactur-
ers, clini-
cians, patients and consumers, experts in
health literacy, representatives of racial and
ethnic minorities, and experts in women’s
and pediatric health.

(2) the reasoning and analysis underlying
that determination.

(3) NONDUPLICATION OF EFFORTS.—If the Secretary deter-
mines under subsection (a) that the addition of
quantitative summaries of the benefits
improving the understanding of patients of	heir medical treatment options.

(2) SHARED DECISIONMAKING RESOURCE
CENTERS.—
"(a) IN GENERAL.—The Secretary shall pro-
glide for the establishment and sup-
port of Shared Decisionmaking Resource
Ceters (referred to in this subsection as the
"Centers") to provide assistance to
providers and to develop and disseminate
best practices and other information to sup-
port and accelerate adoption, implementa-
tion, and effective use of patient care deci-
sion aids and shared decisionmaking by providers.

(b) OBJECTIVES.—The objective of a Cen-
ter is to enhance and promote the adoption
of patient decision aids and shared decision-
making through

"(i) providing assistance to eligible pro-
viders with the implementation and effective
use of, and training on, patient decision aids;

"(ii) the dissemination of best practices
and research on the implementation and ef-
fective use of patient decision aids.

(3) SHARED DECISIONMAKING PARTICIPATION
GRANTS._
"(a) IN GENERAL.—The Secretary shall pro-
glide for the establishment and sup-
port of Shared Decisionmaking Resource
Ceters (referred to in this subsection as the
"Centers") to provide assistance to
providers and to develop and disseminate
best practices and other information to sup-
port and accelerate adoption, implementa-
tion, and effective use of patient care deci-
sion aids and shared decisionmaking by providers.

(b) LIMITATION.—Funds under this para-
graph shall not be used to purchase or imple-
ment use of patient decision aids other than
those certified under the process identified in
subsection (c). (C) GUIDANCE.—The Secretary may issue
guidance to eligible grantees under this sub-
section on the use of patient decision aids.

"(d) FUNDING.—For purposes of carrying
out this section there are authorized to be
appropriated such sums as may be necessary
for fiscal year 2010 and each subsequent fis-
cal year.

SEC. 3507. PRESENTATION OF PRESCRIPTION
DRUG BENEFIT AND RISK INFORMATION.
"(a) IN GENERAL.—The Secretary of Health
and Human Services (referred to in this sec-
tion as the "Secretary"), acting through the
Commissioner of Food and Drugs, shall
determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
(such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

(1) GRANTS TO SUPPORT SHARED DECISION-
MAKING IMPLEMENTATION.—
"(1) IN GENERAL.—The Secretary shall es-
tablish a program to provide for the phased-
inclusion of informational aids, decision
aiding, and evaluation of shared decisionmaking using pa-
tient decision aids to meet the objective of

"(ii) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
(such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

(1) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
(such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

(1) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
(such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.

"(ii) the reasoning and analysis underlying
to determine whether the addition of quantitative
summaries of the benefits and risks of pre-
scription drugs in a standardized format
(such as a table or drug facts box) to the pro-
motional labeling or print advertising of
such drugs would improve health care deci-
sionmaking by clinicians and patients and
consumers.
and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care by making it easier for clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(c) Clarification.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE PROFESSIONAL AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) In General.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) Eligibility.—To be eligible to receive a grant under subsection (a), an entity or consortia may:

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

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program;

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) Matching Funds.—

(1) General.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions, determined by the Secretary, that, at a minimum, are equal to 25 percent of the amount of the grant to be awarded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) Determination of Amount Contributed.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including equipment or services, amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such contributions.

(d) Evaluation.—The Secretary shall take such action as may be necessary to evaluate the projects under this section, and publish, make publicly available, and disseminate the results of such evaluations on a wide as basis as is practicable.

(e) Duration.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representa"
“(4) consult with health professionals, non-
governmental organizations, consumer or-
izations, women’s health professionals, and
other individuals and groups, as appropriate,
on the work of the Centers with regard to
women; and
“(5) serve as a member of the Department
of Health and Human Services Coordinating
Committee on Women’s Health (established
under section 229(b)(4)).

(c) DEFINITION.—As used in this section,
the term ‘women’s health conditions’, with
respect to age, ethnic, and ra-
cial groups, means diseases, disorders, and
conditions—
“(1) acute to, significantly more serious for,
or significantly more prevalent in
women; and
“(2) for which the factors of medical risk or
types or medical interventions are different
for women, or for which there is reasonable
evidence that indicates that such factors or
conditions—
may be different for women.

(d) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this section,
there are authorized to be appropriated such
sums as may be necessary for each of the fiscal
years 2010 through 2014.

(e) OFFICE OF WOMEN’S HEALTH RE-
SEARCH.—Section 486(a) of the Public Health
Service Act (42 U.S.C. 257a(a)) is amended by
inserting ‘‘the Director’’ before the period at the end there
of.

(f) SUBSTANCE ABUSE AND MENTAL HEALTH
SERVICES ADMINISTRATION.—Section 501(f) of
the Public Health Service Act (42 U.S.C. 290aa(f)) is amended—

(1) in paragraph (1), by inserting ‘‘who shall report directly to the Administrator’’ before the period;

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

(3) by inserting after paragraph (3), the fol-
lowing:

“(4) OFFICE.—Nothing in this subsection shall be construed to preclude the Secretary from establishing within the Substance Abuse and Mental Health Administration an Office of Women’s Health.

(g) AGENCY FOR HEALTHCARE RESEARCH AND
QUALITY ACTIVITIES REGARDING WOMEN’S
HEALTH.—Part C of title IX of the Public
Health Service Act (42 U.S.C. 299c et seq.) is amended—

(1) by redesigning sections 925 and 926 as
sections 926 and 927, respectively; and

(2) by inserting after section 926 the fol-
lowing:

“SEC. 925. ACTIVITIES REGARDING WOMEN’S
HEALTH.

“(a) ESTABLISHMENT.—There is established
within the Office of the Director, an Office of
Women’s Health and Gender-Based Research
(referred to in this section as the ‘Office’).

(1) report to the Director on the current
Agency level of activity regarding women’s
health, across, where appropriate, age, bio-
logical, and sociocultural contexts, in all as-
pects of Agency work, including the develop-
ment of evidence reports and clinical prac-
tice protocols and the conduct of research
into patient outcomes; delivery of health care
services, quality of care, and access to
health care;

(2) establish short-range and long-range
goals and objectives within the Agency
that relate to health services and medical
effectiveness research, for issues of
particular concern to women;

(3) identify projects in women’s health
that should be conducted or supported by the
Agency;

(4) consult with health professionals, non-
governmental organizations, consumer or-
izations, women’s health professionals, and
other individuals and groups, as appropriate,
on Agency policy with regard to women; and

(5) serve as a member of the Department
of Health and Human Services Coordinating
Committee on Women’s Health (established
under section 229(b)(4)).

(c) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this section,
there are authorized to be appropriated such
sums as may be necessary for each of the fis-
cal years 2010 through 2014.

(f) HEALTH RESOURCES AND SERVICES
ADMINISTRATION OFFICE OF WOMEN’S
HEALTH.—Title III of the Social Security Act (42 U.S.C. 901 et seq.) is amended by adding at the end the follow:

“SEC. 913. OFFICE OF WOMEN’S HEALTH.

“(a) ESTABLISHMENT.—The Secretary shall
establish within the Office of the Adminis-
trator of the Health Resources and Services
Administration, an office to be known as the
Office of Women’s Health. The Office shall be
headed by a director who shall be appointed by the Administra-
tor.

“(b) PURPOSE.—The Director of the Office shall

“(1) report to the Administrator on the current
Agency level of activity regarding activity
regarding women’s health, across, where appro-
priate, age, biological, and sociocultural con-
texts;

“(2) establish short-range and long-range
goals and objectives within the Health Re-
sources and Services Administration for
women’s health and, as relevant and appro-
priate, coordinate with other appropriate of-
fices on activities within the Administration
that relate to building training, health
service delivery, research, and dem-
onstration projects, for issues of particular
concern to women;

“(3) identify projects in women’s health
that should be conducted or supported by
the bureaus of the Administration;

“(4) consult with health professionals, non-
governmental organizations, consumer or-
izations, women’s health professionals, and
other individuals and groups, as appropriate,
on Administration policy with regard to
women; and

“(5) serve as a member of the Department
of Health and Human Services Coordinating
Committee on Women’s Health (established
under section 229(b)(4)) of the Public Health
Service Act).

(h) NO NEW REGULATORY AUTHORITY.—
Nothing in this section and the amendments
made by this section shall be construed to
create any new regulatory authority.

(i) LIMITATION ON TERMINATION.—Notwith-
standing any other provision of law, a Fed-
eral office of women’s health (including the
Office of the Director of Research on Women’s Health of the National Institutes of Health) or Federal ap-
pointive position with primary responsi-
bility over women’s health issues (including the
Associate Administrator for Women’s Services
under the Substance Abuse and Mental Health Services Administration) that is in existence on the date of enactment of
this section shall not be terminated, reorga-
nized, or have any of it’s powers or duties
transferred unless such termination, reorga-
nization, or transfer is approved by Congress
through the adoption of a concurrent resolu-
tion of approval.

(j) RULE OF CONSTRUCTION.—Nothing in this
section (or the amendments made by this
section) shall be construed to limit the au-
thority of the Secretary of Health and
Human Services with respect to women’s
health, or with respect to activities carried
out through the Department of Health and
Human Services on the date of enactment of
this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.
Section 340A of the Public Health Service
Act (42 U.S.C. 296a) is amended—
(1) by striking subsection (d)(3) and inserting the following:

“(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.”; and

(2) in subsection (e), by adding at the end the following:

“(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main goal or intervention of the navigator involved.”; and

(3) in subsection (m),—

(A) in paragraph (1), by striking “and $3,500,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.”; and

(B) in paragraph (2), by striking “2010” and inserting “2015”.

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (and amendment made by this Act), there is authorized to be appropriated such sums as may be necessary to carry out this subtitle (and amendments made by this Act) for programs and activities authorized under this Act.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL

(a) ESTABLISHMENT.—The President shall establish within the Department of Health and Human Services, a council to be known as the “National Prevention, Health Promotion and Public Health Council” (hereafter referred to in this section as the “Council”)

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Agriculture;

(3) the Secretary of Education;

(4) the Chairman of the Federal Trade Commission;

(5) the Secretary of Transportation;

(6) the Secretary of Labor;

(7) the Secretary of Homeland Security;

(8) the Administrator of the Environmental Protection Agency;

(9) the Director of the Office of National Drug Control Policy;

(10) the Director of the Domestic Policy Council;

(11) the Assistant Secretary for Indian Affairs;

(12) the Chairman of the Corporation for National and Community Service; and

(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and the Congress for meeting the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and disease prevention strategies for the period for which the report is prepared; and

(4) provide a review of the recommendations of the Council during the period for which the report is prepared.

(5) transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal years 2010 through 2015, and ensuring that such amounts are used to implement the strategy and further describes corrective actions recommended by the Council and taken by relevant agencies and organizations to meet the priority goals of Healthy People 2010.

(6) contains a list of national priorities on health promotion and disease prevention to address lifestyle behavior modification (smoking cessation, proper nutrition, appropriate exercise, mental health, behavioral health, substance use disorder, and domestic violence screenings) and the prevention measures for the leading disease killers in the United States;

(7) contains specific plans for creating Federal health programs and Centers that exist to promote healthy behavior and reduce disease risk (including eliminating programs and offices determined to be ineffective in meeting the priority goals of Healthy People 2010);

(8) contains specific plans to ensure that all Federal health care programs are fully coordinated with science-based prevention recommendations by the Director of the Centers for Disease Control and Prevention; and

(9) contains specific plans to ensure that all non-Department of Health and Human Services prevention programs are based on the science-based guidelines developed by the Centers for Disease Control and Prevention under paragraph (4).

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND

(a) PURPOSE.—It is the purpose of this section to establish a Prevention and Public Health Fund (referred to in this section as the “Fund”), to be administered through the Department of Health and Human Services, Office of the Secretary, to provide for expanded and sustained national investment in prevention and public health programs to improve health and lower the rate of growth in private and public sector health care costs.

(b) FUNDING.—There are hereby authorized to be appropriated, and appropriated, to the Fund, out of any monies in the Treasury not otherwise appropriated—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal

November 19, 2009
year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings. Under the Community Preventive Services, the Committee on Immunization Practices, the Advisory Committee on Immunization Practices, and other appropriate agencies; and (d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to sub-section (c).

SEC. 4003. CLINICAL AND COMMUNITY PREVENTIVE SERVICES. (a) PREVENTIVE SERVICES TASK FORCE.—Section 399R of the Public Health Service Act (42 U.S.C. 299b–4) is amended by striking subsection (a) and inserting the following: 

``(a) PREVENTIVE SERVICES TASK FORCE.—''

``(1) ESTABLISHMENT AND PURPOSE.—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services, including primary care professionals, health care system designers, professional societies, employers, community organizations, non-profit organizations, other policy-makers, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such reviews shall consider: (A) the development of additional topic areas for recommended preventive services that address gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations; (B) the enhanced dissemination of recommendations related to specific populations and age groups; (C) in general—Part P of title III of the Public Health Service Act (as amended by paragraph (2), is amended by adding at the end the following: 

``SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.—''

``(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive services for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering community services, including those related to specific sub-populations and age groups; (B) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions; (C) in general—In coordination with Federal Government health objectives and related target setting for health improvement; (D) the enhanced dissemination of recommendations; (E) the provision of technical assistance to those health care professionals, agencies and organizations that request such assistance in implementing recommendations; and (F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

``(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operation of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources and assistance to those organizations requesting it for implementation of the Guide’s recommendations. (4) PROVIDING RECOMMENDATIONS.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force’s recommendations interact at the nexus of clinical and community. (5) OPERATION.—In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code. (6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such Task Force, shall include— (A) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups (which may include both general and specific populations and age groups); (B) general health promotion in interventions related to those topic areas, including those related to specific populations and age groups; (C) evidence-based scientific information for policy, program development, and evaluation.
SEC. 401. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services shall establish a program to provide grants to States to establish school-based health centers. The Secretary shall enter into agreements with States to provide grants for the establishment of school-based health centers.

(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to States to establish school-based health centers. The Secretary shall award grants to States on a competitive basis. The Secretary shall award grants to States on a competitive basis when the Secretary determines that the grants will be used for the purpose of accelerating the establishment of school-based health centers.

(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

(1) be an SBHC (as defined in subsection (d));

(2) be a sponsor of such a center that is located in a medically underserved area or a health professional shortage area by the Secretary;

(3) not be duplicative of any other Federal efforts relating to health promotion and disease prevention;

(4) be subject to an independent evaluation that is conducted by the Secretary and is carried out through the Centers for Disease Control and Prevention, the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration.

(d) SBHC.—The term ‘SBHC’ means the core services of an area, including the ability of the residents of such area to provide for health care services.

(e) D ISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of information on guidelines for nutrition, regular exercise, smoking cessation, obesity reduction, and disease prevention through disease screening programs.

(f) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and disease prevention.

(g) INTERNET PORTAL.—The Secretary shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(h) S Blog.—The Secretary shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(i) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the status and effectiveness of awareness of obesity-related services.

(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized such sums as may be necessary to carry out this section.

Subtitle B—Increasing Access to Clinical Preventive Services

Title I—Personalized Prevention Plans

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to States to establish school-based health centers.

(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

(1) be a school-based health center or a sponsoring facility of a school-based health center; and

(2) submit an application at such time, in such manner, and containing such information as the Secretary may require.

(d) IN GENERAL.—The term ‘medically underserved children and adolescents’ means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

(e) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to applicants who meet the definition of a school-based health center.

(f) REQUIREMENTS.—In awarding grants under this section, the Secretary shall take into account any comments received from the Secretary of the Department of Education.

(g) FUNDING.—Funds appropriated under this section shall remain available until expended.

(h) DEFINITIONS.—In this subsection, the term ‘school-based health center’ and ‘sponsoring facility’ have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397aa(c)(9)).

Title II—Comprehensive Primary Health Services

(a) DEFINITIONS.—In this subsection—

(1) COMPREHENSIVE PRIMARY HEALTH SERVICES.—The term ‘comprehensive primary health services’ means the core services offered by school-based health centers, which shall include the following:

(A) Physiological.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

(B) Mental Health.—Mental health and substance use disorder assessments, crisis intervention, counseling, treatment, and referral to a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs.

(C) Medically Underserved Children and Adolescents.—The term ‘medically underserved children and adolescents’ means a population of children and adolescents who are residents of an area designated as a medically underserved area or a health professional shortage area by the Secretary.

(D) Physical.—Comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions, and referrals to, and follow-up for, specialty care and oral health services.

(b) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants to States for school-based health centers.

(c) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to applicants who meet the definition of a school-based health center.

(d) REQUIREMENTS.—In awarding grants under this section, the Secretary shall take into account any comments received from the Secretary of the Department of Education.

(e) FUNDING.—Funds appropriated under this section shall remain available until expended.

(f) DEFINITIONS.—In this subsection, the terms ‘school-based health center’ and ‘sponsoring facility’ have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397aa(c)(9)).

Title III—Providers

(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized such sums as may be necessary to carry out this section.

(b) REQUIREMENTS.—In awarding grants under this section, the Secretary shall give preference to applicants who meet the definition of a school-based health center.

(c) FUNDING.—Funds appropriated under this section shall remain available until expended.

(d) DEFINITIONS.—In this subsection, the terms ‘school-based health center’ and ‘sponsoring facility’ have the meanings given those terms in section 2110(c)(9) of the Social Security Act (42 U.S.C. 1397aa(c)(9)).
“(B) evidence of local need for the services to be provided by the SBHC; 
“(c) an assurance that— 
“(1) SBHC services will be provided to those health care providers for whom parental or guardian consent has been obtained in cooperation with Federal, State, and local laws governing health care service provision to children; and 
“(ii) the SBHC has made and will continue to make every reasonable effort to establish and maintain collaborative relationships with other health care providers in the catchment area of the SBHC; 
“(iii) the SBHC will provide on-site access during the academic day when school is in session and make arrangements for outreach to children who may not be present at a SBHC and receive additional funding under this section. 
“(D) LIMITATIONS.—Any provider of services that is determined by a State to be in violation of a State law described in subsection (a)(3) shall not be eligible for an SBHC under this section. 

“(1) GRANTS.—The Secretary may award grants which may be used to pay the costs associated with expanding and modernizing existing buildings for use as an SBHC, including the purchase of trailers or manufactured buildings to install on the school property. 
“(2) NO OVERLAPPING GRANT.—No entity that has received funding under section 430 for a grant period shall be eligible for a grant under this section for with respect to the same grant period. 
“(g) Matching Requirement.—(1) In General.—Each eligible entity that receives a grant under this section shall provide, from non-Federal sources, an amount equal to 20 percent of the amount of the grant which is provided in carrying out any in-kind to carry out the activities supported by the grant. 
“(2) Waiver.—The Secretary may waive all or part of the matching requirement described in paragraph (1) for any fiscal year for the SBHC if the Secretary determines that applying the matching requirement to the SBHC would result in serious hardship or an inability to carry out the purposes of this section. 
“(h) Supplement, Not Supplant.—Grant funds provided under this section shall be used to supplement, not supplant, other Federal or State funds. 
“(i) Evaluation.—The Secretary shall develop and implement a plan for evaluating SBHCs and monitoring quality performance under the awards made under this section. 
“(j) Age Appropriate Services.—An eligible entity receiving funds under this section shall only provide age appropriate services through a SBHC funded under this section to an individual. 
“(k) Parental Consent.—(1) An eligible entity receiving funds under this section shall not provide services through a SBHC funded under this section to an individual without the consent of the parent or guardian of such individual if the individual is considered a minor under applicable State law. 
“(2) Authorization of Appropriations.—For purposes of carrying out this section, there are appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.”. 

SEC. 4102. ORAL HEALTHCARE PREVENTION ACTIVITIES. 

“(a) in General.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end the following: 

“PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES. 

“(1) Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 3025, is amended by adding at the end the following: 

“PART T—ORAL HEALTHCARE PREVENTION ACTIVITIES. 

“(a) Establishment.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in consultation with other Federal health, education, and welfare agencies, shall— 

“(1) that is focused on oral healthcare prevention and education, including prevention of oral disease such as early childhood and other periodontal disease; 
“(2) REQUIREMENTS.—In establishing the campaign, the Secretary shall— 

“(1) ensure that activities are targeted towards specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations, including Indians, Alaska Natives and Native Hawaiians (as defined in section 4(c) of the Indian Health Care Improvement Act) in a culturally and linguistically appropriate manner; 
“(2) utilize science-based strategies to convey oral health prevention messages that include, but are not limited to, community water fluoridation and dental sealants. 

“(c) PLANNING AND IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall conduct planning activities with respect to the campaign. 

“SEC. 399LL-1. RESEARCH-BASED DENTAL CARES DISEASE MANAGEMENT. 

“(a) in General.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall award demonstration grants to eligible entities to demonstrate the effectiveness of research-based dental caries disease management activities. 

“(b) Eligibility.—To be eligible for a grant under this section, an entity— 

“(1) be a community-based provider of dental services (as defined by the Secretary), including a Federally-qualified health center, a health center operated by a State or by an instrumentality or a unit of government within a State), a State or local department of health, a dental program of the Indian Health Service, a Tribal or urban Indian organization, an urban Indian organization (as such terms are defined in section 4 of the Indian Health Care Improvement Act). 

“(c) Use of Funds.—A grantee shall use amounts received under a grant under this section to demonstrate the effectiveness of research-based dental caries disease management activities. 

“(d) Use of Information.—The Secretary shall utilize information generated from grantees under this section in planning and implementing the public education campaign under section 310L. 

“SEC. 399LL-2. AUTHORIZATION OF APPROPRIATIONS. 

“There are authorized to be appropriated to carry out this part such sums as may be necessary. 

“(b) SCHOOL-BASED SEALANT PROGRAMS.—SEC. 3025(b)(1) of the Public Health Service Act (42 U.S.C. 247b-14(c)(1)) is amended by striking "may award grants to States and Indian tribes" and inserting "shall award a grant to each of the 50 States and territories and to Indians, Indian tribes, tribal organizations and urban Indian organizations (as such terms are defined in section 4 of the Indian Health Care Improvement Act). 

“(c) ORAL HEALTH INFRASTRUCTURE.—SEC. 317M of the Public Health Service Act (42 U.S.C. 247f-14) is amended— 

“(1) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and 
“(2) by inserting after subsection (c), the following: 

“(1) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Director of the
SEC. 4109. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended by inserting at the end the following:

''(EE) An annual wellness visit (as defined in subsection (h)(1)) that—

(i) begins under part B and shall be eligible for services covered under this part;''.

(b) in subparagraph (EE), by adding “, or” at the end; and

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

''(FF) personalization of prevention plan services (as defined in subsection (h)(2));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking “subsection (w)(1)” and inserting “ subsections (w)(1) and (h)(h).”

SEC. 4103. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as “the Secretary”) shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as “PRAMS”) as it relates to oral healthcare.

(b) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(1) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) measurements developed by the Secretary from 16 States to all 50 States, territory, and Indian tribes or tribal organizations (as those terms are defined in this Act).

(2) FUNDING.—There is authorized to be appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.

(c) UPDATING NATIONAL ORAL HEALTH SURVEILLANCE SYSTEM.

(1) IN GENERAL.—The Secretary shall ensure that the Medical Expenditures Panel Survey by the Agency for Healthcare Research and Quality includes the verification of oral utilization, expenditure, and coverage findings through conduct of a look-back analysis.

(2) NATIONAL ORAL HEATH SURVEILLANCE SYSTEM.

(A) IN GENERAL.—The Secretary shall ensure that the National Oral Health Surveillance System from 16 States to all 50 States, territories, and District of Columbia.

(B) IN GENERAL.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

(C) IN GENERAL.—The Secretary shall ensure that the National Oral Health Surveillance System include the measurement of early childhood caries.

SEC. 4109. MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended by inserting at the end the following:

''(DD) a measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

(2) DETECTION OF ANY COGNITIVE IMPAIRMENT.

''(BB) (EE) establish a model of care under paragraph (4)(A) of the individual’s health status, screening history, and age-appropriate preventive services covered under paragraph (1)(A).

(3) DETECTION OF ANY COGNITIVE IMPAIRMENT.

''(DD) The furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management through lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, and nutrition.

(4) ANY OTHER ELEMENT DETERMINED APPROPRIATE BY THE SECRETARY.

''(EE) Any other element determined appropriate by the Secretary.

(b) in subparagraph (DB), by striking “and” at the end; and

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

''(EE) a measurement of height, weight, body mass index (or waist circumference, if appropriate), blood pressure, and other routine measurements.

(2) DETECTION OF ANY COGNITIVE IMPAIRMENT.

''(FF) The furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs aimed at reducing identified risk factors and improving self-management through lifestyle interventions to reduce health risks and promote self-management and wellness, including weight loss, physical activity, smoking cessation, and nutrition.

(3) ANY OTHER ELEMENT DETERMINED APPROPRIATE BY THE SECRETARY.

''(GG) Any other element determined appropriate by the Secretary.

(3) A health professional described in this paragraph is—

(A) a physician;

(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

(C) a nonprofessional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

(4) (A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of this subsection, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

(i) identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs of the individual; and

(ii) may be furnished—

(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (B); or

(II) during an encounter with a health care professional.

(4) (B) Community-based prevention programs; or

(4) BY ANY OTHER MEANS THE SECRETARY DETERMINES APPROPRIATE TO MAXIMIZE ACCESSIBILITY AND EASE OF USE BY BENEFICIARIES, WHILE ENSURING THE PRIVACY OF SUCH BENEFICIARIES.

(5) Not later than 1 year after the date of enactment of this subsection, the Secretary shall develop and make available to beneficiaries and providers under the Medicare Advantage Program a model for an individual—

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is interoperable with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the development of evidence-based models of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(6) (A) A beneficiary shall only be eligible to receive an initial preventive physical examination (as defined in subsection (w)(1)) at any time during each period of 12 months after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection that the beneficiary has not received such services within the preceding 12-month period.
“(i) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services or counseling process on a periodic basis (as defined in section 1861(hhh)(1)), furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X), as amended—

(1) (A) any clinical preventive services that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, and are appropriate, the Secretary may—

(II) in clause (ii), by striking ‘‘80 percent’’ and inserting ‘‘100 percent’’; and

(III) in clause (ii), by inserting before the semicolon the following: ‘‘(K), or (P)’’.

(c) CONFORMING AMENDMENTS.—Section 1861(hhh)(3) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 4106(c)(1), is amended—

(2) in paragraph (7), by striking ‘‘or (K)’’;

(b) CONSTRUCTION.—Nothing in the amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 4105. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1839 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

“(3) in paragraph (1), by striking ‘‘items and services described in section 1861(a)(10)(A)’’ and inserting ‘‘preventive services described in subparagraph (A) of section 1861(d)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual’’; and

(2) by adding at the end the following new sentence: ‘‘Paragraph (1) of the first sentence on line 1 of section 1839 shall apply to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.”’.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4106. IMPROVING ACCESS TO PREVENTIVE SERVICES AND COLORECTAL CANCER SCREENING TESTS.—Section 1833(b)(2) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 4106(c)(4), is amended—

(1) in paragraph (1), by striking ‘‘items and services described in section 1861(a)(10)(A)’’ and inserting ‘‘preventive services described in subparagraph (A) of section 1861(d)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual’’; and

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

“(b) CONSTRUCTION.—Nothing in the amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 4107. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1865(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)) is amended to read as follows:

“(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;
"(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary through a contract, grant, or cooperative agreement with the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(b) increased FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(B)(A) and 2003(c)(1), is amended in the first sentence—

(1) by striking "", and "")"; and

(2) by inserting before the period the following: "", and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(15), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)), and for items and services described in subparagraph (A) of such subsection, shall be increased by 5 percentage points; and

(c) removal of cost-sharing for counseling and pharmaceutical care for cessation of tobacco use by pregnant women.—

(1) general cost-sharing limitations.—Section 1916(h)(1)(A) of the Social Security Act (42 U.S.C. 1396n–1(b)(3)(B)(iii)) is amended by—

(A) inserting before the period at the end the following: ""; and

(2) in the case of a diabetic, improving the management of that condition.

(Sec. 407. Coverage of comprehensive Tobacco cessation services for pregnant women in Medicaid.)

(a) requiring coverage of Counseling and pharmaceutical care for cessation of tobacco use by pregnant women.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2003(c)(1), is further amended—

(1) in subsection (a)(4)—

(A) by striking "and" before "(C)"; and

(B) by inserting before the semicolon at the end the following new subparagraph: "and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))"; and

(2) by adding at the end the following:

"(bb) Such term shall not include coverage for drugs or pharmaceuticals recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;

(b) increased FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(B)(A) and 2003(c)(1), is amended in the first sentence—

(1) by striking "", and "")"; and

(2) by inserting before the period the following: "", and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(15), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)), and for items and services described in subparagraph (A) of such subsection, shall be increased by 5 percentage points; and

(c) removal of cost-sharing for counseling and pharmaceutical care for cessation of tobacco use by pregnant women.—

(1) general cost-sharing limitations.—Section 1916(h)(1)(A) of the Social Security Act (42 U.S.C. 1396n–1(b)(3)(B)(iii)) is amended by—

(A) inserting before the period at the end the following: ""; and

(b) increased FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 2001(a)(3)(B) and 2003(c)(1), is further amended—

(1) in subsection (a)(4)—

(A) by striking "and" before "(C)"; and

(B) by inserting before the semicolon at the end the following new subparagraph: "and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))"; and

(2) by adding at the end the following:

"(bb) Such term shall not include coverage for drugs or pharmaceuticals recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level;
[The text of the Social Security Act (42 U.S.C. 1396 et seq.) is not fully visible in the image.]
provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) GRANTEE ELIGIBILITY—A grantee shall be eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health department; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) identify the target population.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLIC COORDINATION—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—

Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.—

Screening activities conducted under this subsection may include—

(i) mental health/behavioral health and substance use disorders;

(ii) physical activity, smoking, and nutrition;

(iii) any other measures deemed appropriate by the Secretary.

(D) MONITORING.—Grantees under this section shall develop and maintain a system of screening results under this subparagraph to establish the baseline data for monitoring the targeted population.

(E) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—

(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in subparagraph (D) are referred for follow-up services to reduce such risk.

(ii) MECHANISM—

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help Medicare beneficiaries (particularly beneficiaries who have attained 65 years of age) reduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—The evaluation of the programs authorized under subparagraph (A) shall consist of the following:

(ii) EVIDENCE REVIEW—The Secretary shall review available evidence, literature, best practices, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population. The Secretary may determine the scope of the evidence review and such issues to be considered, which shall include, at a minimum—

(I) physical activity, nutrition, and obesity;

(II) falls;

(III) chronic disease self-management; and

(IV) mental health.

(C) GRANTEE EVALUATION.—An eligible entity may use amounts provided under a grant under this subsection to conduct activities to measure changes in the prevalence of chronic disease risk factors among participants.

(D) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of programs under this subsection. In determining such effectiveness, the Secretary shall consider changes in the prevalence of uncontrolled chronic disease risk factors among new Medicare enrollees (or individuals nearing enrollment, including those who are 63 and 64 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(E) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(4) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES—

(A) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries.

(B) EVALUATION PLAN.—The Secretary shall develop a plan for community-based prevention and wellness programs under paragraph (4)(A) that includes—

(1) METHODS.—The plan shall include—

(i) a description of the evaluation process;

(ii) an assessment of the effectiveness of the programs in reducing chronic disease risk factors;

(iii) a description of the strategies used to achieve the goals of the program; and

(iv) a description of the process for measuring outcomes.

(2) EVALUATION REPORT.—The Secretary shall submit to Congress a report that includes—

(i) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries;

(ii) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(iii) the results of the evaluation under paragraph (2)(B)(ii).

(5) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395l) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395s), in such proportion as the Secretary determines appropriate, of $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(6) ADMINISTRATION.—Chapter 33 of title 42, United States Code shall not apply to this subsection.

(7) MEDICARE BENEFACTORY.—In this subsection, the term “Medicare Benefactory” means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title.

SEC. 4203. REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

“SEC. 510. ESTABLISHMENT OF STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT.”

“(a) STANDARDS.—Not later than 24 months after the date of enactment of the Affordable Health Choices Act and the Transportation Barriers Compliance Board shall, in consultation with the Commissioner of the Food and Drug Administration, promulgate regulatory standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.) setting forth the minimum requirements for medical diagnostic equipment used in (or in conjunction with) a physician’s office, clinics, emergency
rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

(b) Medical Diagnostic Equipment Covered. Notwithstanding section (a) for medical diagnostic equipment shall apply to equipment that includes examination tables, examination chairs (including chairs with armrests, to be used for examinations or procedures, and facial examination chairs), weight scales, mammography equipment, x-ray machines, and other radiological equipment, used for diagnostic purposes by health professionals.

(c) Review and Amendment. — The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (5 U.S.C. 551 et seq.).

SEC. 2402. IMMUNIZATIONS.

(a) State Authority to Purchase Recommended Vaccines for Adults. — Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

"(f) IMMUNIZATION COVERAGE.—Section 317(j) of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

"(1) State Authority to Purchase Vaccines for Adults. —

"(I) In General. — The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

"(II) Participation. — A State may obtain adult vaccines for such adults (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers of vaccines approved by the Secretary, after negotiations with such manufacturers and the Secretary, and the States shall pay for all vaccines purchased under this subsection.

"(II) Reporting. — Not later than 3 years after the date on which a State receives a grant under this subsection, the State shall submit to the Secretary an evaluation of the effectiveness of the demonstration program established under this subsection together with recommendations on whether to continue and expand the program.

"(7) Authorization of Appropriations. — There is authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014."

(b) Demonstration Program to Improve Immunization Coverage. — Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by subsection (a), is further amended by adding at the end the following:

"(m) Demonstration Program to Improve Immunization Coverage.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

"(1) State Plan. — A State plan that describes the interventions such manner, and containing such information as the Secretary may require, including a State plan for evidence-based, population-based interventions for the provision of vaccines for adults as provided for under subsection (e).

"(2) Grant Assistance. — A State may obtain vaccinations for adults through the purchase of vaccines from manufacturers of vaccines approved by the Secretary, after negotiations with such manufacturers and the Secretary, and the States shall pay for all vaccines purchased under this subsection.

"(3) Funding. — Out of any funds in the Treasury not otherwise appropriated, there are appropriated $1,000,000 for fiscal year 2010 to carry out this subsection.

SEC. 2405. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) Technical Amendments. — Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

(1) in subsection (i), by inserting at the beginning "except as provided in clause (H)(III)"; and

(2) in subsection (j), by inserting at the beginning "except as provided in clause (H)(III)".

(b) Labeling Requirements. — Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

"(H) RESTAURANTS, RETAIL FOOD ESTABLISHMENTS, AND VENDING MACHINES. —

"(1) GENERAL REQUIREMENTS FOR RESTAURANTS AND SIMILAR RETAIL FOOD ESTABLISHMENTS. — Except for food described in subsection (ii), in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu item, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii). Servings of a total daily diet, the significance of the nutrient disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

"(bb) a succinct statement concerning suggestions for the daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu;

"(ii) INFORMATION REQUIRED TO BE DISCLOSED BY RESTAURANTS AND RETAIL FOOD ESTABLISHMENTS. — Except for food described in subsection (ii), the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, on the menu listing the item for sale, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

"(bb) a succinct statement concerning suggestions for the daily caloric intake, as specified by the Secretary by regulation and posted prominently on the menu board, designed to...
enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board;

(II) W RITTEN FORM.—A written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (1); and

(IV) ON THE MENU OR MENU BOARD, A PROMINENT, CLEAR, AND CONSPICUOUS STATEMENT REGARDING THE AVAILABILITY OF THE INFORMATION DESCRIBED IN ITEM (III).

(iii) S ELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vi), in the case of a self-service food or beverage establishment, clear, and conspicuous statement regarding the availability of the information described in item (III).

(II) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

(x) REGULATIONS.—

(1) IN GENERAL.—Subclauses (i) through (iv) of this clause, the Secretary shall promulgate regulations to carry out this clause.

(II) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and to the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary’s progress toward promulgating final regulations under this subparagraph.

(vii) NONAPPLICABILITY TO CERTAIN FOOD.—

(1) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

(aa) items that are not listed on a menu or menu board (such as condiments and other items that are placed on the table or counter for general use);

(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

(cc) such other food that is part of a customary menu test appearing on the menu for less than 90 days under terms and conditions established by the Secretary.

(2) WRITTEN FORM.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii), (iii), and (v).

(viii) VENDING MACHINES.—

(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

(aa) is a prospect for purchase or to examine the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines,

the vending machine operator shall provide a sign or label on each article of food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

(ii) VOLUNTARY PROVISION OF NUTRITION INFORMATION.—

(1) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to comply with any element or elements of such clause, by registering biannually the name and address of such restaurant or similar retail food establishment or vending machine operator, as specified by the Secretary by regulation.

(II) REGISTRATION.—Within 120 days of enactment of this clause, the Secretary shall publish in the Federal Register specifying the terms and conditions for implementation of item (I), pending promulgation of regulations.

(iii) RULE OF CONSTRUCTION.—Nothing in this subclause shall be construed to authorize the Secretary to require an application, review, or licensing process for any entity to register with the Secretary, as described in such item.

(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including fact sheets, cookbooks, laboratory analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation), as a related guidance of the Food and Drug Administration.

(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children’s combination meals, through means determined by the Secretary, including ranges, averages, or other methods.

(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (ii);(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosing such nutrient.

(vii) NUTRITIONAL QUALITY OF FOOD.—

(1) IN GENERAL.—Subclauses (i) through (vi) shall apply to any State or local requirement that—

(a) applies to any regulations promulgated under title 40, section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(1) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

(5) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

(1) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

(2) AGREEMENT.—The Secretary shall enter into an agreement with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

(3) WELLNESS PLANS.—

(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subsection may include one or more of the following as appropriate to the individual’s identified risk factors:

(i) Nutritional counseling.

(ii) A physical activity plan.

(iii) Tobacco and smoking cessation counseling and services.

(iv) Stress management.

(v) Dietary supplements that have health claims approved by the Secretary.

(4) REPORTING.—

(II) Compliance assistance provided by a community health center employee.

(B) RISK FACTORS.—Wellness plan risk factors shall include—

(i) Weight;

(ii) Tobacco and alcohol use;

(iii) Exercise rates;

(iv) Blood pressure;

(v) Blood cholesterol levels; and

(vi) Blood pressure.

(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual’s risk factors and a control group of individuals with respect to the risk factors described in subparagraph (B).

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

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

(1) AN EMPLOYER SHALL PROVIDE—

(A) a reasonable break time for an employee to express breast milk for nursing child for 1 year after the child’s birth each time such employee has need to express the milk; and

(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

(2) an employer shall not be required to compensate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

(3) an employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship.
by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer’s business.

(4) Nothing in this subsection shall preempt a State law that provides greater protections to employees than the protections provided for under this subsection.

Subtitle D—Support for Prevention and Health Innovation

SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) In General.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Director of the Centers for Disease Control and Prevention, shall provide funding for research in the area of public health services and systems.

(b) Requirements of Research.—Research supported under this section shall include—

(1) examining evidence-based practices relating to prevention, with a particular focus on high priority areas as identified by the Secretary in the National Prevention Strategy of February 20, 2010, and incorporating community-based public health interventions in terms of effectiveness and cost;

(2) analyzing the translation of interventions from academic settings to real world settings; and

(3) developing effective strategies for organizing, financing, or delivering public health services in real world community settings, including comparing State and local health department structures and systems in terms of effectiveness and cost.

(c) Existing Partnerships.—Research supported under this section shall be coordinated with the Prevention Services Task Force and carried out by building on existing partnerships within the Federal Government while also considering initiatives at the State and local levels and in the private sector.

(d) Annual Report.—The Secretary shall, on an annual basis, submit to Congress a report concerning the activities and findings with respect to research supported under this section.

TITILE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) Uniform Categories and Collection Requirements.—The Public Health Service Act (42 U.S.C. 295 et seq.) is amended by adding at the end the following:

TITILE XXXI—DATA COLLECTION, ANALYSIS, AND QUALITY

SEC. 3101. DATA COLLECTION, ANALYSIS, AND QUALITY.

(a) DATA COLLECTION.—

(1) In General.—The Secretary shall ensure that, by not later than 2 years after the date of enactment of this title, any federally conducted or supported health care or public health program, activity or survey (including Current Population Surveys and American Community Surveys conducted by the Bureau of Labor Statistics and the Bureau of the Census) collects and reports, to the extent practicable—

(A) data on race, ethnicity, sex, primary language, and disability status for applicants, recipients, or participants;

(B) data at the smallest geographic level such as State, local, or institutional levels if such data is collected; and

(C) sufficient data to generate statistically reliable estimates by racial, ethnic, sex, primary language, and disability status subgroups for applicants, recipients, or participants using, if needed, statistical over-samples of these subpopulations; and

(D) any other demographic data as deemed appropriate by the Secretary regarding health disparities.

(2) Collection Standards.—In collecting data described in paragraph (1), the Secretary or designee shall—

(A) use Office of Management and Budget standards, at a minimum, for race and ethnicity measurements;

(B) develop standards for the measurement of sex, primary language, and disability status;

(C) develop standards for the collection of data described in paragraph (1) that, at a minimum—

(i) collects self-reported data by the applicant, recipient, or participant; and

(ii) collects data from a parent or legal guardian if the applicant, recipient, or participant is a minor or legally incapacitated;

(D) survey health care providers and establish other procedures in order to assess access to care and treatment for individuals with disabilities and to identify—

(i) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

(ii) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities, including medical diagnostic equipment that meets the ADA standards and criteria set forth in section 510 of the Rehabilitation Act of 1973;

(iii) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities; and

(E) require that any reporting requirement imposed for purposes of measuring quality under any ongoing or federally conducted or supported health care or public health program, activity, or survey includes requirements for the collection of data on individuals receiving health care items or services under such programs activities by race, ethnicity, sex, primary language, and disability status.

(3) Data Management.—In collecting data described in paragraph (1), the Secretary, acting through the National Coordinator for Health Information Technology shall—

(A) develop national standards for the management of data collected; and

(B) develop national standards and security systems for data management.

(b) Data Analysis.—

(1) In General.—For each federally conducted or supported health care or public health program, activity, or survey included in the requirements for the collection of data on individuals receiving health care items or services under such programs activities, the Secretary shall make the analyses described in (b) available to—

(A) the Office of Minority Health;

(B) the National Center on Minority Health and Health Disparities;

(C) the Agency for Healthcare Research and Quality;

(D) the Centers for Disease Control and Prevention;

(E) the Centers for Medicare and Medicaid Services;

(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

(G) the Office of Rural Health;

(H) other agencies within the Department of Health and Human Services; and

(I) other entities as determined appropriate by the Secretary.

(2) Transparency and Data.—The Secretary shall report data and analyses described in (a) and (b) through—

(A) public postings on the Internet websites of the Department of Health and Human Services; and

(B) any other reporting or dissemination mechanisms determined appropriate by the Secretary.

(3) Availability of Data.—The Secretary may make data described in (a) and (b) available for additional research, dissemination to other Federal agencies, non-governmental entities, and the public, in accordance with any Federal agency’s data use agreements.

(4) Limitations on Use of Data.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would adversely affect any individual.

(5) Protection and Sharing of Data.—Privacy and Data Safeguards.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that—

(A) all data collected pursuant to subsection (a) is protected;

(B) all appropriate information security safeguards are used in the collection, analysis, and sharing of data collected pursuant to subsection (a);

(C) DATA SHARING.—The Secretary shall establish procedures for sharing data collected pursuant to subsection (a), measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including the agencies, centers, and entities within the Department of Health and Human Services specified in subsection (d); and

(D) DATA ON RURAL UNDERSERVED POPULATIONS.—The Secretary shall ensure that any data collected pursuant to this section regarding racial and ethnic minority groups are also collected regarding underserved rural and frontier populations.

(6) Authorization of Appropriations.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

(7) Requirement for Implementation.—Notwithstanding any other provision of this section, data may not be collected under this section unless funds are directly appropriated for such purpose in an appropriations Act.

(8) Consultation.—The Secretary shall consult with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretaries specified in subsection (a), the Director of the Bureau of the Census, the Commissioner of Social Security, and the heads of other appropriate Federal agencies in carrying out this section.

(b) Addressing Health Care Disparities in Medicaid and CHIP.—

(1) Standard Collection Requirements Included in State Plans.—

(A) Medicaid.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 2001(d), is amended—

(i) in paragraph (4), by striking “and” at the end;

(ii) in paragraph (7), by striking the period at the end and inserting “and”;

(iii) by inserting after paragraph (7) the following new paragraph:

(8) Data Collection, Analysis, and Quality;

(B) the National Center on Minority Health and Health Disparities;

(C) the Agency for Healthcare Research and Quality;

(D) the Centers for Disease Control and Prevention;

(E) the Centers for Medicare and Medicaid Services;

(F) the Indian Health Service and epidemiology centers funded under the Indian Health Care Improvement Act;

(G) the Office of Rural Health;

(H) other agencies within the Department of Health and Human Services; and

(I) other entities as determined appropriate by the Secretary.
‘‘(7) provide employers (including small, medium-sized, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers’ employer-based wellness programs, including—

‘‘(A) measuring the participation and methods to increase participation of employees in such programs;

‘‘(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees’ health behaviors, health outcomes, and health care expenditures; and

‘‘(C) evaluating such programs as they relate to changes in the health status of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

‘‘(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.

‘‘SEC. 399MM–2. PRIORITIZATION OF EVALUATION PROGRAM.

‘‘(a) IN GENERAL.—In order to assess, analyze, and monitor over time data about workplace policies and programs, and to develop instruments to assess and evaluate comprehensive workplace chronic disease prevention and health promotion programs, policies and practices, all data funds awarded for the 2 years after the enactment of this part, and at regular intervals (to be determined by the Director) thereafter, the Director shall conduct a national survey and subsurveys to survey employer-based health policies and programs.

‘‘(b) REPORT.—Upon the completion of each study under subsection (a), the Director shall submit to Congress a report that includes the recommendations of the Director for the implementation of effective employer-based health policies and programs.

‘‘SEC. 399MM–3. PROHIBITION OF FEDERAL Workplace WELLNESS REQUIREMENTS.

‘‘Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.

SEC. 4304. EPIDEMIOLOGY-LABORATORY CAPACIT Y GRANTS.

‘‘(a) IN GENERAL.—Subject to the availability of appropriations, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and administer the Epidemiology-Laboratory Capacity Grant Program to award grants to State health departments as well as local health departments and tribal jurisdictions that meet such criteria as the Director determines appropriate. Academic centers that assist State and eligible local and tribal health departments to be eligible for funding under this section as the Director determines appropriate. Grants shall be awarded under this section to assist public health agencies in conducting surveillance for, and response to, infectious diseases and other conditions of public health importance by—

‘‘(1) strengthening epidemiologic capacity to identify and monitor the occurrence of infectious diseases and other conditions of public health importance;

‘‘(2) developing and implementing preventive and control strategies,

‘‘(3) improving information systems including developing and maintaining an information exchange using national guidelines and complying with capacities and functions determined by an advisory council established and appointed by the Director; and

‘‘(4) developing and implementing prevention and control strategies.

‘‘(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $100,000,000 for each of fiscal years 2010 through 2013, of which—

‘‘(1) not less than $37,000,000 shall be made available each such fiscal year for activities under paragraphs (1) and (4) of subsection (a);

‘‘(2) not less than $60,000,000 shall be made available each such fiscal year for activities under subsection (a)(3); and

‘‘(3) not less than $32,000,000 shall be made available each such fiscal year for activities under subsection (a)(2).

SEC. 4305. ADVANCED RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.

‘‘(1) CONVENING.—Not later than 1 year after funds are appropriated under this subsection, the Secretary of Health and Human Services shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain (in this subsection referred to as ‘‘the Conference’’).

‘‘(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care.

(D) establish an agenda for action in both the public and private sectors that will reduce or eliminate barriers to improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine of the National Academies does not enter into an agreement under paragraph (1), the Secretary of Health and Human Services may
enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this subsection, the Director is authorized to appropriate such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Section 403A of title IV of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

SEC. 403JA. PAIN RESEARCH.

(a) RESEARCH INITIATIVES.—
(1) IN GENERAL.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

(2) ANNUAL RECOMMENDATIONS.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that could be undertaken, including the possibility of placing the NIH 402A(a)(1) for the Common Fund or otherwise available for such initiatives.

(3) IN THIS SUBSECTION, THE TERM ‘PAIN CONSORTIUM’ MEANS THE PAIN CONSORTIUM OF THE NATIONAL INSTITUTES OF HEALTH OR A SIMILAR TRANS-NATIONAL INSTITUTES OF HEALTH COORDINATING ENTITY DESIGNATED BY THE SECRETARY FOR PURPOSES OF THIS SUBSECTION.

(b) INTRAAGENCY PAIN RESEARCH COORDINATING COMMITTEE.—
(1) ESTABLISHMENT.—The Secretary shall establish not later than 1 year after the date of the enactment of this section a committee, to be known as the Intragency Pain Research Coordinating Committee (in this section referred to as the ‘Committee’), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

(2) MEMBERSHIP.—
(A) IN GENERAL.—The Committee shall be composed of voting and nonvoting members.

(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

(ii) 12 additional voting members appointed under subparagraph (B).

(B) ADDITIONAL MEMBERS.—The Committee shall be composed of voting and nonvoting members appointed by the Secretary in accordance with the following:

(i) 6 non-Federal members shall be appointed from among scientists, physicians, and other health professionals.

(ii) 6 members shall be appointed from members of the general public, who are representatives of leading research, advocacy, and patient organizations for individuals with pain-related conditions.

(C) NONVOTING MEMBERS.—The Committee shall include such nonvoting members as the Secretary deems appropriate.

(D) CHAIRPERSON.—The voting members of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH.

(E) MEETINGS.—The Committee shall meet at the call of the chairperson of the Committee or the request of the Director of the Pain Consortium, but in no case less often than once each year.

(F) DUTIES.—The Committee shall—
(1) develop a summary of advances in pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

(2) identify critical gaps in basic and clinical research on the causes and potential treatments for pain;

(3) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication and unnecessary duplication of effort;

(4) make recommendations on how best to disseminate information on pain care; and

(5) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

(6) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.

(c) PAIN CARE EDUCATION AND TRAINING.—
Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.

(A) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities to expand collaborative, cross-cutting research on the causes and potential treatments for pain care.

(B) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on:

(1) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

(2) applicable laws, regulations, rules, and policies on controlled substances, including the development and implementation of programs to provide education and training to health care professionals in pain care;

(3) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

(4) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

(5) recent research developments, and improvements in the provision of pain care.

(3) EVALUATION OF PROGRAMS.—The Secretary shall—
(A) immediately after the date of enactment of this section, enter into an agreement with an entity designated by the Secretary for the purpose of carrying out evaluation, with such entity carrying out such evaluation in accordance with applicable laws, regulations, rules, and policies, and the enforcement thereof, may create barriers to patient access to appropriate and effective pain care;

(B) interdisciplinary approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

(C) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations;

(D) recent research developments, and improvements in the provision of pain care.

(4) REVIEW.—The Secretary shall review the effectiveness of programs implemented under subsection (a) in order to determine the effect of such programs on knowledge and practice of pain care.

(d) PAIN CARE DEFINED.—For purposes of this section the term ‘pain care’ means the assessment, diagnosis, treatment, or management of pain regardless of causation or body location.

(e) AUTHORIZATION OF APPROPRIATIONS.—
There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of the fiscal years 2010 through 2012. Amounts appropriated under this section shall remain available until expended.

SEC. 4030. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1313A(c)(5) of the Social Security Act (42 U.S.C. 1320d-23(c)(5)) is amended to read as follows:

(5) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated out of this account, section 25,000,000 for the period of fiscal years 2010 through 2014.

Title V—Health Care Workforce

Subtitle A—Purpose and Definitions

SEC. 5001. PURPOSE.
The purpose of this title is to improve access to and the delivery of health care services for all individuals, including the supply, demand, distribution, diversity, and skills needs of the health care workforce; to enhance health care workforce education and training to improve access to and the delivery of health care services for all individuals; to provide support to the existing health care workforce to improve access to and the delivery of health care services for all individuals; and to ensure that health and wellness initiatives are effective in achieving their stated goals.

Subtitle B—Special Populations

Title VI—Health Care Workforce

Subtitle A—Purpose and Definitions

SEC. 6001. DEFINITIONS.
(a) This Title.—In this title:

(1) ALLIED HEALTH PROFESSIONAL.—The term ‘allied health professional’ means an allied health professional as defined in section 798(b)(3) of the Public Health Service Act (42 U.S.C. 355(b)) who—

(A) has graduated from an allied health professions degree or certificate program and has received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed by a Federal, State, local, or tribal public health agency, in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residency, and other settings located in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ‘health care career pathway’ means a...
rigorous, engaging, and high quality set of courses and services that—
(A) includes an articulated sequence of academic and career courses, including 21st century skills; and
(B) is aligned with the needs of healthcare industries in a region or State;
(C) prepares students for entry into the full range of entry-level education options, including registered apprenticeships, and careers;
(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;
(E) meets economic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applicable standards; and
(F) leads to 2 or more credentials, including—
(i) a secondary school diploma; and
(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.
(3) INSTITUTION OF HIGHER EDUCATION.—The term ‘institution of higher education’ means the term given in sections 101 and 102 of the Higher Education Act of 1965 (29 U.S.C. 1001 and 1002).
(4) LOCAL WORKFORCE INVESTMENT BOARD, STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—
(A) LOW-INCOME INDIVIDUAL.—The term ‘low-income individual’ has the meaning given that term in section 101 of the Workforce Investment Act of 1998 (29 U.S.C. 2801).
(B) STATE WORKFORCE INVESTMENT BOARD, LOCAL WORKFORCE INVESTMENT BOARD.—The terms ‘State workforce investment board’ and ‘local workforce investment board’, refer to the workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2823), respectively.
(5) POSTSECONDARY EDUCATION.—The term ‘postsecondary education’ means—
(A) a 2-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of higher education;
(B) a certificate or registered apprenticeship program at the postsecondary level that comes with technical and theoretical training and the job learning with related instruction (in a classroom or on the job) while an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to competency, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.
(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 751(b) of the Public Health Service Act (42 U.S.C. 296) is amended—
(1) by striking paragraph (3) and inserting—
(‘‘13A AREA HEALTH EDUCATION CENTER PROGRAM.—The term ‘area health education center program’ means cooperative programs consisting of a community health center, a teaching health center, a rural health center, a university health center, or a state university health center operated by an accredited institution of higher education, in one or more area health education centers, which carry out the required activities described in section 751(c), satisfies the program requirements in one or more of its principal functions identifying and implementing strategies and activities that address health care workforce needs in its service area, in coordination with the local workforce investment boards.
(14) CLINICAL SOCIAL WORKER.—The term ‘clinical social worker’ has the meaning given the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).
(15) CULTURAL COMPETENCY.—The term ‘cultural competency’ shall be defined by the Secretary in a manner consistent with section 1707(d)(3).
(16) DIRECT CARE WORKER.—The term ‘direct care worker’ has the meaning given that term in the Federal Workforce Investment Act (42 U.S.C. 1395x(hh)(1)).
(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term ‘federally qualified health center’ has the meaning given that term in section 331(a)(1) of the Public Health Service Act (42 U.S.C. 254(a)).
(18) FRONTIER HEALTH PROFESSIONAL SHORTAGE AREA.—The term ‘frontier health professional shortage area’ means an area—
(A) with a population density less than 6 persons per square mile within the service area; and
(B) with respect to which the distance or time for the population to access care is excessive.
(19) GRADUATE PSYCHOLOGY.—The term ‘graduate psychology’ means an accredited program in professional psychology.
(20) HEALTH DISPARITY POPULATION.—The term ‘health disparity population’ has the meaning given such term in section 903(d)(1).
(21) HEALTH LITERACY.—The term ‘health literacy’ means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health care decisions.
(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term ‘mental health service professional’ means an individual with a degree or similar credential from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional psychology.
(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term ‘one-stop delivery system center’ means a one-stop delivery system described in section 801(g)(2) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).
(24) PARAPROFESSIONAL CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term ‘paraprofessional child and adolescent mental health worker’ means an individual who is not a mental or behavioral health service professional, but who works at the first stop or contact with children or their families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.
(25) RACIAL AND ETHNIC MINORITY GROUP; RACIAL AND ETHNIC MINORITY POPULATION.—The terms ‘racial and ethnic minority group’ and ‘racial and ethnic minority population’ have the meaning given the term ‘racial and ethnic minority group’ in section 1707.
(26) RURAL HEALTH CLINIC.—The term ‘rural health clinic’ has the meaning given that term in section 331(a)(2) of the Social Security Act (42 U.S.C. 1395x(aa)).
(27) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 296) is amended—
(1) in paragraph (2)—
(A) by striking “means a” and inserting “means an accredited” (as defined in paragraph (8)); and
(B) by striking the period at the end and inserting the following: “where graduates are—
(A) authorized to sit for the National Council Licensure Examination—Registered Nurse (NCLEX-RN); or
(B) licensed registered nurses who will receive a graduate or equivalent degree or training to become accredited interested in the education nurse as defined by section 811(b)”; and
(2) by adding at the end the following:
(28) ACCELERATED NURSING DEGREE PROGRAM.—The term ‘accelerated nursing degree program’ means a program of education in professional nursing offered by an accredited school of nursing in which an individual holding a bachelors degree in another discipline receives a baccalaureate degree in nursing in an accelerated time frame as determined by the accredited school of nursing.
(29) BRIDGE OR DEGREE COMPLETION PROGRAM.—The term ‘bridge or degree completion program’ means a program of education in professional nursing offered by an accredited school of nursing, as defined in paragraph (2), that leads to a baccalaureate degree in nursing. Such programs may include—
(A) a registered nurse (RN) to Bachelor’s of Science of Nursing (BSN) programs, RN to MSN (Master of Science of Nursing) programs, or BSN to Doctoral programs.
Subtitle B—Innovations in the Health Care Workforce
SEC. 5101. NATIONAL HEALTH CARE WORKFORCE COMMISSION.
(a) PURPOSE.—It is the purpose of this section to establish a National Health Care Workforce Commission that—
(1) serves as a national resource for Congress, the President, States, and localities; and
(B) the Departments of Health and Human Services, Labor, Veterans Affairs, Homeland Security, and Education on related activities adminis- tered by one or more of those Departments.
(2) develops and commissions evaluations of education and training activities to deter- mine whether the demand for health care workers is being met; and
(3) identifies barriers to improved coordi- nation at the Federal, State, and local levels.
and recommend ways to address such barriers; and
(5) encourages innovations to address population needs, constant changes in technological and other environmental factors.

(b) Establishment.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the ‘‘Commission’’).

(c) Membership.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members to be appointed by the Comptroller General, without regard to political affiliation, within 30 days after the expiration of the term of any member until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(2) QUALIFICATIONS.—

(A) IN GENERAL.—The membership of the Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation between public, private, suburban, rural, and frontier representatives.

(B) INCLUSION.—

(i) IN GENERAL.—The membership of the Commission shall include no less than one representative of—

(I) the health care workforce and health professionals;

(II) employers;

(III) third-party payers;

(IV) individuals skilled in the conduct and interpretation of health care services and health economics research;

(V) representatives of consumers;

(VI) students;

(VII) State or local workforce investment boards; and

(VIII) educational institutions (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) SPECIAL MEMBERS.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) MAJORITY NON-PROVIDERS.—Individuals who are directly involved in health care professions education or practice shall not constitute a majority of the membership of the Commission.

(d) Ethical Disclosure.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of the Comptroller General of the United States.

(e) Compensation.—The members of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for travel away from home and to the regular place of business of a member. The members of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for travel away from home and to the regular place of business of a member, which may be allowed travel expenses by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay under paragraphs (3) and (4)), employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States.

(f) Meetings.—The Commission shall meet at the call of the Chairman, but not less frequently than on a quarterly basis.

(g) Duties.—

(1) Review, Dissemination, and Communication.—The Commission shall—

(A) recognize efforts of Federal, State, and local partnerships to develop and offer health care career pathways of proven effectiveness;

(B) disseminate information on promising retention practices for health care professionals;

(C) communicate information on important policies and practices that affect the recruitment, education and training, and retention of the health care workforce; and

(2) Review of Health Care Workforce and Annual Reports.—In order to develop a financially sustainable integrated workforce that supports an accessible health care delivery system that meets the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(A) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(B) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(C) by not later than October 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing the results of such reviews and recommendations concerning health care delivery systems that meet the needs of patients and populations, the Commission, in consultation with relevant Federal, State, and local agencies, shall—

(i) review current and projected health care workforce supply and demand, including the topics described in paragraph (3);

(ii) make recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies;

(D) by not later than April 1 of each year (beginning with 2011), submit a report to Congress and the Administration containing a review of the recommendations described in paragraph (C) of this subsection, a review of the employment status of health care professionals, a review of the employment status of Health Care Professionals, and recommendations on how such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.); and

(E) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2931 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved communities.

(3) SPECIFIC TOPICS TO BE REVIEWED.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, supply and demand, and projected demands during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeship programs; the number of qualified faculty; the role and training of infrastructure; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2931 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 292 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Workforce Investment Act of 1998 (29 U.S.C. 2931 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations for new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, if designated as medical underserved communities.

(4) HIGH PRIORITY AREAS.—

(A) IN GENERAL.—The initial high priority topics described in this paragraph include each of the following:

(i) integrated health care workforce planning that identifies health care professional shortages and excesses, including the health care needs of special populations across disciplines;

(ii) an analysis of the nature, scopes of practice, and demands for health care workers in the enhanced information technology and management workplace;

(iii) an analysis of how to align Medicare and Medicaid graduate medical education programs with national health workforce priorities and goals;

(iv) the education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels; and

(II) Oral health care workforce capacity at all levels;

(III) Mental and behavioral health care workforce capacity at all levels;

(IV) Allied health and public health care workforce capacity at all levels;

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels; and

(VI) The geographic distribution of health care providers as compared to the identified
health care workforce needs of States and regions.

(B) Future Determinations.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development and to develop special areas that require special attention.

(5) Grant Program.—The Commission shall—

(a) review implementation progress reports and any other reports to Congress about the State Health Care Workforce Development Grant Program established in section 5102;

(b) in collaboration with the Department of Labor, Education, Commerce, Agriculture, and Veterans Affairs and the Environmental Protection Agency, the Department of Health and Human Services, the Department of Education, and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 5102(b) for grant recipients under section 5102;

(C) assess the implementation of the grants under such section; and

(D) collect and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute such information to the Commission and, to the extent practicable, to Federal and State agencies.

(6) Study.—The Commission shall study effective mechanisms for financing education and training activities in health care, including public health and allied health.

(7) Recommendations.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(A) Consultation with Federal, State, and local agencies, Indian tribes, tribal organizations, and other relevant public-private health care partnerships.

(B) Obtaining and disseminating information, including identified models and best practices, on grants from the fiscal and administrative agent.

(C) Review of implementation progress reports and any other reports to Congress about the State Health Care Workforce Development Grant Program established in section 5102(b) for grant recipients under section 5102.

(D) Assess the implementation of the grants under such section.

(E) Collect and report information, including identified models and best practices, on grants from the fiscal and administrative agent.

(8) Authorization of Appropriations.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations for the Comptroller General.

(9) Authorization.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(10) Grants and Services.—The Commission may accept gifts, bequests, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(11) Definitions.—In this section:

(1) Health care workforce.—The term "health care workforce" includes all health care providers (direct patient care providers, health care paraprofessionals, direct care workers, health care professionals, psychologists and other behavioral health professionals, social workers, social workers, and occupational therapists), certified nurse midwives, school nurses, certified nurse midwives, school nurses, certified nurse midwives, school nurses, licensed complementary and alternative medicine providers, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(2) Health professionals.—The term "health professionals" includes—

(A) health care providers, including physicians, nurses, nurse practitioners, physician assistants, social workers, social workers, and occupational therapists, certified nurse midwives, school nurses, licensed complementary and alternative medicine providers, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(3) Eligibility.—To be eligible to receive a planning grant, an entity shall be an eligible provider of health care services, a State workforce investment board, or an entity that is not a State workforce investment board and includes or modifies the members to include at least one representative from each of the following: health care providers, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(4) Eligible providers of health care services.—Eligible providers of health care services include—

(A) health care providers, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.

(5) Eligible planning and implementation grants.—An eligible planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $100,000.

(6) Eligibility.—To be eligible to receive planning grants, an entity shall be an eligible provider of health care services, a State workforce investment board, or an entity that is not a State workforce investment board and includes or modifies the members to include at least one representative from each of the following: health care providers, public health professionals, and any other health professional that the Comptroller General of the United States determines appropriate.
higher education, the recognized State federation of labor, the State public secondary education agency, the State P-16 or P-20 Council if such a council exists, and a philanthropic foundation that is actively involved in, among other things, providing learning, mentoring, and work opportunities to recruit, educate, and train individuals for, and retain individuals in, careers in health care and related industries. Each application submitted for a planning grant shall be received by the Governor of the State receiving a planning grant and an administrative agency for the partnership.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The Governor of the State receiving a planning grant has the authority to appoint a fiscal and administrative agent for the partnership.

(4) APPLICATION.—Each State partnership desiring a planning grant shall submit an application to the Administrator of the Administration at such time and in such manner, and accompanied by such information as the Administrator requires. Each application submitted for a planning grant shall include a description of the State partnership, the activities for which assistance is sought, the proposed performance benchmarks to be used to measure progress under the planning grant, a budget for use of the funds to complete the required activities described in subsection (b), and such additional assistance and information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) REQUIRED ACTIVITIES.—A State partnership receiving a planning grant shall carry out the following:

(A) Analyze State labor market information in order to create health care career pathways for students and adults, including disadvantaged workers.

(B) Identify current and projected high demand or need State or regional health care sectors for purposes of planning career pathways.

(C) Identify Federal, State, and private resources and potential partners to recruit, educate or train, and retain a skilled health care workforce and strengthen partnerships.

(D) Describe the academic and health care industry skill standards for high school graduation, for entry into postsecondary education, and for various credentials and licenses.

(E) Describe State secondary and postsecondary education and training policies, models, or practices for the health care sector, including career information and guidance counseling.

(F) Identify Federal or State policies or rules that are barriers to a comprehensive health care workforce development strategy and barriers and a plan to resolve these barriers.

(G) Participate in the Administration’s evaluation and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before the State partnership receives a planning grant and the Administration determines that the grantee is ready to carry out the activities supported by the grant, the State partnership shall collect data to report progress in meeting the performance benchmarks that shall be established for the purposes of the planning grant, including but not limited to:

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the planning grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of the activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of the involvement of the State partnership in meeting the performance benchmarks.

(7) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind, that is not less than 15 percent of the amount of the grant, to carry out the activities supported by the grant. The matching requirement may be provided from funds available under other Federal, State, local, or private sources to carry out the activities.

(8) REPORT.—(A) REPORT TO ADMINISTRATION.—Not later than 1 year after a State partnership receives a planning grant, the partnership shall submit a report to the Administration on the State’s performance of the activities under the grant, including the use of the funds, including matching funds, to carry out required activities, and a description of the progress of the State workforce investment board in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit to Congress an analysis of the planning activities, performance, and fund utilization of each State grant recipient, including an identification of promising practices and a profile of the activities of each State grant recipient.

(d) IMPLEMENTATION GRANTS.—

(1) IN GENERAL.—The Administration shall—

(A) competitively award implementation grants to State partnerships to enable such partnerships to implement activities that will result in a coherent and comprehensive plan for health workforce development that will address current and projected workforce demands in the State; and

(B) inform the Commission and Congress about the awards made.

(2) DURATION.—An implementation grant shall be awarded for a period of no more than 2 years, except in those cases where the Administration determines that the grantee is high performing and the activities supported by the grant warrant up to 1 additional year of funding.

(3) ELIGIBILITY.—To be eligible for an implementation grant, a State partnership shall have—

(A) received a planning grant under subsection (c) and completed all requirements of such grant;

(B) completed a satisfactory application, including a plan to coordinate with required partners and complete the required activities during the 2 year period of the implementation grant.

(4) FISCAL AND ADMINISTRATIVE AGENT.—A State partnership receiving an implementation grant shall select an administration at such time, in such manner, and accompanied by such information as the Administrator determines to be essential to ensure compliance with the grant program requirements.

(5) APPLICATION.—Each eligible State partnership desiring an implementation grant shall submit an application to the Administration.

(6) MATCH.—Each State partnership receiving an implementation grant shall provide an amount, in cash or in kind, that is not less than 15 percent of the amount of the grant, to carry out the activities supported by the grant.

(7) PERFORMANCE AND EVALUATION.—Before the State partnership receives an implementation grant, it and the Administrator shall jointly determine the performance benchmarks that shall be established for the purposes of the implementation grant, including but not limited to:

(A) a description of the members of the State partnership;

(B) a description of how the State partnership completed the required activities under the implementation grant, if applicable;

(C) a description of the activities for which implementation grant funds are sought, including grants to regions by the State partnership to advance coherent and comprehensive regional health care workforce planning activities;

(D) a description of the activities during the duration of an implementation grant;

(E) a budget proposal of the cost of the activities supported by the implementation grant and a timeline for the provision of matching funds required;

(F) proposed performance benchmarks to be used to assess and evaluate the progress of the partnership activities;

(G) a description of the involvement of the State partnership in meeting the performance benchmarks.

(8) REPORT.—(A) REPORT TO ADMINISTRATION.—For each year of the implementation grant, the State partnership receiving the implementation grant shall submit a report to the Administration on the performance of the State’s implementation activities, including the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.

(B) REPORT TO CONGRESS.—The Administration shall submit a report to Congress analyzing the implementation activities and how the use of the funds, including matched funds, to complete activities, and a description of the performance of the State partnership in meeting the performance benchmarks.
(2) Implementation grants.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 5103. HEALTH CARE WORKFORCE ASSESSMENT.

(a) In General.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (c); and

(2) by striking subsection (b) and inserting the following:

"(b) NATIONAL CENTER FOR HEALTH CARE WORKFORCE ANALYSIS.—

"(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the 'National Center').

"(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Care Workforce Commission (established in section 5101 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

"(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

"(B) carry out the activities under section 762(a); and

"(C) annually evaluate programs under this title;

"(D) develop and publish performance measures and benchmarks for programs under this title; and

"(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

"(3) COLLABORATION AND DATA SHARING.—

"(A) IN GENERAL.—The National Center shall collaborate with Federal agencies and relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

"(B) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with regional and local health care organizations or societies for the purpose of providing the National Center with the data necessary to accomplish the purposes of this section.

"(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

"(1) ESTABLISHMENT.—The Secretary shall award grants to, or enter into contracts with, eligible entities for the purpose of—

"(A) collecting, analyzing, and reporting data on the characteristics of the health care workforce and workforce related issues from the local and regional centers established under section 5101 and the National Center; and

"(B) providing technical assistance to local and regional entities on the collection, analysis, and reporting of data.

"(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

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

"(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

"(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

"(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

"(A) establishing and maintaining national Internet registries and databases to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

"(B) collecting and reporting data on performance measures for programs under this title;

"(C) providing for the development, implementation, and use of guidelines for longitudinal evaluations (as described in section 761(d)(2)) for programs under this title; and

"(D) recommend appropriation levels for programs under this title.

(b) Health Workforce Analysis.—For the purpose of carrying out subsection (a), there are authorized to be appropriated $150,000,000 for each of fiscal years 2010 through 2014.

SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) Medical Schools and Primary Health Care Schools.—Section 729 of the Public Health Service Act (42 U.S.C. 292s) is amended—

"(1) LOAN AMOUNT.—With respect to any fiscal year, the loan amount for a student under this subsection shall not exceed $2,500 for fiscal year 2010; $3,500 for fiscal year 2011; $4,500 for fiscal year 2012; $5,500 for fiscal year 2013; and $6,500 for fiscal year 2014.

"(2) NONCOMPLIANCE BY STUDENT.—Each agreement entered into with a student pursuant to paragraph (1) shall provide that, if the student fails to comply with such agreement, the loan involved will begin to accrue interest at a rate of 2 percent per year greater than the rate at which the student would pay if compliant in such year.

"(3) NONCOMPLIANCE BY LENDER.—If a lender does not comply with the provisions of paragraph (2), the Secretary shall terminate the lender’s participation in the Federal Family Education Loan Program, or any other loan program, for which the lender is participating.

"(3) IN GENERAL.—The Secretary shall establish guidelines to determine the repayment terms for loans made under this section.

SEC. 5202. NURSING STUDENT LOAN PROGRAM.

(a) Loan Agreements.—Section 786(a) of the Public Health Service Act (42 U.S.C. 297f(a)) is amended—

"(1) by striking ''$2,500'' and inserting ''$3,500''

"(2) by striking ''$4,500'' and inserting ''$5,500''

"(3) by striking ''$13,000'' and all that follows through the period and inserting ''$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for the cost-of-attendance for the yearly loan rate and the aggregate of the loans.''

Title C—Increasing the Supply of the Health Care Workforce...
SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 295n et seq.) is amended by adding at the end the following:

"Subpart 3—Recruitment and Retention Programs"

"SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC HEALTH CARE WORKFORCE.

"(a) Establishment. The Secretary shall establish a fellowship program in pediatric clinical research under which an eligible individual agrees to be employed full-time for a specified period (not to exceed 2 years) in a pediatric medical specialty or subspecialty. The Secretary shall enter into contracts with institutions of higher education, in the case of a fellowship program in pediatric clinical research, or in the case of a fellowship program in pediatric medical specialty or subspecialty, with institutions of higher education and other eligible entities, in each case, for the purpose of supporting the development of pediatric clinical research. Each contract shall provide for the payment of a payment incentive to the individual and the institution of higher education or other eligible entity, in each case, in an amount not to exceed the greater of $20,000 or $10,000 for each year of obligated service that the individual provides in the program.

"(b) Program Administration. Through the program established under this section, the Secretary shall enter into contracts with institutions of higher education, in the case of a fellowship program in pediatric clinical research, or in the case of a fellowship program in pediatric medical specialty or subspecialty, with institutions of higher education and other eligible entities, in each case, for the purpose of supporting the development of pediatric clinical research. Each contract shall provide for the payment of a payment incentive to the individual and the institution of higher education or other eligible entity, in each case, in an amount not to exceed the greater of $20,000 or $10,000 for each year of obligated service that the individual provides in the program.

"(c) Priority. In entering into contracts under this subsection, the Secretary shall give priority to individuals who:

"(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary education setting;

"(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

"(3) are accepted for enrollment, or are enrolled, as a student in an accredited academic institution.

"(d) Authorization of appropriations. There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2012 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5203, is further amended by adding at the end the following:

"SEC. 776. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

"(a) Establishment. The Secretary shall establish the Public Health Workforce Loan Repayment Program to provide loans to individuals who agree to serve in public health professions in underserved areas. Each contract entered into under this section shall be conditioned on funds being appropriated for loan repayments under this section.

"(b) Eligibility. To be eligible to participate in the Loan Repayment Program, an individual shall contain—

"(1) a written contract, as appropriate, on the part of the individual, for the period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

"(A) 3 years; or

"(B) such longer period of time as determined appropriate by the Secretary and the individual;

"(2) an agreement, as appropriate, on the part of the individual to relocate to a public health agency or a related entity in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

"(3) a commitment that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

"(4) a statement of the damages to which the United States is entitled, under this section for the individual's breach of the contract;

"(5) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

"(c) Payments. (1) In general. A loan repayment provided for an individual under a written contract entered into under this section shall consist of payments made for an individual under a written contract entered into under this section.

"(2) Payments for years served. For each year of obligated service that an individual contracts with respect to public health service, the individual shall, in addition to such payments, make payments to the individual in an amount not to exceed 39 percent of the amount of loan repayments made for the taxable year involved.

"(3) Tax liability. For the purpose of providing reimbursements for tax liability incurred by an individual in paragraph (2) on behalf of an individual, the Secretary shall, in addition to such payments, make payments to the individual in an amount not to exceed (A) the amount of the tax liability incurred by the individual, or (B) 39 percent of the amount of loan repayments made for the taxable year involved.

"(4) Other payments. The Secretary shall, in addition to the payments provided for in paragraphs (2) and (3), make payments to an individual in an amount not to exceed the lesser of—

"(A) the amount of the tax liability incurred by the individual, or (B) 39 percent of the amount of loan repayments made for the taxable year involved.

"(d) Authority. The Secretary may enter into contracts under this section voluntarily.
(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of a period of obligated service may be postponed as approved by the Secretary.

(f) BREACH OF CONTRACT.—An individual who breaches the contract entered into under subsection (c) shall be subject to the same financial penalties as provided for under section 335E for breaches of loan repayment contracts under section 338B.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $156,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 5208. ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAMS.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients may require health care services, including acute care facilities, ambulatory care facilities, personal residence, and other settings recognized by the Secretary of Health and Human Services by authorizing an Allied Health Workforce Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1096l) is amended—

(1) in subsection (b), by adding at the end the following:

"(18) ALLIED HEALTH PROFESSIONALS.—The individual is employed full-time as an allied health professional—

"(A) in a Federal, State, local, or tribal public health agency; or

"(B) in a setting where patients may require health care services, including acute care facilities, ambulatory care facilities, personal residence, and other settings recognized by the Secretary of Health and Human Services by authorizing an Allied Health Workforce Program.

SEC. 5207. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338H(a) of the Public Health Service Act (42 U.S.C. 254a) is amended to read as follows:

"(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated, out of any funds in the Treasury not otherwise appropriated, the following:

"(1) For fiscal year 2010, $230,461,632.

"(2) For fiscal year 2011, $411,955,394.

"(3) For fiscal year 2012, $576,442,442.

"(4) For fiscal year 2013, $691,431,432.


"(6) For fiscal year 2015, $1,154,510,336.

"(7) For fiscal year 2016, $1,325,987,595.

"(8) public health workforce loan repayment programs; or"

"(b) TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFESSIONALS.—Part E of title VII of the Public Health Service Act (42 U.S.C. 294m et seq.), as amended by section 5204, is further amended by adding at the end the following:

"(77) TRAINING FOR MID-CAREER PUBLIC AND ALLIED HEALTH PROFES- SIONALS.

"(i) IN GENERAL.—The Secretary may make grants to an entity into contracts with, any eligible entity to award scholarships to individuals to enroll in degree or professional training programs for the purpose of attracting professionals in the public health and allied health workforce to receive additional training in the field of public health and allied health.

"(B) ELIGIBILITY.—

"(1) ELIGIBLE ENTITY.—The term 'eligible entity' includes a public health workforce loan repayment program under section 338K of the Higher Education Act of 1965 (20 U.S.C. 1090l), and any entity that offers an accredited educational program that offers a course of study, certificate program, or professional training program in public or allied health or a related discipline, as determined by the Secretary.

"(2) ELIGIBLE INDIVIDUALS.—The term ‘eligible individuals’ includes those individuals employed in public and allied health professions and programs, including those employed in administrative, tribal, or local level positions who are interested in returning or upgrading their education.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for the purpose of carrying out this section, $60,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

"(e) POSTPONING OBLIGATED SERVICE.—In paragraph (7), by striking ''. or'' and by inserting in its place—

"(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

"(B) one plus the average percentage change in the number of individuals residing in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the number of individuals residing in such areas during the previous fiscal year.

"(f) SEC. 5208. NURSE-MANAGED HEALTH CLINICS.

(a) PURPOSE.—The purpose of this section is to fund the development and operation of nurse-managed health clinics.

(b) GRANTS.—Subpart 1 of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by inserting after section 330A-1 the following:

"SEC. 330A-1. GRANTS TO NURSE-MANAGED HEALTH CLINICS.

"(a) DEFINITIONS.—

"(1) COMPREHENSIVE PRIMARY HEALTH CARE SERVICES.—In this section, the term 'comprehensive primary health care services' means the primary health services described in section 330(b)(1).

"(2) NURSE-MANAGED HEALTH CLINIC.—The term 'nurse-managed health clinic' means a nurse-managed health clinic managed by an advanced practice nurse, that provides primary care or wellness services to underserved or vulnerable populations and that is affiliated with a school, college, university, or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.

"(3) AUTHORITY TO AWARD GRANTS.—The Secretary shall award grants for the cost of the operation of nurse-managed health clinics that meet the requirements of this section.

"(c) APPLICATIONS.—To be eligible to receive a grant under this section, an entity shall—

"(1) be an NMHC; and

"(2) submit to the Secretary an application at such time, in such manner, and containing—

"(A) assurances that nurses are the major providers of services at the NMHC and that at least 1 advanced practice nurse holds an executive management position within the organizational structure of the NMHC;

"(B) an assurance that the NMHC will continue providing comprehensive primary health care services to underserved or vulnerable populations without regard to income or insurance status of the patient for the duration of the grant period; and

"(C) an assurance that, not later than 90 days of receiving a grant under this section, the NMHC will establish a community advisory committee, for which a majority of the members shall be individuals who are served by the NMHC.

"(d) GRANT AMOUNT.—The amount of any grant made under this section for each fiscal year shall be determined by the Secretary, taking into account—

"(1) the financial needs of the NMHC, considering State, local, and other operational funding provided to the NMHC; and

"(2) other factors, as the Secretary determines appropriate.

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for the fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2014.

"SEC. 5209. ELIMINATION OF CAP ON COMMIS- SIONED CORPS.

Section 202 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking "not to exceed 2,800".

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

"SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There shall be in the Service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

"(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

"(3) APPOINTMENT.—Commissioned officers of the Ready Reserve Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

"(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times
be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

"(5) WARRANT OFFICERS.—Warrant officers may be appointed by the Secretary to fulfill the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service is considered for purposes of this Act and title 37, United States Code, to be a commissioned officer within the Commissioned Corps of the Service.

"(b) RECRUITING RESERVE CORPS OFFICERS INTO THE REGULAR CORPS.—Effective on the date of enactment of the Patient Protection and Affordable Care Act, all individuals classified as Reserve Corps officers under this section (as such section existed on the day before the date of enactment of such Act) and serving on active duty shall be deemed to be commissioned officers of the Regular Corps.

"(c) PURPOSE AND USE OF READY RESEARCH.—

"(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Corps personnel available on short notice (similar to the uniformed services reserve program) to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

"(2) USES.—The Ready Reserve Corps shall—

"(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

"(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed services reserve personnel; and

"(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Corps members, as well as to respond to the public health emergencies, both foreign and domestic; and

"(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 799B) to improve access to health services.

"(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps."

Subtitle D—Enhancing Health Care Workforce Education and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANT TRAINING.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

"SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

"(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

"(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, school of nursing, or college of a certified physician assistant training program, or a public or private nonprofit entity which the Secretary has determined is capable of carrying out such programs.

"(A) to plan, develop, operate, or participate in an accredited professional training program, including an accredited residency or internship or in the field of family medicine, general internal medicine, or general pediatrics for medical students, interns, residents, or practicing physicians as defined by the Secretary;

"(B) to provide need-based financial assistance in the form of traineeships and fellowships to full-time students, interns, or practicing physicians, or other medical personnel, who are participants in any such program, and who plan to specialize or work in the practice of the fields defined in subparagraph (A);

"(C) to plan, develop, and operate a program for the training of physicians who plan to teach in family medicine, general internal medicine, or general pediatrics training programs;

"(D) to plan, develop, and operate a program for training of physicians teaching in community-based settings;

"(E) to provide financial assistance in the form of traineeships and fellowships to physicians who are participants in any such programs and who plan to teach or conduct research in a family medicine, general internal medicine, or general pediatrics training program;

"(F) to plan, develop, and operate a physician assistant education program, and for the training of individuals who will teach in such program;

"(G) to plan, develop, and operate a demonstration program that provides training in new competencies, as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, which may include—

"(i) providing training to primary care physicians relevant to providing care through patient-centered medical homes;

"(ii) developing tools and curricula relevant to patient-centered medical homes; and

"(iii) providing continuing education to primary care physicians relevant to patient-centered medical homes; and

"(H) to plan, develop, and operate joint degree programs to provide interdisciplinary and interprofessional graduate training in public health and other health professions to provide training in environmental health, infectious disease control, disease prevention and health promotion, epidemiological studies and injury control.

"(2) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

"(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

"(4) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

"(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $500,000 for each of fiscal years 2010 through 2014.

"SEC. 5302. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by inserting after section 747, as amended by section 5301, the following:

"SEC. 747A. TRAINING OPPORTUNITIES FOR DIRECT CARE WORKERS.

"(a) IN GENERAL.—The Secretary shall award grants to eligible entities to enable employees to promote opportunities for direct care workers who are employed in long-term care settings such as

"(b) PRIORITY IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to applicants that—

"(1) propose a collaborative project between academic administrative units of primary care;

"(2) propose innovative approaches to clinical teaching and training of primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of care that incorporate activities in health settings and integration physical and mental health professionals;

"(3) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

"(4) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

"(5) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

"(6) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas that or that serve underserved populations;

"(7) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

"(8) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, preventive health, medication management, and other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act; or

"(9) provide training in cultural competency and health literacy.

"(6) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this section shall be 5 years.

"(7) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—For purposes of carrying out this subsection (a)(1), there are authorized to be appropriated $125,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

"(2) TRAINING PROGRAMS.—Fifteen percent of the amount appropriated pursuant to paragraph (1) in each such fiscal year shall be allocated to the physician assistant training programs described in subsection (a)(1)(F), which prepare students for practice in primary care.

"(3) INTEGRATING ACADEMIC ADMINISTRATIVE UNITS.—For purposes of carrying out subsection (b)(1)(B), there are authorized to be appropriated $500,000 for each of fiscal years 2010 through 2014.
nursing homes (as defined in section 1909(e)(1) of the Social Security Act (42 U.S.C. 1396(e)(1)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

"(b) Eligibility.—Any individual who is an eligible entity under this section shall be eligible to receive a grant under this section, an entity shall—

"(1) be in an institution of higher education (as defined in section 102 of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

"(B) has established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

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

"(c) Amounts awarded to an eligible entity under this section to provide assistance to individuals with disabilities, or other long-term care provider, and "(2) Amounts awarded to an eligible entity under this subsection and maintain satisfactory academic progress in such courses.

"(b) Condition of Assistance.—As a condition of receiving assistance under this section, an individual shall agree that, following completion of the assistance period, the individual will work in the field of geriatrics, disabilities, services, long term services and supports, or chronic care management for a minimum of 2 years under guidelines set by the Secretary.

"(e) Authorization of Appropriations.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(1) redesignating section 748, as amended by section 5103 of this Act, as section 749; and

inserting after section 747A, as added by section 5302, the following:

"SEC. 74B. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

"(a) Support and Development of Dental Training Programs.

"(1) General.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit agency which the Secretary has determined is capable of carrying out such grant or contract—

"(A) to plan, develop, and operate a program for the training of dental care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(B) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(C) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(D) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, public health dentistry;

"(E) to meet the costs of projects to establish, maintain, or improve dental faculty development programs in primary care (which may include departments, divisions or other units);

"(F) to meet the costs of projects to establish, maintain, or improve predoctoral and postdoctoral training in primary care programs;

"(G) to create a loan repayment program for faculty in dental programs; and

"(H) to provide technical assistance to pediatric training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

"(2) Loan Repayment Program.—

"(A) In General.—A grant or contract under subsection (a)(1)(G) may be awarded to a program of general, pediatric, or public health dentistry on the basis of a plan to—

"(i) individuals agree to serve full-time as faculty members;

"(ii) the program of general, pediatric or public health dentistry agrees to pay the principal and interest on the outstanding student loan balance as calculated based on principal and interest owed at the time of the awards.

"(b) Eligible Entity.—For purposes of this subsection, entities eligible for such grants or contracts in general, pediatric, or public health dentistry shall include entities that have programs in general, pediatric, or public health dentistry; approved residency or advanced education programs in the practice of general, pediatric, or public health dentistry. Eligible entities shall—

"(1) be an institution of higher education, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

"(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary determines to be appropriate.

"(c) Priorities in Making Awards.—With respect to training provided for under this subsection, the Secretary shall give priority in awarding grants or contracts to the following—

"(1) Qualified applicants that propose to collaborate with departments of primary care and departments of general, pediatric, or public health dentistry.

"(2) Qualified applicants that have a record of training individuals who are from a rural and other underserved communities.

"(3) Qualified applicants that have a record of training individuals who are from a rural and other underserved communities.

"(d) Application.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(e) Duration of Award.—The period during which payments are made under contract or grant shall be—

"(1) a fiscal year or a fiscal year and the following fiscal year;

"(2) a fiscal year and the following fiscal year;

"(3) a fiscal year and the following fiscal year.

"(f) Duration of Award.—To be eligible to receive a grant under subsection (a) the entity shall—

"(1) plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(2) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(3) plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(4) plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene;

"(5) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

"(6) Qualified applicants that include educational activities in cultural competency and health literacy.

"(7) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health profession short supply areas, or who achieve a significant increase in the rate of placing graduates in such settings.

"(8) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical level of education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and vulnerable elderly.

"(d) Application.—An eligible entity desiring a grant under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(e) Duration of Award.—The period during which payments are made under a contract or grant shall be—

"(1) a fiscal year or a fiscal year and the following fiscal year;

"(2) a fiscal year and the following fiscal year;

"(3) a fiscal year and the following fiscal year.

"(f) Authorization of Appropriations.—For the purpose of carrying out subsections (a) and (b), there is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015.

"(g) Carryover Funds.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years."
(1) be—
(A) an institution of higher education, including a community college;
(B) a public-private partnership;
(C) a critical access hospital or a rural hospital;
(D) an Indian Health Service facility or a tribe or tribal organization; or
(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization;

(2) be within a program accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution; and

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

(4) ADMINISTRATIVE PROVISIONS.—
(a) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.

(b) POOLING OF FUNDS.—
(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disperse to any entity receiving a grant under this section not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under paragraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

(c) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

(d) EVALUATION.—The Secretary shall conduct with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

(e) CLARIFICATION REGARDING DENTAL HEALTH AID PROGRAM.—Nothing in this section shall prohibit a dental health aide training program approved by the Indian Health Service from being eligible for a grant under this section.

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

(2) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—
(A) carry out the fellowship program described in paragraph (3) of this section; and
(B) carry out 1 of the 2 activities described in paragraph (5).

(g) FELLOWSHIP PROGRAM.—
(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses of at least 30 hours in a discipline as a ‘fellowship’ that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical education and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

(B) ELIGIBLE INDIVIDUALS.—Amounts awarded under this subsection shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with a geriatric education center, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary with which the geriatric education centers are affiliated.

(C) CME CREDIT.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements by the profession in which the recipient is engaged.

(d) ADDITIONAL REQUIRED ACTIVITIES DESCRIPTION.—
(1) USE OF FUNDS.—Amounts awarded under this subsection shall use such funds to carry out 1 of the 2 activities described in such paragraph.

(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an award under paragraph (1), an individual shall—
(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or have completed any required training in a discipline or other parameters established by the Secretary.

(3) TARGETS.—A geriatric education center that receives an award under this subsection shall use such funds to carry out this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.

(e) GERIATRIC CAREER INCENTIVE AWARDS.—

(f) EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.—Section 753(c) of the Public Health Service Act (42 U.S.C. 294(c)) is amended—
(1) by redesignating paragraphs (4) and (5) as paragraphs (5) and (6), respectively;
(2) by striking paragraph (2) through paragraph (5) and inserting the following:

(3) ELIGIBLE INDIVIDUALS.—To be eligible to receive an Award under paragraph (1), an individual shall—
(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

(B) have dementia in all training courses, where appropriate.

(4) TARGETS.—A geriatric education center that receives an award under this subsection shall meet targets approved by the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

(5) AMOUNT OF AWARD.—An award under this subsection shall be in an amount of not more than 24 geriatric education centers may receive an award under this subsection.

(6) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

(7) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.

(8) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.

(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.

(10) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.

(11) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated to carry out this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.
“(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

(2) MAINTENANCE OF EFFORT.—No Award under paragraph (1) shall provide funds to the Secretary provided to the eligible individual under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual; and

(3) in paragraph (5), as so designated—

(A) in subparagraph (A)—

(i) by inserting “for individuals who are physicians” after “this section”; and

(ii) by inserting after the period at the end the following:—The Secretary shall determine the amount of an Award under this section for individuals who are not physicians; and

(B) by adding at the end the following:—

“(C) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—Section 855 of the Public Health Service Act (42 U.S.C. 296c) is amended—

(1) in subsection (b)—

(A) in paragraph (3), by striking “or” at the end;

(B) in paragraph (4), by striking the period at the end and inserting “; or”; and

(C) by adding at the end the following:—

“(5) establish traineeships for individuals who are preparing for advanced education in geriatric nursing, long-term care, geriatric psychosocial or other nursing areas that specialize in the care of the elderly population; and

(2) in subsection (c), by striking “2003 through 2007” and inserting “2010 through 2014”.

SEC. 5306. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

(a) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(1) striking section 757;

(2) redesignating section 756 (as amended by section 706) as section 757; and

(3) inserting after section 755 the following:

“SEC. 756. MENTAL AND BEHAVIORAL HEALTH EDUCATION AND TRAINING GRANTS.

“(a) GRANTS.—The Secretary may award grants to eligible institutions of higher education to support the recruitment of students for, and education and clinical experience of the students in—

(1) baccalaureate, master’s, and doctoral degree programs of social work, as well as the dual master’s degree program;

(2) accredited master’s, doctoral, internship, and post-doctoral residency programs of psychology for the development and implementation of interdisciplinary training of psychology graduate students for providing behavioral and mental health services, including substance abuse prevention and treatment services;

(3) accredited institutions of higher education or accredited professional training programs that are establishing or expanding interprofessional field placement programs in child and adolescent mental health in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse prevention and treatment, marriage and family therapy, school counseling, or professional counseling; and

(4) State-licensed mental health nonprofit and for-profit organizations to enable such organizations to pay for programs for preservice or in-service training of paraprofessional child and adolescent mental health workers.

“(b) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under this section, an institution shall—

(1) participate in the institutions’ programs of individuals and groups from different racial, ethnic, cultural, geographic, religious, linguistic, and class backgrounds, and different genders and sexual orientations;

(2) knowledge and understanding of the concerns of individuals and groups described in subsection (a);

(3) any internship or other field placement program assisted under the grant will prioritize cultural and linguistic competency;

(4) the institution will provide to the Secretary such data, assurances, and information as the Secretary may require; and

(5) with respect to any violation of the agreement between the Secretary and the institution, the institution will pay such liquidated damages as prescribed by the Secretary by regulation.

“(c) INSTITUTIONAL REQUIREMENTS.—For grants authorized under subsection (a)(1), at least 80 percent of the grant recipients shall be historically black colleges or universities or other minority-serving institutions.

“(d) PRIORITY.—

(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

(A) are awarded by the Council on Social Work Education;

(B) have a graduation rate of not less than 80 percent for social work students; and

(C) either recruit social workers from and place social workers in areas with a high need and high demand population.

(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions in which training focuses on the needs of vulnerable groups such as adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (a)(4), the Secretary shall give priority to applicants that—

(A) have demonstrated the ability to collect data in the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

“(C) have programs designed to increase the number of professionals and paraprofessionals serving high-risk areas and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

“(D) offer curriculum taught collaboratively with a family on the consumer and by family lived experience or the importance of family-professional or family-paraprofessional partnerships; and

“(E) provide services through a community mental health program described in section 1913(b)(1).

“(e) AUTHORIZATION OF APPROPRIATION.—For fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

(1) $8,000,000 for training in social work in subsection (a)(1); and

(2) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

“(3) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

“(4) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).

“(f) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended—

(1) in subsection (b), by striking the imbalances in subsection (a)(3); and

(2) in subsection (c), by striking “$35,451,000” and inserting “sections 751(b)(1)(A), 753(b), 754(3)(A), and 755(b)”.

SEC. 2307. CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING.

(a) TITLE VII.—Section 741 of the Public Health Service Act (42 U.S.C. 290e) is amended—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting “CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES GRANTS”; and

(B) in paragraph (1), by striking “for the purposes of” and all that follows through the period at the end and inserting “for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, and public health and implementing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs for the purposes determined as appropriate by the Secretary.”; and

(2) by striking subsection (b) and inserting the following:

“(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and public health and disability groups, community-based organizations, and other organizations as determined appropriate by the
Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807.

"(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under sections 741 and such other means as determined appropriate by the Secretary.

"(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of the curricula and research and demonstration projects, and model curricula for cultural competency, prevention, and public health, and working with individuals with a disability training curricula, and the facilitate inclusion of those competency measurements in quality measurement systems as appropriate.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.

(b) Title VIII.—Section 807 of the Public Health Service Act (42 U.S.C. 296e–1) is amended—

1) in subsection (a)—
2) by striking the subsection heading and inserting "CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITY TRAINING CURRICULA AND RESEARCH AND DEMONSTRATION PROJECTS.

3) in subsection (b)(3), by striking "managed care, quality improvement" and inserting "coordinated care, quality improvement";
4) in subsection (g), by inserting "-, as defined in section 801(2), after "school of nursing"; and
5) in subsection (h), by striking through the semicolon and inserting "that is directly related to nursing activities".

"(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with the entities described in section 741(b). The Secretary shall coordinate with curricula and research and demonstration projects developed under such section 741.

"(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated and evaluated in the same manner as model curricula developed under section 741, as described in subsection (c) of such section ; and
4) in subsection (d), as so redesignated—
(A) by striking paragraph (a) and inserting "this section"; and
(B) by striking "2001 through 2004" and inserting "2010 through 2015".

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS.

Section 811 of the Public Health Service Act (42 U.S.C. 296u) is amended—
1) in subsection (a)—
2) by striking "AND NURSE MIDWIFERY PROGRAMS";
3) by striking "and nurse midwifery";
4) in subsection (b), by striking paragraph (2) and by redesigning paragraph (3) as paragraph (2); and
5) by redesigning subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and
6) by inserting after subsection (c), the following:

"(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for funds under this section are educational programs that—

1) have as their objective the education of midwives; and
2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.

SEC. 5310. LOAN REPAYMENT AND SCHOLARSHIP PROGRAM.

(a) LOAN REPAYMENTS AND SCHOLARSHIPS.—Section 866(a)(3) of the Public Health Service Act (42 U.S.C. 297n(a)(3)) is amended by inserting before the semicolon the following: "or in an accredited school of nursing, as defined by section 801(3), as nurse faculty.".

(b) TECHNICAL AND CONFORMING AMENDMENTS.—Title VIII of the Public Health Service Act (42 U.S.C. 296 et seq.) is amended—

1) by redesignating section 810 relating to scholarships for students attending school on the basis of sex as section 809 and moving such section so that it follows section 808.
2) in sections 835, 836, 838, 840, and 842, by striking the term "this subpart" each place it appears and inserting "this part";
3) in section 836(b), by striking the last sentence;
4) in section 836, by redesigning subsection (l) as subsection (k);
5) in section 839, by striking "839" and all that follows through the semicolon and inserting "839 (a);"
6) in section 835(b), by striking "841" each place it appears and inserting "871;"
7) by redesigning subsection 871, moving part F to the end of the title, and redesignating such part as part I;
8) in part G—
(A) by redesigning section 845 as section 851; and
(B) by redesigning part G as part F;
9) in part H—
(A) by redesigning sections 851 and 852 as sections 861 and 862, respectively; and
(B) by redesigning part H as part G; and
10) in part I—
(A) by redesigning section 855, as amended by section 5305, as section 866; and
(B) by redesigning part I as part H.

SEC. 5311. NURSE FACULTY LOAN PROGRAM.

(a) IN GENERAL.—Section 846A of the Public Health Service Act (42 U.S.C. 297n–1) is amended—

1) in subsection (a)—
2) by striking the heading of the subsection and inserting "Establishment and inserting "School of Nursing Student Loan Fund"; and
3) by inserting "and" after "agreement";
4) in subsection (b)—
(A) by redesigning paragraph (2), by striking "$30,000" and all that follows through the semicolon and inserting "$35,000, during fiscal years 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan.

5) in subsection (c), by redesigning paragraph (3)(A), by inserting "an accredited" after "faculty member".

6) in subsection (d)—
(A) by redesigning paragraph (3)(A) and inserting "and an accredited school" and
(B) by redesigning paragraph (3)(A)
7) by striking "the Secretary shall submit to the Congress before the end of each fiscal year a report on the grants awarded and the contracts entered into under this section. Each such report shall identify the overall number of such grants and contracts and provide an explanation of why each such grant or contract was selected to meet the priority need of the nursing workforce.

"(c) ELIGIBLE ENTITY.—For purposes of this section, the term 'eligible entity' includes an accredited school or institution as defined by section 801(2), a health care facility, or a partnership of such a school and facility.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2012.
Service Act is amended by inserting after section 846A (42 U.S.C. 297n-1) the following:

SEC. 847. ELIGIBLE INDIVIDUAL STUDENT LOAN REPAYMENT.

(a) In general.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, may enter into an agreement with eligible individuals for the repayment of education loans, in accordance with this section, to increase the number of qualified nursing facility workers.

(b) AGREEMENTS.—Each agreement entered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a total period, in the aggregate, of at least 4 years during the 6-year period beginning on the date the United States becomes so entitled.

(1) the date on which the individual receives a master's or doctorate nursing degree from an accredited school of nursing; or

(2) the date on which the individual enters into an agreement under this subsection.

(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on, any loan of that individual obtained to pay for such degree;

(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

(A) payments may not exceed $10,000 per calendar year; and

(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be adjusted to provide for a cost-of-attendance increase for the yearly loan rate and the aggregate loan); and

(3) for an individual who has completed a doctorate or equivalent degree in nursing—

(A) payments may not exceed $20,000 per calendar year; and

(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same paragraph (2)(B)).

(d) BREACH OF AGREEMENT.—

(1) In general.—In the case of any agreement made under subsection (b), the individual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal prevailing rate, if the individual fails to meet the agreement terms required under such subsection.

(2) WAIVER OR SUSPENSION OF LIABILITY.—In the case of an individual making an agreement for purposes of paragraph (1), the Secretary shall provide for the waiver or suspension of such paragraph in compliance with the agreement involved is impossible or would involve extreme hardship to the individual or if enforcement of the agreement with respect to the individual would be unconscionable.

(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Federal Government may be entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-year period beginning on the date the United States becomes so entitled.

(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

(5) ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, an ‘eligible individual’ means an individual who—

(1) is a United States citizen, national, or lawful permanent resident;

(2) holds an unencumbered license as a registered nurse; and

(3) has already completed a master’s or doctorate nursing program at an accredited school of nursing currently enrolled on a full-time or part-time basis in such program.

(e) PRIORITY.—For the purposes of this section and subsection (b), funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing students or Individual Student Loan Repayment that support doctoral nursing students.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014."

SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VIII.

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended as follows:

SEC. 871. AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated $40,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2014.

SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280 et seq.) is amended by adding at the end the following:

SEC. 399V. GRANTS TO PROMOTE POSITIVE COMMUNITY HEALTH BEHAVIORS AND OUTCOMES.

(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Secretary, shall award grants to eligible entities to provide evidence-based interventions for populations in medically underserved communities through the use of community health workers.

(b) USE OF FUNDS.—Grants awarded under subsection (a) shall be used to support community health workers—

(1) to educate, guide, and provide outreach regarding health problems prevalent in medically underserved communities, particularly racial and ethnic minority populations;

(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors and discourage risky health behaviors;

(3) to educate and provide guidance regarding enrollment in health insurance including the Children's Health Insurance Program under title XXI of the Social Security Act, Medicaid under title XVIII of such Act and Medicare under title XIX of such Act;

(4) to identify, educate, refer, and enroll underserved populations to appropriate healthcare agencies and community-based programs and organizations in order to increase access to quality healthcare services and to eliminate duplicative care; or

(5) to educate and provide home visitation services regarding maternal health and prenatal care.

(c) APPLICATION.—Each eligible entity that receives an Individual Student Loan Repayment under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require.

(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

(1) propose to target geographic areas—

(A) with a high percentage of residents who suffer from chronic diseases; or

(B) with a high infant mortality rate;

(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

(3) have documented community activity and experience with community health workers.

(2) COLLABORATION WITH ACADEMIC INSTITUTIONS AND THE ONE-STOP DELIVERY SYSTEM.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions and one-stop delivery systems under section 134(c) of the Workforce Investment Act of 1998. Nothing in this section shall be construed to require such collaboration.

(f) EVIDENCE-BASED INTERVENTIONS.—The Secretary shall encourage community health worker programs receiving funding under this section to implement a process or an outcome-based payment system that rewards community health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such a payment.

(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for ensuring the cost-effectiveness of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section and shall determine whether such programs are in compliance with the guidelines established under subsection (g).

(k) DEFINITIONS.—In this section:

(1) COMMUNITY HEALTH WORKER.—The term ‘community health worker’, as defined by the Department of Labor as Standard Occupational Classification [21–1994] means an individual who promotes health or nutrition within the community in which the individual resides;

(A) by serving as a liaison between community health agencies and healthcare providers;

(B) by providing guidance and social assistance to the community;

(C) by enhancing community residents' ability to effectively communicate with healthcare providers;

(D) by providing culturally and linguistically appropriate health or nutrition education;

(E) by advocating for individual and community health;

(F) by providing referral and follow-up services or otherwise coordinating care; and

(G) by proactively identifying and enrolling eligible individuals.

(2) COMMUNITY.—The term ‘community’ means a federal, state, local, private or nonprofit health and human services program.
SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 292 et seq.) is amended by adding at the end thereof the following:

"PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

SEC. 271. ESTABLISHMENT.

(a) UNITED STATES PUBLIC HEALTH SERVICES TRACK

(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (referred to in this section as the 'Track') by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, emphasizes patient-centered, interdisciplinary, and mental health, public health, and emergency preparedness and response. It shall be organized as to graduate not less than—

(A) 150 medical students annually, 10 of whom shall be awarded studentships to the Uniformed Services University of Health Sciences;

(B) 100 dental students annually;

(C) 250 nursing students annually;

(D) 100 public health students annually;

(E) 100 behavioral and mental health professional students annually;

(F) 1004 hospitalist trainees or nurse practitioner students annually; and

(G) 100 pharmacy students annually.

(2) LOCATIONS.—The Track shall be located at educational entities that offer affiliated health professions education training programs at academic health centers located in regions of the United States determined by the Secretary, in consultation with the National Health Care Workforce Commission established in section 519 of the Patient Protection and Affordable Care Act.

(b) NUMBER OF GRADUATES.—Except as provided in subsection (a), the number of persons graduated from the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

(c) DEVELOPMENT.—The development of the Track may be by such phases as the Secretary may prescribe, subject to the requirements of subsection (a).

(d) INTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient-centered, interdisciplinary, and care coordination skills. Experience with deployment of emergency response teams shall be included during the clinical experiences.

(e) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of health care delivery urban, tertiary, and inpatient venues.

SEC. 272. ADMINISTRATION.

(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Department of Health and Human Services, the National Health Care Workforce Commission. Funds may be used to assist the Surgeon General in an advisory capacity.

(b) FACULTY.—

(1) IN GENERAL.—The Surgeon General, after consideration by the recommendations of the National Health Care Workforce Commission, shall obtain the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health professions training institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so that the employment of the faculty and staff on a comparable basis with the employes of fully accredited schools of the health professions within the United States.

(b) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

(c) NONAPPLICATION OF PROVISIONS.—The limitations in section 3573 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

(d) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize a reimbursable basis appropriate existing Federal medical resources located in the United States. Such agreements may include provisions for affiliated educational services provided students participating in Department of Health and Human Services educational programs.

(f) AUTHORITY OF THE SURGEON GENERAL.—

(1) IN GENERAL.—The Surgeon General is authorized—

(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing enterprises;

(B) to enter into agreements with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track, including any gift, devise, or bequest for the support of an academic chair, teaching, research, or demonstration project;

(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

(E) to accept the voluntary services of guest scholars and other persons.
to make outlays in advance of the enactment of budget authority for such outlays."

(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Surgeon General to perform work for which they are considered to be employees of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be employees for the purposes of chapter 33 of title 31, shall not be considered to be employees of the Federal Government for purposes of this part.

(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee for the purposes of chapter 33 of title 31, as determined by the Surgeon General.

(b) Tuition and student stipend.—

(I) Tuition remission rates.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept as payment in full the remission rate established under this subparagraph.

(2) Tuition and student stipend.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students in the Track.

(c) Second 2 years of service.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing student is enrolled in the Track, training should be designed to prioritize clinical rotations in Federal medical facilities in health professional shortage areas, and emphasize hospital and community-based experiences, and training within interdisciplinary teams.

(d) Tuition, physician assistant, pharmacist, behavioral and mental health professional, public health professional, and nurse training.—The Surgeon General shall establish provisions applicable, with respect to dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students that are comparable to those for medical students under this section, including service obligations, tuition support, and stipend support. The Surgeon General shall give priority to health professions schools that meet the conditions described in subparagraph (B).

(e) Formula for allocations.—The Secretary shall make available:

(1) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

(2) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

(f) Funding in excess of $20,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $20,000,000 but are less than $30,000,000—

(i) 80 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the requirements described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

(ii) 20 percent of such excess amount shall be made available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

(g) Funding in excess of $30,000,000.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

(ii) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions pursuant to subsection (e)); and

(iii) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).
schools that meet the conditions described in subsection (c)(5); and

(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds awarded under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

SEC. 751. AREA HEALTH EDUCATION CENTERS.

(a) AREA HEALTH EDUCATION CENTER PROGRAM.—Sec- tion 751 of the Public Health Service Act (42 U.S.C. 293a) is amended by striking the first sentence and inserting the following:

"For the purpose of grants and contracts under section (a)(1) to a school of nursing."

(b) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—An eligible entity shall make awards to eligible entities to maintain and improve the effectiveness and capabili- ties of an existing area health education center program, and may use funds awarded under paragraph (i) to support such activities by region to improve quality, efficiency, and effectiveness of health care delivery system under section 134(c) of the Medicare and Medicaid Programs Act (42 U.S.C. 293c).

(c) USE OF FUNDS.—

(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under this section to support such activities by region to improve quality, efficiency, and effectiveness of health care delivery system under section 134(c) of the Medicare and Medicaid Programs Act (42 U.S.C. 293c).

(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term ‘eligible entity’ means an entity that has received funds under this sec- tion, is operating an area health education center program, including an area health education center program, and has a center or centers that are no longer eligible to re- ceive financial assistance under subsection (a)(1)."
entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

(1) the nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of the nursing school; and

(2) the nursing school includes in the area health education center program area program.

(B) An entity receiving funds under subsection (a)(2) shall distribute funds to entities identified to a center that is eligible to receive funding under subsection (a)(1).

(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that each area health education center program includes at least 1 area health education center, and that each such center—

(A) is a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine, a pass-through institution, or a consortium of such entities;

(C) designates an underserved area or population to be served by the center which is in a location removed from the main location of the teaching facilities of the schools participating in the program with such center and does not duplicate, in whole or in part, the geographic area or population served by any other center;

(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

(G) has a community-based governing or advisory board that reflects the diversity of the communities involved.

(2) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance, an institution shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs.

(3) LIMITATION.—Not less than 25 percent of the total amount provided for an area public health education center program, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under subsection (a)(2).

(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the per health education center amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an area health education center program established in subsection (j)(2) is maintained.

(2) EXCEPTION.—The period described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 702(a) shall not apply to an area health education center funded under this section.

(j) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—The amounts authorized to be appropriated to carry out this section $125,000,000 for each of the fiscal years 2010 through 2014.

(2) REQUIREMENTS.—Of the amounts appropriated for a fiscal year under paragraph (1)—

(A) not more than 35 percent shall be used for awards under subsection (a)(1);

(B) not less than 60 percent shall be used for awards under subsection (a)(2); and

(C) not more than 1 percent shall be used for grants that provide technical assistance to entities receiving awards under this section.

(k) CARRIERS OF FUNDS.—An entity that receives an award under this section may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary. In no case may any funds be carried over pursuant to the preceding sentence for more than 3 years.

(l) SENSE OF CONGRESS.—It is the sense of the Congress that every State have an area health education center program in effect under this section.

SEC. 752. CONTINUING EDUCATIONAL SUPPORT FOR HEALTH PROFESSIONALS SERVING IN UNDERSERVED COMMUNITIES.

(a) IN GENERAL.—The Secretary shall make grants to, and enter into contracts with, eligible entities to improve health care, particularly primary care, and increase access to care for the minorities, women, and children of all ages, developing a sustainable partnership with patients, and contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative communications, and other strategies.

(b) EVOLUTION OF NATIONAL ADVISORY COUNCIL.—The Secretary shall periodically review this section and make such modifications, improvements, or revisions to this section as the Secretary determines appropriate by the Secretary''.

(c) EXTENSION OF PERIODS OF FUNDING.—All periods described in subsection (b) are extended by 6 years.

(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant or contract under this section to provide innovative supportive activities to enhance education through distance learning, continuing educational activities, collaborative communications, and other strategies.

SEC. 5404. WORKFORCE DIVERSITY GRANTS.

Section 821 of the Public Health Service Act (42 U.S.C. 296m) is amended—

(1) in subsection (a)—

(A) by striking "The Secretary may" and inserting the following:

"(1) AUTHORITY.—The Secretary may":

(B) by striking "pre-entry preparation, and retention activities" and inserting the following:

"(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers and educators about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse and mental health services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such evidence into their practices and to improve community health by working with community-based health connectors (referred to in this section as "Health Extension Agents")", and

(2) in subsection (b)—

(A) by striking "The Secretary shall" and inserting the following:

"(A) ESTABLISHMENT, PURPOSE AND DEFINITIONS.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a Primary Care Extension Program.

"(2) PURPOSE.—The Primary Care Extension Program shall provide support and assistance to primary care providers and educators about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse and mental health services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such evidence into their practices and to improve community health by working with community-based health connectors (referred to in this section as "Health Extension Agents")", and

(3) DEFINITIONS.—In this section:

(A) HEALTH EXTENSION AGENT.—The term "Health Extension Agent" means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

(B) PRIMARY CARE PROVIDER.—The term "primary care provider" means a clinician who provides care to individuals, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive services to men, women, and children of all ages, developing a sustained partnership with patients, and
practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

(b)(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

(A) shall consist of, at a minimum, the State health department, the entity responsible for the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care; and

(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract with the Secretary under section 332(a) of the Social Security Act, consumer groups, and other appropriate entities.

(b)(3) LOCAL ACTIVITIES.—

(A) Establish hubs.—Hubs established under a grant subsection (b) shall—

(i) develop a plan for financial sustainability of the Hub not described in subsection (b)(2)(A); and

(ii) provide reimbursement to the Hub for a period of 2 years.

(C) organize and administer grant funds for the purpose of: (i) developing a plan for a Hub, for a period of 2 years; or (ii) developing plans for the implementation of a Hub, for a period of 6 years; or

(D) carry out this section for each of fiscal years 2013 through 2014.

(c) STATE AND LOCAL ACTIVITIES.—

(A) Grants.—The Secretary shall—

(i) award grants to entities established by a State pursuant to paragraph (1) to—

(A) establish and administer a State-level Primary Care Extension Program State Hubs (referred to in this section as ‘Hubs’). (B) (2) APPLICATIONS.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(B) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by an evaluation panel appointed by the Secretary.

(C) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluations with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

(D) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this section shall not be used for funding direct patient care.

(E) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities as the Secretary determines appropriate.

(F) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395n) is amended by adding at the end the following new subsection:

"(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

"(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

"(2) DEFINITIONS.—In this subsection:

(A) PRIMARY CARE PRACTITIONER.—The term ‘primary care practitioner’ means an individual—

(i) who—

(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(ii) for whom primary care services are accepted at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) PRIMARY CARE SERVICES.—The term ‘primary care services’ means services identified, as of January 1, 2009, by the HCPCS codes and as subsequently modified by the Secretary:

(i) 99201 through 99215.

(ii) 99304 through 99348.

(iii) 99391 through 99350.

C. COORDINATING WITH OTHER PAYMENTS.—

The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

D. LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1787, or otherwise, respecting the identification of primary care practitioners under this subsection.

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395n) is amended by adding at the end the following new subsection:

"(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

"(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395n) is amended by adding at the end the following new subsection:

"(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

"(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.
physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02—General Surgery as their primary specialty code in the physician’s enrollment under section 1861(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w(a)(3)(A))."

(b) Major Surgical Procedures.—The term ‘major surgical procedures’ means physicians’ services which are surgical procedures that require an inpatient hospital stay of 2 or more consecutive calendar days or an inpatient hospital stay of 90 or more days.

(2) CONFORMING AMENDMENT.—Section 1833,h,(2),(B) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (2), by striking ‘‘Section 1833(h)(2)(B)’’ in the last sentence;

(2) in paragraph (4), by striking ‘‘Sections 1833(h)(2)(B)’’ in the last sentence;

(3) in paragraph (6), by striking ‘‘Section 1833(h)(2)(B)’’ in the last sentence;

(4) in paragraph (8), by striking ‘‘Sections 1833(h)(2)(B)’’ in the last sentence.

(3) Coordination with Other Payments.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

(4) Application.—The provisions of paragraphs (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).

SEC. 5002. MEDICARE QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) Expansion of Medicare-Overaged Preventive Services at Federally Qualified Health Centers.—

(1) in general.—Section 1861(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w(a)(3)(A)) is amended—

(1) in general.—Section 1861(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w(a)(3)(A)) is amended—

(2) in paragraph (2), by striking ‘‘Section 1833(h)(2)(B)’’ in the last sentence;

(3) in paragraph (4), by striking ‘‘Sections 1833(h)(2)(B)’’ in the last sentence;

(4) in paragraph (6), by striking ‘‘Section 1833(h)(2)(B)’’ in the last sentence;

(5) in paragraph (8), by striking ‘‘Sections 1833(h)(2)(B)’’ in the last sentence.

(2) Effective Date.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

SEC. 5003. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ‘‘paragraph (7)’’ and inserting ‘‘paragraphs (7) and (8)’’;

(2) in paragraph (4)(H)(i), by striking ‘‘paragraph (7)’’ and inserting ‘‘paragraphs (7) and (8)’’;

(3) in paragraph (5)(E), by inserting ‘‘or paragraph (8)’’ before the period at the end; and

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

(‘‘8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—‘‘(A) REDUCTIONS IN LIMIT BASED ON UNBASED POSITIONS.—‘‘(1) IN GENERAL.—‘‘Except as provided in clause (i), if a hospital’s reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 3% of the difference between such otherwise applicable resident limit and such reference resident level.

(2) EXCEPTIONS.—This subparagraph shall not apply to—

(i) a hospital located in a rural area (as defined in subsection (d)(2)(D)) with fewer than 250 acute care inpatient beds;

(ii) a hospital that is part of a hospital medical center that has, for 5 years (commencing with the year in which the hospital was permitted to participate in the Medicare program), been designated as anacrocare or general surgery residency training program for residents; and

(iii) a hospital that is part of a hospital medical center that has, for 5 years (commencing with the year in which the hospital was permitted to participate in the Medicare program), been certified by the Secretary as a hospital medical center that has been designated to participate in the Medicare demonstration project for providing comprehensive training for residents in the area of primary care.

(b) IN GENERAL.—The Secretary shall develop a prospective payment system for payment for Federally qualified health services furnished in Federally qualified health centers under this title. Such system shall include a process for appropriately describing the services furnished by Federally qualified health centers.

(c) Collection of Data and Evaluation.—The Secretary shall require Federally qualified health centers to submit to the Secretary such information as the Secretary may require in order to develop and implement the prospective payment system under this paragraph, including the reporting of services using HCPCS codes.

(d) Implementation.—

(i) IN GENERAL.—Notwithstanding section 1886(a)(3)(B), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 2014, for payments for Federally qualified health services furnished by Federally qualified health centers under this title in accordance with the prospective payment system developed by the Secretary under paragraph (1).

(ii) INITIAL PAYMENTS.—The Secretary shall implement such prospective payment system so that the estimated amount of expenditures under this title for Federally qualified health services in the first year that the prospective payment system is implemented is 10% percent of the estimated amount of expenditures under this title that would have occurred for such services in such year if the system had not been implemented.

(iii) PAYMENTS IN SUBSEQUENT YEARS.—In the year after the first year of implementation of such system, and in each subsequent year, the payment rate for Federally qualified health services furnished in the year shall be equal to the payment rate established for such services furnished in the preceding year under this paragraph, increased by the percentage increase in the MEP (as defined in 1942(i)(3)) for the year involved.

SEC. 5004. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ‘‘paragraph (7)’’ and inserting ‘‘paragraphs (7) and (8)’’;

(2) in paragraph (4)(H)(i), by striking ‘‘paragraph (7)’’ and inserting ‘‘paragraphs (7) and (8)’’;

(3) in paragraph (5)(E), by inserting ‘‘or paragraph (8)’’ before the period at the end; and

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

(‘‘8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—‘‘(A) REDUCTIONS IN LIMIT BASED ON UNBASED POSITIONS.—‘‘(1) IN GENERAL.—‘‘Except as provided in clause (i), if a hospital’s reference resident level (as defined in subparagraph (H)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (H)(ii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, as determined by the Secretary, and (ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)),

(2) EXCEPTIONS.—This subparagraph shall not apply to—

(i) a hospital located in a rural area (as defined in subsection (d)(2)(D)) with fewer than 250 acute care inpatient beds;

(ii) a hospital that is part of a hospital medical center that has, for 5 years (commencing with the year in which the hospital was permitted to participate in the Medicare program), been designated as anacrocare or general surgery residency training program for residents; and

(iii) a hospital that is part of a hospital medical center that has, for 5 years (commencing with the year in which the hospital was permitted to participate in the Medicare program), been certified by the Secretary as a hospital medical center that has, for 5 years (commencing with the year in which the hospital was permitted to participate in the Medicare program), been designated to participate in the Medicare demonstration project for providing comprehensive training for residents in the area of primary care.

(b) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this paragraph by a number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of enactment of this paragraph, that the number of full-time equivalent primary care residents, as defined in paragraph (9)(A)(iv), that the hospital may increase by during the 5-year period is less than 75 percent of the number of positions attributable to such increase in the 5-year period.

(c) COORDINATION WITH OTHER PAYMENTS.—The Secretary shall take into account provisions applying to the determination of additional payments attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) when determining whether a hospital is a ‘‘minor rural training track’’ as described in paragraph (4)(H)(iv) for purposes of this paragraph.

(d) DISTRIBUTION.—

(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by a number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011. The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of enactment of this paragraph, that—

(1) the number of full-time equivalent primary care residents, as defined in paragraph (9)(A)(iv), that the hospital may increase by during the 5-year period is less than 75 percent of the number of positions attributable to such increase in the 5-year period;

(ii) whether the hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including the end of such 5-year period; and

(iii) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(iv) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(e) CONSIDERATIONS FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary; and

(ii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

(f) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall disburse the increase to hospitals based on the following factors:

(i) Whether the hospital is located in a State with a resident-to-population ratio in the lowest quartile (as determined by the Secretary);

(ii) Whether the hospital is located in a State, a territory of the United States, or the District of Columbia that is among the top 10 States, territories, or Districts in terms of the ratio of—
“(I) the total population of the State, territory, or District living in an area designated (under such section 332A(a)(1)) as a health professional shortage area (as of the date of enactment of this paragraph); and
“(II) the total population of the State, territory, or District (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).
“(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

''(1) EXCEPTION. —Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

''(i) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

''(ii) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the increase in the time, as described in subparagraph (A), approved FTE per resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

(H) DEFINITIONS.—In this paragraph:

''(i) Reference resident level.—The term ‘reference resident level’ means, with respect to a hospital, the highest resident level for any of the 3 most recent cost reporting periods ending before the date of the enactment of this Act (42 U.S.C. 1395ww(h)), such a cost report has been settled (or, if not, submitted (subject to audit)), as determined by the Secretary.

''(ii) Resident level.—The term ‘resident level’ has the meaning given such term in paragraph (7)(O)(1).

''(iii) Otherwise applicable resident limit.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the limit otherwise applicable under subparagraph (v)(II) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

(b) IME.—

''(1) In general.—Section 1886(h)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

''(A) by striking “subsection (h)(7)” and inserting “subsections (h)(7) and (h)(8)”;

''(B) by striking “it applies” and inserting “they apply”;

(2) CONFORMING AMENDMENT.—Section 1886(h)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

‘‘(x) For discharges occurring on or after July 1, 2011, insofar as an additional payment amount under this subparagraph is attributable to positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.’’.

(3) CONFORMING AMENDMENT.—Section 422(h)(2) of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by striking ‘‘section 1886(h)(5)(B)’’ and inserting ‘‘paragraphs (7) and (8) of subsection (h) of section 1886 of the Social Security Act’’.

SEC. 5504. COUNTING RESIDENT TIME IN NON-PROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

''(1) by striking ‘‘shall be counted and that all the time’’ and inserting ‘‘shall be counted and that’’;

''(2) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting ‘‘; and’’;

''(3) by inserting after clause (i), as so inserted, the following new clause:

‘‘(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if a hospital incurs the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting. If more than one hospital incurs the costs of the stipends and fringe benefits of the resident, that hospital shall be counted a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.’’;

and

''(3) by adding at the end the following flush sentence:

‘‘Any hospital claiming under this subparagraph for time spent in a nonprovider setting shall maintain and make available to the Secretary records regarding the amount of such time and such amount in comparison with amounts of such time in such base year as the Secretary shall specify.’’.

(b) IME.—Section 1886(h)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended—

''(1) by striking ‘‘(iv) Effective for discharges occurring on or after October 1, 1997’’ and inserting ‘‘(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010’’;

and

''(2) by inserting after clause (i), as inserted by paragraph (1), the following new subparagraph:

‘‘(II) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such terms are defined by the Secretary, that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.’’.

(2) in paragraph (5), by adding at the end the following new subparagraph:

‘‘(K) Treatment of certain other activities.—In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program on non-patient care activities, such as didactic conferences and seminars, that is either directly or through a third party, hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.’’.

(c) EFFECTIVE DATES.—

''(1) in paragraph (4)—

‘‘(A) in subparagraph (E), by striking ‘‘such rules’’ and inserting ‘‘Subject to paragraph (4) and (K), such rules’’; and

‘‘(B) by adding at the end the following new subparagraphs:

‘‘(J) Treatment of certain nonprovider and nonprimary care activities.—The Secretary shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.’’.

‘‘(K) Treatment of certain other activities.—In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program on non-patient care activities, such as didactic conferences and seminars, that is either directly or through a third party, hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.’’.

(2) in paragraph (5), by adding at the end the following new subparagraph:

‘‘(K) Nonprimary care setting.—The term ‘nonprimary care setting’ means a nonprimary care setting that is primarily engaged in furnishing patient care. The term ‘nonprimary care setting’ means a nonprimary care setting that is primarily engaged in furnishing patient care;’’.

(3) in paragraph (6), by adding at the end the following new subparagraphs:

‘‘(J) Treatment of certain nonprovider and nonprimary care activities.—The Secretary shall provide that all time spent by an intern or resident in an approved medical residency training program on non-patient care activities, such as didactic conferences and seminars, that is either directly or through a third party, hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.’’.

(4) in paragraph (11), by adding at the end the following new provisions:

‘‘(DD) is a provider-based hospital out-patient department.

‘‘(EE) is reimbursed under a reimbursement system authorized under section 1840b(3); or

‘‘(DD) is a provider-based hospital out-patient department.”

III In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

‘‘(a) recognized as a subsection (d) hospital;

‘‘(bb) is recognized as a subsection (d) hospital;

‘‘(cc) is reimbursed under a reimbursement system authorized under section 1840b(3); or

‘‘(dd) is a provider-based hospital out-patient department.

(3) In determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, that is either directly or through a third party, hospitals shall count a proportional share of the time, as determined by written agreement between the hospitals, that a resident spends training in that setting.’’

(4) EFFECTIVE DATES.—
(1) In general.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after January 1, 1983.

(2) GME.—Section 1886(h)(4)(J) of the Social Security Act, as added by subsection (b), with respect to cost reporting periods beginning on or after July 1, 2009.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), with respect to reporting periods beginning on or after October 1, 2001. Such section, as so added, shall not give rise to any information law in effect prior to such date should be interpreted.

SEC. 5506. PRESERVATION OF RESIDENT CAP POSTITIONS FROM CLOSED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H)(ii) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end of such section the following new clause:

"""(v) DISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

"""(1) In general.—Subject to the succeeding provisions of this clause, the Secretary shall, to the extent necessary to ensure that there is no duplicative effect on the date of enactment of this Act (as determined in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the implementation of this clause.

"""(2) Application.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictional appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section 1395ww(h))."

(b) GME.—Section 1886(h)(4)(H)(vi) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(vi)) is amended by striking """"paragraph or paragraph (8)"""" and inserting """"paragraph, paragraph (8), or paragraph (4)(H)(v)"""".

SEC. 5507. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS IN LOW-INCOME FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) Authority to conduct demonstration projects.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end of such title the following:

""""SEC. 2008. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

""""(a) Demonstration Projects to Provide Low-Income Family-to-Family Education, Training, and Workforce Advancement to Address Health Professions Workforce Needs.—

""""(1) In general.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with access to care, child care, care management, and other supportive services.

""""(2) Requirements.—

""""(A) AID AND SUPPORTIVE SERVICES.—An eligible entity conducting a demonstration project shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

""""(B) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

""""(C) DEFINITIONS.—In this subsection:

""""(i) Eligible entity means an entity that meets the requirements described in this subsection.

""""(ii) Other low-income individuals.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

""""(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given to such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

""""(D) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

""""(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary

the Social Security Act 1395ww(h)(4)(H) and the State TANF program recognized under the Act of August 16, 1997 (commonly known as the 'State TANF program'), or if no agency has been recognized in the State under subpart VA of part D of title IV of the Workforce Investment Act of 1998, and that the project will be carried out in coordination with such entities.
assistance for needy families program funded under part A of title IV.

"(G) TRIBAL COLLEGE OR UNIVERSITY.—The term ‘Tribal College or University’ has the meaning given such term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

"(h) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

"(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

"(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

"(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies is not less than the number of hours of training required under any applicable State or Federal law or regulation.

"(1) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

"(2) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

"(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

"(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

"(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

"(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

"(iv) Personal care skills.

"(v) Health care support.

"(vi) Nutritional support.

"(vii) Infection control.

"(viii) Safety and emergency training.

"(ix) Training specific to an individual consumer’s needs (including older individuals, those individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

"(x) Life skills.

"(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

"(i) The length of the training.

"(ii) The appropriate trainer to student ratio.

"(iii) The amount of instruction time spent in the field compared to on-site in the home or a facility.

"(iv) Trainer qualifications.

"(v) Content for a ‘hands-on’ and written certification exam.

"(vi) Continuing education requirements.

"(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

"(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

"(ii) meet the training standards established in subparagraph (C); and

"(iii) meet such additional criteria as the Secretary may specify.

"(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

"(i) geographic and demographic diversity;

"(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

"(iii) that the existing training standards for personal or home care aides in each participating State are—

"(A) different from such standards in the other participating States; and

"(B) different from the core training competencies described in paragraph (3)(A); and

"(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

"(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

"(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

"(E) EVALUATION AND REPORT.—

"(A) IN GENERAL.—The Secretary shall conduct an experimental or control group testing of the core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel.

"(B) MEANING.—The term ‘core training competencies’ has the meaning given such term in paragraph (3)(A).

"(C) PERSONAL OR HOME CARE AIDE.—The term ‘personal or home care aide’ means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer’s disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

"(D) STATE.—The term ‘State’ has the meaning given that term for purposes of title XIX.

"(E) FUNDING.—

"(i) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2014.

"(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects.

"(3) EXTENSION OF FUNDING.—

"(a) IN GENERAL.—Except as provided in paragraph (2), the funding levels provided in this section shall not apply to grant awards under this section.

"(b) LIMITATIONS ON USE OF GRANTS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 1396p(c)(1)(A)(iii)) is amended by striking ‘‘fiscal year 2009’’ and inserting ‘‘each of fiscal years 2009 through 2012’’.
SEC. 3508. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.), as added by section 338(3), is further amended by inserting after section 749 the following:

"SEC. 749A. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

"(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teach the health centers for the purpose of establishing new accredited or expanded primary care residency programs.

"(b) AMOUNT.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $300,000.

"(c) USE OF FUNDS.—The amounts provided under a grant under this section shall be used to cover the costs of—

"(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

"(A) curriculum development;

"(B) recruitment, training and retention of residents and faculty;

"(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

"(D) faculty salaries during the development phase; and

"(2) technical assistance provided by an eligible entity.

"(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(e) PREFERENCE FOR CERTAIN APPLICANTS.—A teaching health center seeking a grant under this section, the Secretary shall give preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

"(f) DEFINITIONS.—In this section,

"(1) ELIGIBLE ENTITY.—The term eligible entity means an entity that—

"(A) in general.—The term teaching health center means an entity that—

"(i) is a community based, ambulatory patient care center; and

"(ii) operates a primary care residency program;

"(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:

"(i) a qualified teaching health center (as defined in section 1905(c)(2)(B), of the Social Security Act).

"(ii) a community mental health center (as defined in section 340I(f)(3)(B) of the Social Security Act).

"(iii) a rural health clinic, as defined in section 1915(a)(4)(A) of the Social Security Act.

"(iv) a program operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

"(v) an entity receiving funds under title X of the Public Health Service Act.

"(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and $50,000,000 for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.

"(h) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338(a)(3) of the Public Health Service Act (42 U.S.C. 293a(a)) is amended to read as follows:

"(a) SERVICE IN FULL TIME CLINICAL PRACTICE.—Except as provided in section 338D, (as defined in section 1861(ff)(3)(B) of the Social Security Act), each qualified teaching health center shall provide service in the full-time clinical practice of such individual's profession to any member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.

"(i) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Support of Graduate Medical Education in Qualified Teaching Health Centers

"SEC. 340H. PROGRAM OF PAYMENTS TO TEACHING HEALTH CENTERS THAT OPERATE GRADUATE MEDICAL EDUCATION PROGRAMS.

"(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers that are listed as sponsoring entities in the Graduate Education and Fiscal year.

"(b) AMOUNT OF PAYMENTS.—

"(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following:

"(A) DIRECT EXPENSE AMOUNT.—The amount determined under subsection (c) for direct expenses associated with sponsoring an approved graduate medical residency training programs.

"(B) INDIRECT EXPENSE AMOUNT.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

"(2) CAPPED AMOUNT.—

"(A) IN GENERAL.—The total of the payments made to qualified teaching health centers under paragraph (1) (A) or paragraph (1)(B) in a fiscal year do not exceed the total amount of funds appropriated under subsection (g) for such payments for that fiscal year.

"(B) LIMITATION.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments do not exceed the total amount of funds appropriated under a fiscal year under subsection (g).

"(c) AMOUNT OF PAYMENT FOR DIRECT GRADUATE MEDICAL EDUCATION.—

"(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate medical education programs under a grant under this section for a fiscal year is equal to the product of—

"(A) the amount national per resident amount for direct graduate medical education, as determined under paragraph (2); and

"(B) the average number of full-time equivalent residents in the teaching health center's graduate approved medical residency training programs as determined section 1905(c)(4) of the Social Security Act (without regard to the limitation under subparagraph (f) of such section) during the fiscal year.

"(2) UPDATED NATIONAL PER RESIDENT AMOUNT FOR DIRECT GRADUATE MEDICAL EDUCATION.—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

"(A) DETERMINATION OF QUALIFIED TEACHING HEALTH CENTER.—The Secretary shall compute for each individual qualified teaching health center a per resident amount.

"(i) by dividing the national average per resident amount computed under section 1905(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B);

"(ii) by multiplying the wage-related portion by the factor applied under section 1905(c)(2)(E) of the Secretary (but without application of section 4110 of the Balanced Budget Act of 1997 (42 U.S.C. 1320m note) during the proceeding fiscal year for the teaching health center's area; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

"(B) UPDATING RATE.—The Secretary shall update such per resident amount for each such teaching health center as determined by the Secretary as determined by the Secretary.

"(d) AMOUNT OF PAYMENT FOR INDIRECT MEDICAL EDUCATION.—

"(1) IN GENERAL.—The amount determined under this subsection for payments to qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

"(2) FACTORS.—In determining the amount under paragraph (1), the Secretary shall—

"(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers;

"(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this section and the payments for direct graduate medical education as determined under subsection (c) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g); and

"(3) INTERIM PAYMENT.—Before the Secretary makes a payment under this subsection pursuant to a determination in subparagraph (A), the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

"(e) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—Payments under this section—

"(1) shall be in addition to any payments—

"(A) for the indirect costs of medical education, as determined under paragraph (2); and

"(B) for direct graduate medical education costs under section 1905(c)(4) of such Act; and
“(C) for direct costs of medical education under section 1886(k) of such Act; “(2) shall not be taken into account in applying the limitation on the number of total full-time equivalent residents under paragraphs (2) or under section 1886b(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886b(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and “(3) shall not include the time in which a resident is counted toward full-time equivalency under paragraphs (2) or under section 1886b(h)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886b(d)(5)(B) of such Act, or section 306E of this Act. “(f) The Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made to pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1788 of the Social Security Act and shall be subject to review and judicial review under that section in the same manner as the amount of payment under section 1186(d) of such Act is subject to review under such section. “(g) Funding.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $200,000,000, for the period of fiscal years 2011 through 2015. “(h) Annual Reporting Required.— “(1) Annual Report.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner specified by the Secretary) the following information: “(A) the academic year in which the training program was completed immediately prior to such fiscal year; “(B) the number of approved training positions for residents described in paragraph (4); “(C) the number of residents described in paragraph (4) who completed their residency training at the end of such fiscal year; “(D) other information as deemed appropriate by the Secretary. “(2) Audit Authority; Limitation on Payment.— “(A) Audit Authority.—The Secretary may audit a qualified teaching health center to ensure the accuracy and completeness of the information submitted in a report under paragraph (1). “(B) Limitation on Payment.—A teaching health center may only receive payment in respect of any fiscal year for costs described in this section to a qualified teaching health center for the following: “(i) the qualified teaching health center has furnished the Secretary, as an addendum to the application under this section for such fiscal year, the report required under paragraph (1) for the previous fiscal year; or “(ii) such report fails to provide complete and accurate information required under any subparagraph of this paragraph. “(B) Notice and Opportunity to Provide Accurate and Missing Information.—Before imposing a reduction under subparagraph (A) the Secretary shall provide notice of such failure and the Secretary’s intention to impose such reduction and shall provide the teaching health center with the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center does not provide such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information. “(4) Residents.—The residents described in this paragraph are those who are in part-time or full-time equivalent resident training positions at a qualified teaching health center. “(5) Reduction in Payment for Failure to Demonstrate.—The Secretary shall prorate the payment amounts to each eligible hospital for the following: “(a) The Secretary determines that— “(1) Approved Graduate Medical Residency Programs.—For purposes of this section, an approved graduate medical residency program means a residency or other postgraduate medical training program approved under section 1186(c). “(2) Primary Care Residency Program.—The term ‘primary care residency program’ has the meaning given that term in section 79A. “(3) Qualified Teaching Health Center.—The term ‘qualified teaching health center’ has the meaning given that term in section 79A. “(B) Notice.—The demonstration shall include up to 5 eligible hospitals. “(3) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration. “(4) Administration.—Chapter 33 of title 44, United States Code, shall apply to the implementation of this section. “(B) Written Agreements With Eligible Partners.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agreement with the eligible partners of the hospital. Such written agreement shall describe, at a minimum— “(1) the obligations of the eligible partners with respect to the provision of qualified training and care; and “(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to the eligible partner. “(5) Evaluation.—No later than October 17, 2017, the Secretary shall submit to Congress a report on the demonstration. Such report shall include an analysis of the following: “(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demonstration. “(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (e)(1). “(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration. “(6) Funding.— “(A) In General.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, including the design, implementation, monitoring, and evaluation of the demonstration. “(B) Proration.—If the aggregate payments to eligible hospitals under the demonstration exceed $50,000,000 for a fiscal year described in paragraph (1), the Secretary shall prorate the payment amounts to each eligible hospital in such proportion that the aggregate payments do not exceed such amount. “(7) Without Fiscal Year Limitation.—Amounts appropriated under this subsection shall remain available without fiscal year limitation. “(e) Definitions.—In this section: “(1) Advanced Practice Registered Nurse.—The term ‘advanced practice registered nurse’ includes the following: “(A) A clinical nurse specialist (as defined in subsection (b)(2)(C) of the Social Security Act (42 U.S.C. 1395x)). “(B) A nurse practitioner (as defined in subsection (b)(2)(C) of the Social Security Act (42 U.S.C. 1395x)).
(D) A certified nurse-midwife (as defined in subsection (g)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term "applicable non-hospital community-based care setting" means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with such an eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital community-based care settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term "applicable school of nursing" means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with an eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term "demonstration" means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term "eligible hospital" means a hospital (as defined in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x)) or a critical access hospital (as defined in subsection (mm)(1) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term "eligible partners" includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(C) QUALIFIED NURSE— (A) IN GENERAL.—The term "qualified nurse" means—

(i) that provides an advanced practice registered nurse with the clinical skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of title XVIII of the Social Security Act, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XIX of the Social Security Act, or enrolled under part B of title XIX of the Social Security Act; and

(ii) the establishment of a sliding fee scale for low-income patients.

SEC. 5602. NEGOTIATED RULEMAKING FOR DESIGNATING MEDICALLY UNDERSERVED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) Establishment.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish, through a negotiated rulemaking process under subchapter V of such title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254e(a));

(2) FACTORS TO CONSIDER.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities), Federal agencies, health care organizations, health centers and other affected entities, and other interested parties; and

(B) shall consider—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations;

(ii) the degree of ease or difficulty that will face potential applicants for such designations in securing the necessary data; and

(iii) the extent to which the methodology accurately measures various barriers that confront individuals and population groups in seeking health care services.

(b) Publication of Notice.—In carrying out the rulemaking process under this subsection, the Secretary shall publish the notice provided for under section 56(a) of title 5, United States Code, not later than 45 days after the date of the enactment of this Act.

(c) Target Date for Publication of Rule.—As part of the notice under subsection (b), and for purposes of this subsection, the "target date for publication", as referred to in section 56(a)(5) of title 5, United States Code, shall be July 1, 2010.

(d) Appointment of Negotiated Rulemaking Committee and Facilitator.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the criteria for designating medically underserved populations and health professions shortage areas.

(2) the establishment of a sliding fee scale for low-income patients.

(e) Preliminary Committee Report.—The negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the criteria for designating medically underserved populations and health professions shortage areas.

(f) Final Committee Report.—If the committee fails to make significant progress toward such consensus or is unable to reach such consensus by the target date, the Secretary may designate such process and provide for the publication of a rule under this section through such other methods as the Secretary may determine.

(g) Publication of Final Rule.—The Secretary shall publish a rule in the Federal Register not later than 60 days after the date of the enactment of this Act.

(h) Reauthorization of the Wakefield Emergency Medical Services for Children Program.

Section 1910 of the Public Health Service Act (42 U.S.C. 300b-9) is amended by striking "(a)" and inserting "(a)" and inserting the following:

(1) in subsection (a), by striking "3-year period (with an optional 4th year)" and inserting "3-year period (with an optional 5th year)"; and

(2) in subsection (d)—

(A) by striking "and such sums" and inserting "such sums".

SEC. 5608. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290b-31 et
(a) Definitions.—In this section—
"(1) COMMUNITY.—The term "community" means a qualified community mental health program defined under section 1912(b) of title 42.
"(2) SPECIAL POPULATIONS.—The term "special populations" means adults with mental illnesses who have co-occurring primary care conditions and chronic diseases.
(b) Authority.—The Secretary, acting through the Administrator shall award grants and cooperative agreements to eligible entities to establish demonstration projects for the provision of coordinated and integrated services to special populations through the co-location of primary and specialty care services in community-based mental and behavioral health settings.
(c) Application.—To be eligible to receive a grant or cooperative agreement under this section, an eligible entity shall submit an application to the Administrator at such time, in such manner, and accompanied by such information as the Administrator may require, including a description of partnerships, or other arrangements with local primary care providers, including community health centers, to provide services to special populations.
(d) Use of Funds.—
(1) In general.—For the benefit of special populations, an eligible entity shall use funds awarded under this section for—
"(A) the provision, by qualified primary care professionals, of on site primary care services;
"(B) reasonable costs associated with medically necessary referrals to qualified specialty care professionals, other coordinators of care or, if permitted by the terms of the grant or cooperative agreement, by qualified specialty care professionals on a reasonable cost basis on site at the eligible entity;
"(C) information technology required to accommodate the clinical needs of primary and specialty care professionals; or
"(D) facility modifications needed to bring primary and specialty care professionals on site at the eligible entity.
(2) Limitation.—Not to exceed 15 percent of grant or cooperative agreement funds may be used for activities described in subparagraphs (C) and (D) of paragraph (1).
(e) Evaluation.—Not later than 60 days after the grant or cooperative agreement awarded under this section expires, an eligible entity shall submit to the Secretary the results of an evaluation to be conducted by the entity concerning the effectiveness of the activities carried out under the grant or agreement.
(f) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section, $50,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.

SEC. 5605. KEY NATIONAL INDICATORS.
(a) Definitions.—In this section:
"(1) ACADEMY.—The term "Academy" means the National Academy of Sciences.
"(2) COMMISSION.—The term "Commission" means the Commission on Key National Indicators established under subsection (b).
(b) Commission on Key National Indicators.—
(1) Establishment.—There is established a "Commission on Key National Indicators", (2) Membership.—
"(A) Number and Appointment.—The Commission shall be composed of 8 members, to be appointed equally by the majority and minority leader of the House of Representatives.
"(B) Prohibited Appointments.—Members of the Commission shall not include Members of Congress or other elected Federal, State, or local government officials.
"(C) Qualifications.—In making appointments under paragraph (A), the majority and minority leaders of the Senate and the Speaker and minority leader of the House of Representatives shall appoint individuals who have shown a dedication to improving civic dialogue and decision-making through the wide use of scientific evidence and factual information.
"(D) Period of Appointment.—Each member of the Commission shall be appointed for a 2-year term, except that 1 initial appointment shall last only for the remainder of that term.
(3) Chairpersons.—The Commission may select a Chair and Vice Chair from among its members.
(c) Duties of the Commission.—
(1) In General.—The Commission shall—
"(A) conduct comprehensive oversight of a newly established key national indicators system consistent with the purpose described in this subsection;
"(B) make recommendations on how to improve the key national indicators system;
"(C) consult with Federal, State, and local government users and information providers to assure access to relevant and quality data; and
"(D) enter into contracts with the Academy.
(2) Reports.—
"(A) Annual Report to Congress.—Not later than 1 year after the selection of the 2 Co-Chairpersons, and thereafter, the Commission shall submit to Congress a report that contains a detailed statement of findings and conclusions of the Commission on the activities of the Academy and a designated Institute related to the establishment of a Key National Indicators System, and
"(B) Annual Report to the Academy.—
"(i) In General.—Not later than 6 months after the selection of the 2 Co-Chairpersons of the Commission, and thereafter, the Commission shall submit to the Academy a report making recommendations concerning potential issue areas and key indicators to be included in the Key National Indicators System.
"(ii) Limitation.—The Commission shall not have the authority to direct the Academy or, if established, the Institute, to adopt, modify, or delete any key indicators.
"(3) Contract with the National Academy of Sciences.
(1) In General.—As soon as practicable after the selection of the 2 Co-Chairpersons of the Commission, the Co-Chairpersons shall enter into a contract with the National Academy of Sciences under which the Academy shall—
"(i) review available public and private sector research on the selection of a set of key national indicators;
"(ii) determine how best to establish a key national indicator system that reflects an appropriately balanced set of key national indicators that reflect the current state of knowledge, and that reflects the U.S. Congress, the President, the Administration, or the Federal Government;
"(iii) if the Academy designates an independent Institute under clause (ii), provide scientific and technical advice for the Institute and create an appropriate governance mechanism that balances Academy involvement and the independence of the Institute; and
"(iv) provide an annual report to the Commission addressing scientific and technical issues related to the key national indicator system and, if established, the Institute, and governance of the Institute’s budget and operations.
(2) Participation.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall convene a multi-sector, multi-disciplinary process to define major scientific and technical issues associated with developing, maintaining, and implementing a Key National Indicators System and, if an Institute is established, to provide it with scientific and technical advice.
(d) Establishment of a Key National Indicators System.—
(1) In General.—In executing the arrangement under subparagraph (A), the National Academy of Sciences shall establish a Key National Indicators System by—
"(I) creating its own institutional capability; or
"(II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.
(e) Authority.—If the Academy designates an Institute under clause (i)(II), such Institute shall be a non-profit entity (as defined for purposes of section 501(c)(3) of the Internal Revenue Code of 1986) with an educational mission, a governance structure that emphasizes independence, and character traits that make such entity appropriate for establishing a key national indicator system.
(f) Responsibilities.—Either the Academy or the Institute designated under clause (i) shall be responsible for the following:
"(I) Identifying and selecting issue areas to be represented by the key national indicators.
"(II) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).
"(III) Identifying and selecting data to populate the key national indicators described under subclause (II).
"(IV) Designing, publishing, and maintaining a public website that contains a freely available database allowing public access to the key national indicators.
"(V) Developing a quality assurance framework to ensure rigorous and independent processes and the selection of quality data.
"(VI) Developing a budget for the construction and maintenance of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission funding of Academy and, if an Institute is established, Institute activities.
(g) Reporting annually to the Commission regarding its selection of issue areas, key indicators, data, and progress toward establishing a web-accessible database.
(VIII) Responding directly to the Commission’s response to in the Form of these recommendations and to the Academy regarding any inquiries by the Academy.
(iv) Governance.—Upon the establishment of a key national indicator system, the Academy shall create an appropriate governance mechanism that incorporates advisory and operational committees. If an Institute is designated under clause (i)(II), the governance mechanism shall balance appropriate Academy involvement and the independence of the Institute.

(v) Modification and changes.—The Academy shall retain the sole discretion, at any time, to alter its approach to the establishment of an indicator system, if an Institute is designated under clause (i)(II), to alter any aspect of its relationship with the Institute or to designate a different non-profit organization to carry out such activities.

(vi) Construction.—Nothing in this section shall be construed to limit the ability of the Academy or the Institute designated under clause (i)(II) to receive private funding for activities related to the establishment of a key national indicator system.

(D) Annual report.—As part of the arrangement under subparagraph (A), the National Academy of Sciences shall, not later than 270 days after the date of enactment of this Act, and annually thereafter, submit to the Committee on Commerce, Science, and Transportation a report that contains the findings and recommendations of the Academy.

(d) Government Accountability Office Studies and Investigations.—

(1) GAO study.—The Comptroller General of the United States shall conduct a study of previous work conducted by all public agencies, private organizations, or foreign countries with respect to best practices for a key national indicator system. The study shall be submitted to the appropriate authorizing committees of Congress.

(2) GAO financial audit.—If an Institute is established under this section, the Comptroller General shall conduct an annual audit of the financial statements of the Institute, in accordance with generally accepted government auditing standards and submit a report on such audit to the Commission and the appropriate authorizing committees of Congress.

(3) GAO programmatic review.—The Comptroller General of the United States shall conduct programmatic assessments of the Institute established under this section as determined necessary by the Comptroller General and report the findings to the Commission and the appropriate authorizing committees of Congress.

(e) Authorization of Appropriations.—(1) In general.—There are authorized to be appropriated to carry out the purposes of this section $10,000,000 for fiscal year 2010, and $7,500,000 for each of fiscal years 2011 through 2013.

(2) Availability.—Amounts appropriated under paragraph (1) shall remain available until expended.

Subtitle H—General Provisions

SEC. 5701. REPORTS.

(a) Reports by Secretary of Health and Human Services.—On an annual basis, the Secretary of Health and Human Services shall submit to the appropriate Committees of Congress a report on the activities carried out under the amendments made by this title, and the effectiveness of such activities.

(b) Reports by Recipients of Funds.—The Secretary of Health and Human Services may require, as a condition of receiving funds under the amendments made by this title, that the entity receiving such award submit to such Secretary such reports as the Secretary may require, on activities carried out with such award, and the effectiveness of such activities.

Title VI—Transparency and Program Integrity

Subtitle A—Physician Ownership and Other Transparencies

SEC. 6001. LIMITATION ON MEDICARE EXCEPT.—The prohibition in subsection (i) of section 1877 of the Social Security Act (42 U.S.C. 1395m–2) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking “and” and inserting “; and”;

(B) in subparagraph (B), by striking the period at the end and inserting “; and”;

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

“(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D);”;

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking “and” and inserting “; and”;

(B) in subparagraph (C), by striking the period at the end and inserting “; and”;

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

“(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of enactment of this subparagraph.;” and

(3) by adding at the end the following new subsection:

“(d) Requirements for Hospitals to Qualify for Rural Provider and Hospital Exception to Ownership or Investment Prohibition.—

(1) Requirements described.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

(A) PROVIDER AGREEMENT.—The hospital had—

(i) physician ownership or investment on February 1, 2010; and

(ii) a provider agreement under section 1866 in effect on such date.

(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of enactment of this paragraph is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

(C) PROHIBITION AGAINST INTEREST OF OWNERS.—(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

(II) the nature and extent of all ownership and investment in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary.

(iii) The hospital does not condition any physician ownership or investment interest of the treating physician to the hospital or any other owner or investor the opportunity to directly provide loans or financing for any investment in the hospital by a physician owner or investor.

(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual, group, or organization, that is related to acquiring any ownership or investment interest in the hospital.

(v) Ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

(vi) The hospital does not direct, or indirectly, any guaranteed receipt of any amount under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

(E) Patient Safety.—

(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during the hours in which the hospital is providing services to such patient, before admitting the patient—

(I) the hospital discloses such fact to a patient; and

(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

(ii) The hospital has the capacity to—

(I) provide assessment and initial treatment for patients; and

(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

(F) Limitation on Application to Certain Converted Facilities.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

(G) Exception to Prohibition on Expansion of Facility Capacity.—

(i) Process.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) of this subsection on the public website of the Centers for Medicare & Medicaid Services.

(ii) Exception to Prohibition on Expansion of Facility Capacity.—The Secretary shall establish and implement a process under
which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

(2) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (1) shall provide individuals and entities in the community in which the applicable hospital applying for an exception with the opportunity to provide input with respect to the application.

(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (1) on August 1, 2011.

(iv) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (1).

(b) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

(c) PERMITTED INCREASE.—(1) IN GENERAL.—Subject to clause (1) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds for which the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the applicable hospital was licensed before the date on which the applicable hospital was licensed as of the date of enactment of this subsection.

(2) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (1) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, and beds’ means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date on which the applicable hospital was licensed as of the date of enactment of this subsection.

(iv) DELEGATION TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this paragraph may only occur in facilities on the main campus of the applicable hospital.

(E) APPLICABLE HOSPITAL.—In this paragraph, the term ‘applicable hospital’ means a hospital—

(1) that is located in a county in which the percentage increase in the population during the 5-year period ending on the date of the application under subparagraph (A) is at least 150 percent of the percentage increase in the population growth of the State in the county in which the hospital is located during that period, as estimated by Bureau of the Census;

(2) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

(3) that does not discriminate against beneficiaries of Federal health care programs by requiring or permitting physical examinations of patients in the hospital to discriminate against such beneficiaries;

(4) that is equal to or greater than the average per-capita occupancy rate in the State in which the hospital is located.

(F) PROCEDURE ROOMS.—In this subsection, the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

(G) PUBLICATION OF FINAL DECISIONS.—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

(iv) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1876, or otherwise of the process under this paragraph (including the establishment of such process).

(iv) COLLECTION OF OWNER- AND INVESTMENT INFORMATION.—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

(v) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection, the term ‘physician owner or investor’ means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

(vi) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital’s provider agreement if noncompliance with regulations implementing section 1866.

(b) ENFORCEMENT.—(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(8), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(b) ENFORCEMENT.—(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(8), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals. 12 CFR 1.12.13: Not later than November 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in subsection (i)(1) of section 1877 of the Social Security Act.

SEC. 6002. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

“Sec. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

“ Sec. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

(a) TRANSPARENCY REPORTS.—(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—(A) IN GENERAL.—On March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security or mutual fund, as described in section 1877(a)(1)), in the applicable manufacturer or applicable group purchasing organization during the preceding year:

1. The dollar amount invested by each physician holding such an ownership or investment interest;

2. The value and terms of each such ownership or investment interest.

(b) Special Rule for Certain Payments or Other Transfers of Value.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

(c) Time for Submission.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security or mutual fund, as described in section 1877(a)(1)), in the applicable manufacturer or applicable group purchasing organization during the preceding year:

1. The dollar amount invested by each physician holding such an ownership or investment interest;

2. The value and terms of each such ownership or investment interest.

(b) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

(c) Time for Submission.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security or mutual fund, as described in section 1877(a)(1)), in the applicable manufacturer or applicable group purchasing organization during the preceding year:

1. The dollar amount invested by each physician holding such an ownership or investment interest;

2. The value and terms of each such ownership or investment interest.

(b) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

(c) Time for Submission.—In addition to the requirement under paragraph (1)(A), on March 31, 2013, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security or mutual fund, as described in section 1877(a)(1)), in the applicable manufacturer or applicable group purchasing organization during the preceding year:

1. The dollar amount invested by each physician holding such an ownership or investment interest;

2. The value and terms of each such ownership or investment interest.
designated on behalf of a physician holding such an ownership or investment interest, including the information described in clauses (i) through (vii) of paragraph (1)(A), except that such clauses, `physician' shall be substituted for `covered recipient' each place it appears.

(D) Any other information regarding the ownership interest the Secretary determines appropriate.

(2) Known failure to report.

(A) In general.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, except to the extent that such failure results in a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A as imposed and collected under that section.

(B) Limitation.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

(3) Use of funds.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(4) Procedures for submission of information and public availability.—

(I) In general.—Not later than October 1, 2012, the Secretary shall establish procedures—

(A) Establishment.—Not later than October 1, 2012, the Secretary shall establish procedures—

(B) Definition of terms.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate for purposes of this section.

(C) Public availability.—Except as provided in subparagraph (E), the procedures established under subparagraph (A) shall ensure that such information is made available to the public on which the information is made available to the public under such subsection.

(D) Delayed publication for payments made pursuant to product research or development agreements and clinical investigations.—

(I) In general.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value described in subsection (c)(1)(E) on or after January 1, 2012, such information shall be provided to the public in a timely manner by the Secretary.

(II) Annual reports to Congress.—In the case of information submitted under subsection (a) during the preceding year, the Secretary shall prepare an annual report to Congress that describes the information submitted during such year, including any penalties imposed under such subsection.

(E) Use of funds.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(5) Consultation.—In establishing the procedures under paragraph (4), the Secretary shall consult with the General Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

(6) Annual reports and relation to state laws.—

(I) Annual report to Congress.—Not later than April 1 of each year beginning in 2013, the Secretary shall submit to Congress a report that includes the following:

(II) Relation to state laws.—

(A) In general.—In the case of a payment or other transfer of value described in subsection (a) during the preceding year, any state or political subdivision of a State that requires an applicable manufacturer to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value, the Secretary shall consult with the General Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such section is presented in the appropriate overall context.
“(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

“(iv) a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.”

“Nothing in subparagraph (A) shall be construed to limit the discovery or accessibility of information described in such subparagraph in a criminal, civil, or administrative proceeding associated with the application for, or payment of, a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.”

“(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means a manufacturer, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.”

“(3) COVERED DEVICE.—The term ‘covered device’ means a drug, biological product, device, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States, under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

“(4) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICALLY SUPPLIED.—The term ‘covered drug, device, biological, or medical supply’ means any drug, biological product, device, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States, under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

“(5) COVERED RECIPIENT.—The term ‘covered recipient’ means—

“(i) a patient;

“(ii) a teaching hospital;

“(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

“(7) EMPLOYEE.—The term ‘employee’ has the meaning given such term in section 1877(b)(2).

“(8) ORIGINALLY.—The term ‘originally’ has the meaning given such term in section 3729(b) of title 31, United States Code.

“(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICALLY SUPPLIED.—The term ‘manufacturer of a covered drug, device, biological, or medical supply’ means any entity which is engaged in the production, preparation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance, support to such entity with respect to the production, preparation, compounding, conversion, marketing, promotion, sale, distribution of a covered drug, device, biological, or medical supply).

“(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

“(A) IN GENERAL.—The term ‘payment or other transfer of value’ means a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is aware of the identity of the covered recipient.

“(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

“(i) A transfer of anything of value which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2009, the dollar amount specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

“(ii) Product samples that are not intended to be sold and are intended for patient use.

“(iii) Educational materials that directly benefit patients or are intended for patient use.

“(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

“(v) Items or services provided under a contractual agreement, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

“(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a physician, available only to provide services to medical professionals.

“(vii) Educational materials that directly benefit patients or are intended for patient use.

“(viii) Discounts (including rebates).

“(ix) In-kind items used for the provision of charity care.

“(x) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

“(A) in the case of a manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan;

“(B) in the case of a covered recipient who is a physician, a transfer of anything of value which is subject to subsection (b) of such section during that year, aggregated by—

“(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

“(B) any other category of information determined appropriate by the Secretary.

“Such requirements shall, in the case of an applicable manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

“(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

“(B) any other category of information determined appropriate by the Secretary.

“(C) Nothing in subparagraph (A) shall be construed to limit the discovery or accessibility of information described in such subparagraph in a criminal, civil, or administrative proceeding associated with the application for, or payment of, a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.”

“SEC. 6001. DISCLOSURE REQUIREMENTS FOR OFFICE ANCILLARY SERVICES EXAMINATIONS.”

“SEC. 6002. DISCLOSURE REQUIREMENTS FOR DRUG SAMPLES.”

“SEC. 6003. DISCLOSURE REQUIREMENTS FOR OFFICE ANCILLARY SERVICES EXAMINATIONS.”

“SEC. 6004. EXEMPTION FROM DISCLOSURE REQUIREMENTS FOR CERTAIN ILLIMIATING SERVICES.”

“SEC. 6005. PHARMACY BENEFIT MANAGERS.”

“SEC. 1150A. PHARMACY BENEFIT MANAGERS.”

“SEC. 1150B. PHARMACY BENEFIT MANAGERS.”
Title B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) In General.—Section 1121 of the Social Security Act (42 U.S.C. 1320a-3) is amended by adding at the end the following new subsection:

"(c) Required disclosure of ownership and additional disclosable parties information.—

"(1) Disclosure.—A facility shall have the information described in paragraph (2) available—

"(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 610(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

"(2) Information described.—

"(A) In general.—The following information is described in this paragraph:

"(i) the identity of and information on—

"(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

"(II) each person or entity who is an officer, director, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

"(III) each additional disclosable party of the facility.

"(B) Organizational structure.—The organizational structure of each additional disclosable party of the facility inaccuracy with respect to a facility, any person or entity who has an indirect or direct ownership or control interest, including such additional disclosable party to the facility and to one another.

"(C) Special Rule Where Information Is Already Disclosed.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may provide such Form or such information submitted to meet the requirements of paragraph (1).

"(C) Special Rule.—In applying subparagraph (A)(i)—

"(I) with respect to subsections (a) and (b), ownership or control interest shall be defined in the same manner as such provisions apply to a manufacturer with an agreement under that section.

"(II) subsection (a)(3) shall provide that the beneficiary of an agreement is the entity or entity that is the owner of a whole or part interest in any drug, device, or service, or the entity or entity that is the owner of such interest held by another entity.

"(III) subsection (b) shall provide that the risk, benefit, or the entity that is the owner of such interest, if it is equal to or exceeds 5 percent of the total property or assets of the entity.

"(3) Reporting.—

"(4) No Effect on Existing Reporting Requirements.—Nothing in this subsection shall reduce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

"(5) Definitions.—In this subsection:

"(A) Additional Disclosable Party.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

"(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

"(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

"(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

"(B) Facility.—The term 'facility' means a disclosing entity which is—

"(i) a hospital, a skilled nursing facility, or an intermediate care facility for the mentally retarded, a nursing facility (including, as applicable, what period of service of each such member; and

"(iii) each such person or entity.

"(C) Managing Employee.—The term 'managing employee' means, with respect to a facility an individual (including a general manager, business manager, administrator, director, or consultant) who, directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the Medicare or Medicaid program.

"(D) Organizational Structure.—The term 'organizational structure' means, in the case of—

"(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

"(ii) a limited liability company, the members of the limited liability company (including, as applicable, what percentage each member and manager has of the membership and management of the limited liability company, and the president or managing member of the limited liability company who have a membership and management interest in the limited liability company which is equal to or exceeds 5 percent; and

"(iii) a general partnership, the partners of the general partnership.

"(iv) a limited partnership, the general partner and any limited partner who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent; and

"(v) a limited liability partnership or limited liability corporation which is equal to or exceeds 10 percent.

"(B) Notice to the Secretary.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under this subsection.

"(C) Guidelines.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under this subsection.

"(D) Reporting.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, with respect to the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (1) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the best of the facility's knowledge, accurate and current.

"(2) The percentage of all prescriptions that were provided through retail pharmacies and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchant pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM for a contract year.

"(3) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

"(4) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchant pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM for a contract year.

"(5) Confidentiality.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

"(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

"(2) To permit the Comptroller General to review the information provided.

"(3) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

"(d) Penalties.—The provisions of section 1121(c) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section."
"(vii) any other person or entity, such informa-
tion as the Secretary determines ap-
propriate.".

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act (42 U.S.C. 1395I–3(d)(i)) are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—(1) In title X of the Social Security Act, (42 U.S.C. 1301 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128H the following new section:

"SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1310 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1128H the following new section:

"SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES.

(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

(1) a skilled nursing facility (as defined in section 1819(a)); or

(2) a nursing facility (as defined in section 1919(a)).

(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

(REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

(A) The organization must have established compliance standards and procedures to formally identify and address actual or potential violations of law, regulation, and industry standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act and in promoting quality of care; and

(B) includes at least the required components specified in paragraph (4).

(4) REQUIRED COMPONENTS OF PROGRAM.—

The required components of a compliance and ethics program of an operating organization are the following:

(A) The organization must have established compliance standards and procedures to formally identify and address actual or potential violations of law, regulation, and industry standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act.

(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

(C) The organization must have used due care not to provide discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization for which federal action is appropriate.

(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

(H) The organization must periodically undertake reassessment of its compliance program and substance necessary to reflect changes within the organization and its facilities.

(1) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—

(I) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit nursing homes.

(II) Standards.—The Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide for the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (1), a facility shall submit to the Secretary a plan for the facility to meet such standards and implement the results of the assessment. The Secretary shall have the authority to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1861(m)(1) and 1861(v)(1)(B), as applicable.

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.

SEC. 6102. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1128I of the Social Security Act (42 U.S.C. 1395I–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

"(1) NURSING HOME COMPARE WEBSITE.

"(a) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for a comparison of nursing homes on the official Internet website of the Federal Government for Medicare bene-

(b) EFFECTIVE DATE.—The amendments made by this section take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

"(c) NURSING HOME COMPARE MEDICARE DATABASE.

"(1) IN GENERAL.—The Secretary shall conduct a plan to develop, maintain, and disseminate a nursing home compare Medicare database (or a successor database) that shall include—

"(I) concise explanations of how to interpret the data (such as a plain English ex-

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation of which appropriate staffing levels vary based on patient case mix.

(2) LINKS TO STATE INTERNET WEBSITES.—The Secretary shall maintain a website (or a successor website) the following information in a manner that is updated, on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

(1) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1123(g), including information on staffing mix, average caseload, that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and quality of care; and

(IV) an explanation of which appropriate staffing levels vary based on patient case mix.

(3) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAMS.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit nursing homes.

(2) STANDARDS.—The Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide for the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (1), a facility shall submit to the Secretary a plan for the facility to meet such standards and implement the results of the assessment. The Secretary shall have the authority to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1861(m)(1) and 1861(v)(1)(B), as applicable.

SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1128I of the Social Security Act (42 U.S.C. 1395I–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

"(1) NURSING HOME COMPARE WEBSITE.

"(a) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for a comparison of nursing homes on the official Internet website of the Federal Government for Medicare bene-

(2) EFFECTIVE DATE.—The amendments made by this section take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

"(c) NURSING HOME COMPARE MEDICARE DATABASE.

"(1) IN GENERAL.—The Secretary shall conduct a plan to develop, maintain, and disseminate a nursing home compare Medicare database (or a successor database) that shall include—
Congressional Record - Senate

November 19, 2009

S11768

“(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside the facility;

(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual conduct, or other violations or crimes that resulted in serious bodily injury; and

(iii) the number of civil monetary penalties assessed against the facility, employees, contractors, and other agents.

(B) DEADLINE FOR PROVIDING INFORMATION.—

(I) In general.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection;

(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than the date on which the requirements under section 1128(g) are implemented.

(2) REVIEW AND MODIFICATION OF WEBSITE.—

(A) IN GENERAL.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the date before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revise the website in accordance with the review conducted under clause (i).

(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) any other representatives of programs or groups the Secretary determines appropriate.

(3) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end the following new subparagraph:

"(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under section (i) and provided on the Nursing Home Compare Medicare website under subsection (j), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly."

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r(f)) is amended by adding at the end the following new paragraph:

"(8) SPECIAL FOCUS FACILITY PROGRAM.—

"(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of such facility in the program not less than once every 6 months.

(C) NURSING FACILITIES.—

(I) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (j) the following new subsection:

"(i) NURSING HOME COMPARE WEBSITE.—

(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, reliably understandable to consumers of long-term care services, and searchable:

(I) staffing data for each facility (including resident data and data on the average hours of care provided per resident per day) based on data submitted under section 1128(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities in the State and national averages for the facilities. Such format shall include:

(I) concise explanations of how to interpret the data (such as plain English explanations of data reflecting ‘nursing home staff hours per resident day’);

(II) differences in types of staff (such as training associated with different categories of staff);

(III) the relationship between nurse staffing levels and outcomes; and

(IV) an explanation that appropriate staffing levels vary based on patient case mix.

(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report. Any such links shall be in the form of a direct hyperlink to the website of the State;

(iii) the standardized complaint form developed under section 1128(f), including explanatory material on what complaint forms are, how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

(iv) Information on the number, type, severity, and outcome of substantiated complaints.

(III) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

(I) that were committed inside of the facility; and

(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elderly person.

(B) DEADLINE FOR PROVIDING INFORMATION.—

(i) In general.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than the date on which the requirements under section 1128(g) are implemented.

(ii) EXCEPTION.—The Secretary shall ensure that the information described in paragraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128(g) are implemented.

(4) REVIEW AND MODIFICATION OF WEBSITE.—

(A) IN GENERAL.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the date before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(i) State long-term care ombudsman programs;

(ii) consumer advocacy groups;

(iii) provider stakeholder groups; and

(iv) skilled nursing facility employees and their representatives; and

(v) any other representatives of programs or groups the Secretary determines appropriate.

(5) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under section (i), each State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website under subsection (i), such State shall submit information respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.
SEC. 6101. STANDARDIZED COMPLAINT FORM.

(a) In general.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staffing (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

(b) Effective date.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6102. ENSURING STAFFING ACCOUNTABILITY.

(a) In general.—The Secretary shall develop a standardized complaint form to be used by a resident or a person acting on the resident’s behalf in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

(b) Complainant information.—The State shall require that the complaint form include the following information:

(1) the facility name and address;

(2) the names and contact information of the complainant or the person acting on the resident’s behalf;

(3) the nature of the complaint.

SEC. 6103. EFFORTS TO IMPROVE STAFFING.

(a) In general.—The Secretary shall ensure that States implement efforts to improve staffing for skilled nursing facilities and nursing facilities.

(b) Reporting efforts.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall disseminate information regarding efforts to improve staffing for skilled nursing facilities and nursing facilities.

SEC. 6104. REPORTING OF EXPENDITURES.

(a) Requirement.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended by adding after such paragraph the following new paragraph:

“(h) Reporting of direct care expenditures.—

“(1) In general.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staffing (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

“(2) Modification of form.—The Secretary may specify under the procedures established by the Secretary in consultation with private sector advocates, organizations representing the interests of long-term care facilities, and the quality of care provided by individuals or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

“(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

“(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

“(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

“(3) Rule of construction.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident’s behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).”

(b) Effective date.—The amendment made by this subsection shall take effect 1 year after the date of the enactment of this Act.

SEC. 6106. SHARING ACCOUNTABILITY INFORMATION ON NURSING FACILITIES.

(a) In general.—The Secretary shall ensure that States disseminate information on nursing facilities to the public.

(b) Reporting efforts.—The Secretary shall ensure that States disseminate information on nursing facilities to the public.

SEC. 6107. SEXUAL ASSAULT ON RESIDENTS.

(a) In general.—The Secretary shall ensure that States disseminate information to residents and their representatives about sexual assault on residents.

(b) Reporting efforts.—The Secretary shall ensure that States disseminate information to residents and their representatives about sexual assault on residents.

SEC. 6108. REPORTING OF EXPENDITURES.

(a) Requirement.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended by adding after such paragraph the following new paragraph:

“(h) Reporting of direct care expenditures.—

“(1) In general.—For cost reports submitted under this title for cost reporting periods beginning on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staffing (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff.

“(2) Modification of form.—The Secretary may specify under the procedures established by the Secretary in consultation with private sector advocates, organizations representing the interests of long-term care facilities, and the quality of care provided by individuals or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

“(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

“(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

“(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

“(3) Rule of construction.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident’s behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).”

(b) Effective date.—The amendment made by this subsection shall take effect 1 year after the date of the enactment of this Act.
‘(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories such as nursing staff, before other categories of certified employees.

Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.”

§ 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM

(a) Study.—The Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;
(2) any problems associated with such system or its implementation; and
(3) how such system could be improved.

(b) Report.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

§ 6111. CIVIL MONEY PENALTIES

(a) Skilled Nursing Facilities.—

(1) In General.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(b)(2)(B)(ii)) is amended—

(A) by striking “Penalties.”—The Secretary and inserting “Penalties.”; and

(B) in the case where the facility successfully appeals the penalty, may provide for the return of amounts collected (plus interest) to the facility; and

(2) In General.—Subject to clause (ii), the Secretary; and

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

(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause, the Secretary shall—

(A) determine the amount of such deficiency;

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

(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (III) and (IV), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause, the Secretary shall—

(A) by striking “Penalties.”—The Secretary and inserting “Penalties.”;

(B) in the case where the facility successfully appeals the penalty, may provide for the return of amounts collected (plus interest) to the facility; and

(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

(aa) Repeal Deficiencies.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain Other Deficiencies.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to create a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(iv) Collection of Civil Money Penalties.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept separate from information on employee staffing.

§ 6112. NATIONAL INDEPENDENT MONITOR DEMONSTRATION PROJECT

(a) Establishment.—

(1) In General.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct a demonstration project to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) Selection.—The Secretary shall select chains of skilled nursing facilities and nursing facilities that—

(A) provide services approved by the Secretary (including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (includin—

§ 6113. IMPLEMENTATION

(a) Establishment.—The Secretary shall implement the demonstration project under this section for a 2-year period.

(b) Requirements.—The Secretary shall evaluate chains selected to participate in the demonstration project, based on criteria selected by the Secretary, including where evidence suggests that a
number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities involved in the "Focus Facility" program (or a successor program) or multiple facilities with a record of repeat serious safety and quality care deficiencies.

(c) **Responsibilities.**—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to reviews, analyses, and oversight to the chain, the Secretary, and the State or States; and

(5) publish the results of such reviews, analyses, and oversight.

**d. Implementation of Recommendations.**—

(1) **Receipt of Finding by Chain.**—Not later than 10 days after receipt of a finding that is consistent with subsection (c)(4), a chain participating in the demonstration project shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) **Receipt of Report by Independent Monitor.**—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State or States, containing such final recommendations.

(e) **Cost of Appointment.**—A chain shall be responsible for the appointment of the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion of the Secretary for an amount and in accordance with procedures established by the Secretary.

(f) **Waiver Authority.**—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the Secretary to carry out the demonstration project under this section.

(g) **Authorization of Appropriations.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) **Definitions.**—In this section:

(1) **Responsive Party.**—The term "responsive party" has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) **Facility.**—The term "facility" means a skilled nursing facility or a nursing facility.

(3) **Nursing Facility.**—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) **Secretary.**—The term "Secretary" means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) **Skilled Nursing Facility.**—The term "skilled nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(i) **Evaluation and Report.**—

(1) **Evaluation.**—In consultation with the Inspector General of the Department of Health and Human Services, the Secretary shall perform an evaluation of the demonstration project conducted under this section.

(2) **Report.**—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis; and

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(c) **Cost of Appropriation.**—A chain shall—

(1) submit to the Secretary, the State or States, and the Secretary to participate in the conduct of the demonstration project under this section.

(2) I **Forming Amendments.**—Section 1128I(b)(3) of the Social Security Act (42 U.S.C. 1395l-3(h)(3)) is amended by—

(1) in the first sentence, by striking "the Secretary shall terminate'' and inserting "the Secretary shall terminate''; and

(2) in the second sentence, by striking "subsection (c)(2)'' and inserting "subsection (c)(2)'' and section 1128I(h).''.

(ii) **Effective Date.**—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

**SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.**

(a) **In General.**—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and adopt best practices in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) **Conduct of Demonstration Projects.**—

(1) **Grant Award.**—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 or more grants.

(2) **Consideration of Special Needs of Residents.**—Each demonstration project conducted under this section shall take into consideration the needs of the residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(3) **Duration and Implementation.**—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(4) **Implementation.**—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

**SEC. 6115. DEFINITIONS.**

(1) **Nursing Facility.**—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) **Secretary.**—The term "Secretary" means the Secretary of Health and Human Services.

(3) **Skilled Nursing Facility.**—The term "skilled nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) **Authority of Appropriations.**—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(5) **Report.**—Not later than 9 months after the completion of the demonstration project,
the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 6211. DEMENTIA AND ABUSE PREVENTION TRAINING

(a) SKILLING LONG-Term FACILITIES.—

In general.—Section 1819(b)(2)(A)(1)(i) of the Social Security Act (42 U.S.C. 1395i–3(b)(2)(A)(1)(i)) is amended by inserting "(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training)" before "(I)".

(b) NURSING FACILITIES.—

In general.—Section 1919(b)(2)(A)(1)(i) of the Social Security Act (42 U.S.C. 1395i–3(b)(2)(A)(1)(i)) is amended by inserting "(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training)" before "(I)".

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence: "Such term includes an individual who provides such services through an agency or under a contract with the facility."

(b) NURSING FACILITIES.—

In general.—Section 1919(b)(2)(A)(1)(i) of the Social Security Act (42 U.S.C. 1395i–3(b)(2)(A)(1)(i)) is amended by inserting "(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training)" before "(I)".

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence: "Such term includes an individual who provides such services through an agency or under a contract with the facility."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of enactment of this Act.

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

SEC. 6201. NATIONALWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a program to identify efficient, effective, and economically viable long-term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the "nationwide program"). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act (42 U.S.C. 1395w–23) (including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsection (b)(3)(A) and (b)(6), respectively, of such section 307):

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307; and

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement under paragraphs (c)(1) and (c)(2) of such section 307; but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a)(1) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement under paragraphs (c)(1) and (c)(2) of such section 307; but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a)(1) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain an original copy of a complete set of the prospective employee's fingerprints from a Federal agency containing such information and, if the Secretary determines appropriate, utilizing a search of State and Federal criminal history records, including a fingerprint check of such record;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of "rap back" capability such that, if a direct patient access employee of a long-term care facility or provider utilizing a search of State and Federal criminal history records, including a fingerprint check of such record;

(C) require that criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(D) immediately reporting to the long-term care facility or provider that requested the fingerprint check the results of such review; and

(E) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1125 of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section.

(v) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vi) appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (3) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, pending completion of the required criminal history background check and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (as defined in the regulations established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision); provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employee who have disputes regarding such information, which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevant information about the employee with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such record;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the background check the results of such review; and

(iv) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1125 of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section.

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to the State in carrying out the nationwide program, that the State will make available (directly
or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (i).

(ii) Federal Match.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—Applying part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to costs incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (i).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for a relevant crime or a finding of patient or resident abuse.

(B) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395xw(d)(1)(B)(iv)) or any other entity or provider of long-term care services under such titles as the participating State determines appropriate.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395xw(d)(1)(B)(iv)) or any Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect (including deprivation of patient or resident property; or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ‘direct patient access employee’ means any person who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ‘long-term care facility or provider’ means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1919(a) of the Social Security Act (42 U.S.C. 1395f-3(a))).

(ii) A home health agency (as defined in section 1919(a) of such Act (42 U.S.C. 1395n(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(j)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 106(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing requirements, background checks for direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(iii) A study of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(iv) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(B) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Treasury Secretary of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $500,000 of the amount transferred under paragraph (1) to provide for the conduct of the evaluation under section (a)(7)(A).
A19NO6.083

S11774

ommended by the methodology committee
clinical trials, molecularly informed trials,
quent to the date of the enactment of this
cluding original research conducted subse-
paragraph (9) using methods, including the
research project agenda established
medical treatments, services, and items de-
dissemination of research findings with re-
variations in patient subpopulations, and the
search and evidence synthesis that considers
appropriately be prevented, diagnosed, treat-
tent in which diseases, disorders, and other
health conditions can effectively and appropri-
ately be prevented, diagnosed, treated, and
aged through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to health outcomes, effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

(d) Duties of the Institute.

(1) Identifying Research Priorities and Establishing Research Project Agenda.—

(A) Identifying Research Priorities.—The Institute shall identify national priorities for research, taking into account factors of disease incidence, prevalence, and burden in the United States (with emphasis on chronic conditions), gaps in evidence in terms of outcomes, practice variations and health disparities in terms of delivery and outcomes of care, the potential for new or improved practices, well-being, and the quality of care, the effect on national expenditures associated with a health care treatment, strategy, or health condition, and priorities in the National Health Care Quality Agenda established under section 399H of the Public Health Service Act that are consistent with this section.

(B) Establishing Research Project Agenda.—The Institute shall carry out a research project agenda for research to address the priorities identified under subparagraph (A), taking into consideration the types of research that might address each priority and the relative value (determined based on the cost of conducting research compared to the potential usefulness by the public) of the research associated with the different types of research, and such other factors as the Institute determines appropriate.

(2) Carrying Out Research Project Agenda.—

(A) Research.—The Institute shall carry out the research project agenda established under this section in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

(i) Systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

(iii) Other methodologies recommended by the methodology committee established under paragraph (6) that are adopted by the Board under paragraph (9).

(B) Management of Funding and Conduct of Research.—

(1) In General.—In accordance with the research project agenda established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with paragraph (4).

(aa) Appropriate agencies and instrumentalities of the Federal Government.

(bb) Appropriate academic research, private sector research, or study-conducting entities.

(2) Preference.—In entering into contracts, the Institute shall give preference to the Agency for Healthcare Research and Quality and the National Institutes of Health, but only if the research to be conducted or managed under such contract is authorized by the governing statutes of such Agency or Institutes.

(3) Conditions for Contracts.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

(I) abide by the transparency and conflicts of interest requirements of subsection (b) that apply to the Institute with respect to the research managed or conducted under such contract;

(II) comply with the methodological standards adopted under paragraph (9) with respect to such research;

(III) consult with the expert advisory panels for clinical trials and rare disease pointed under clauses (ii) and (iii), respectively, of paragraph (4)(A);

(iv) Subject to clause (iv), permit a researcher who conducts original research under paragraph (5) to use data, including applicable control data, that is needed to carry out the research.

(v) Have appropriate processes in place to manage data privacy and meet ethical standards for the research;

(vi) Comply with the requirements of the Institute for making the information available to the public under paragraph (8); and

(vii) Comply with other terms and conditions determined necessary by the Institute to carry out the research agenda adopted under paragraph (2).

(4) Coverage of Copayments or Coinurance.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the validity of a research project, such as in the case where the research project must be blinded.

(5) Inclusion of Appropriate Representation of Populations.—Any research published under clause (1)(IV) shall be within the bounds of and entirely consistent with the evidence and methodology of the contract with the Institute under this subparagraph. If the Institute determines that those requirements are not met, the Institute shall not consider the results of the contract published in the Institute, instrumentality, or entity which managed or conducted such research for a period determined appropriate by the Institute (but not more than 5 years).

(6) Review and Update of Evidence.—The Institute shall review and update evidence on a periodic basis as appropriate.

(7) Taking Into Account Potential Differences.—Research shall be designed, as appropriate, to take into account the potential differences in the effectiveness of health care services, items, and services as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different characteristics, molecular subtypes, or quality of life preferences and include members of such subpopulations as subjects in the research as feasible and appropriate.

(8) Differences in Treatment Modalities.—Research shall be designed, as appropriate, to take into account different characteristics of interventions that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

(9) Data Collection.—

(A) In General.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data collected under section 937(f) of the Public Health Service Act, as the Institute and its contractors may require to carry out this section. The Institute shall also require access from Federal, State, or private entities, including data from clinical databases and registries.

(B) Use of Data.—The Institute shall only use data provided under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy regulations.

(4) Appointing Expert Advisory Panels.—

(A) Appointment.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

(B) Expert Advisory Panels for Clinical Trials.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A)(i). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including important patient subgroups and other parameters of the research. Such panels shall be used as a resource for technical questions that may arise during the conduct of such research.

(5) Expert Advisory Panel for Rare Disease.—In the case of a research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of the research study and determining the relative value and feasibility of conducting the research study.

(6) Composition.—An expert advisory panel appointed under subparagraph (A) shall include representatives of research clinicians, patients, and experts in scientific and health services research, health services delivery, and evidence-based medicine who have expertise in the relevant topic, and as appropriate, experts in integrative health and primary prevention strategies. The Institute may include a technical expert of each manufacturer or each medical technology that is included under the relevant topic, project, or category for which the panel is established.

(7) Supporting Patient and Consumer Representatives.—The Institute shall provide support and resources to help patient and consumer representatives effectively participate on the Board and expert advisory panels appointed by the Institute under paragraph (4).

(6) Establishing Methodology Committee.—

(A) In General.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

(B) Appointment and Composition.—The methodology committee established under subparagraph (A) shall be composed of not more than 15 members appointed by the Secretary, including at least 5 members appointed by the Secretary who are representatives of private sector research entities. Members appointed to the methodology committee shall be experts in their scientific
field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise and from academic institutions, governmental entities with relevant expertise, and nonprofit or other private and governmental entities with relevant expertise shall be appointed to the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health and the Board, the National Academy of Medicine, the Institute of Medicine of the National Academies and academic, nonprofit, or other private and governmental entities with relevant expertise shall provide opportunities for public comment. Such standards shall include methods by which patient subpopulations can be accessed for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodological standards for defined categories of health interventions and for each of the major categories of comparative clinical effectiveness research methods (determined as of the date of enactment of the Patient Protection and Affordable Care Act).

(i) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are likely to address each specific research question.

(ii) The methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research and shall develop and update the methodology committee's performance of the functions described in subparagraph (C), and reports shall contain recommendations for the Institute to adopt methodological standards developed and updated by the methodology committee as well as other actions deemed necessary to comply with such methodological standards.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

(A) IN GENERAL.—The Institute shall ensure that the processes for peer review of primary research described in subparagraph (A) of paragraph (2) that is conducted under such paragraph. Under such process—

(B) COMPOSITION.—Such peer-review processes shall be designed in a manner so as to ensure that expert advisory panels of the Board shall include the Institute to determine research methods and a Board of Governors, which shall consist of the following members:—

(C) TERMS; VACANCIES.—A member of the Board shall serve as Chairperson or Vice Chairperson of the Board from among the following members:

(1) 3 members representing patients and health care consumers.

(2) 3 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

(3) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 2 members shall represent employers who self-insure employee benefits.

(4) 3 members representing pharmaceutical, device, and diagnostic manufacturer and developers.

(5) 1 member representing quality improvement or independent health service researchers.

(6) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

(A) IN GENERAL.—The Institute shall ensure that the processes for peer review of primary research described in subparagraph (A) of paragraph (2) that is conducted under such paragraph. Under such process—

(B) COMPOSITION.—Such peer-review processes shall be designed in a manner so as to ensure that expert advisory panels of the Board shall include the Institute to determine research methods and a Board of Governors, which shall consist of the following members:—

(C) TERMS; VACANCIES.—A member of the Board shall serve as Chairperson or Vice Chairperson of the Board from among the following members:

(1) 3 members representing patients and health care consumers.

(2) 3 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

(3) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 2 members shall represent employers who self-insure employee benefits.

(4) 3 members representing pharmaceutical, device, and diagnostic manufacturer and developers.

(5) 1 member representing quality improvement or independent health service researchers.

(6) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

(A) IN GENERAL.—The Institute shall ensure that the processes for peer review of primary research described in subparagraph (A) of paragraph (2) that is conducted under such paragraph. Under such process—

(B) COMPOSITION.—Such peer-review processes shall be designed in a manner so as to ensure that expert advisory panels of the Board shall include the Institute to determine research methods and a Board of Governors, which shall consist of the following members:—

(C) TERMS; VACANCIES.—A member of the Board shall serve as Chairperson or Vice Chairperson of the Board from among the following members:

(1) 3 members representing patients and health care consumers.

(2) 3 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

(3) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 2 members shall represent employers who self-insure employee benefits.

(4) 3 members representing pharmaceutical, device, and diagnostic manufacturer and developers.

(5) 1 member representing quality improvement or independent health service researchers.

(6) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—
such sources of funding should be continued

whether the activities conducted under section 937 of the
Public Health Service Act, including a determination as to whether, based on the utilization and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.

Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization and disparities in health care, and the effect of the research conducted and disseminated on innovation and the health care economy of the United States.
to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation."

(c) The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors to improve information technology focused on clinical decision support, private professional associations, and Federal and private health plans about the value of the information disseminated and the assistance provided under this section.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from making grants and findings publically available as required under section 1181(d)(8) of the Social Security Act.

(2) Building Data for Research.—The Agency for Health Care Research and Quality, in consultation with the National Institutes of Health, shall build capacity for comparative clinical effectiveness research by establishing a grant program that provides for the training of researchers in the methods used to conduct such research, including systematic reviews of existing research and primary research such as clinical trials. At a minimum, such training shall be in methods that meet the methodological standards adopted under section 1181(d)(9) of the Social Security Act.

(i) Building Data for Research.—The Agency shall provide for the coordination of research data networks, in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

(g) Authority to Contract With the Institution.—Agencies of the Federal Government may enter into agreements with the Institute, and accept and retain funds, for the conduct and support of research described in this part, provided that the research to be conducted or supported under such agreements is authorized under the governing statutes of such agencies and is necessary.

(h) Limitations on Certain Uses of Comparative Clinical Effectiveness Research

Sec. 1182. (a) The Secretary may only use evidence and findings from research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which includes public comment and considers the effect on subpopulations.

(b) Nothing in section 1181 shall be construed to—

(1) supercede or modify the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1882(a)(1); or

(2) authorize the Secretary to deny coverage of items or services under title XVIII solely on the basis of comparative clinical effectiveness research.

(c)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research conducted under section 1181 to determine coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual's age, disability, or terminal illness.

(2) In the case of an individual whose life is younger, non-life, or enrolled under part B, of title XVIII during such fiscal year beginning after September 30, 2017, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, enrolled under part B, of title XVIII during such fiscal year, multiplied by the average number of individuals entitled to benefits under part A, enrolled under part B, of title XVIII during such fiscal year.
PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1811(b) of the Social Security Act for carrying out part D of title XI of the Social Security Act (as in effect on the date of enactment of such Act).

"(2) TRANSFER OF FUNDS.—"(A) by law—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each fiscal year for the years ending in 2010 and 2011 through to the Secretary of Health and Human Services to carry out subsection 937 of the Public Health Service Act.

"(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

"(C) IN GENERAL.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

"(1) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other office designated by the Agency for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

"(2) 20 percent to the Secretary to carry out—

"(i) the activities described in section 937 of the Public Health Service Act; and

"(ii) the activities described in subsection 4376.

"(D) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

"Sec. 9511. Patient-centered outcomes research.—

"Sec. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for any fiscal year ending after September 30, 2012, there is hereby imposed a fee equal to $2 per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

"(b) LIABILITY FOR FEE.—

"(1) IN GENERAL.—The fee imposed by this subsection shall be paid by the plan sponsor.

"(2) PLAN SPOKESPEOPLE.—The purposes of paragraph (1) the term ‘plan sponsor’ means—

"(A) the employer in the case of a plan established or maintained by a single employer;

"(B) the employee organization in the case of a plan established or maintained by an employee organization;

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations;

"(ii) a multiple employer welfare arrangement,

"(iii) a voluntary employees’ beneficiary association; or

"(E) SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘self-insured health plan’ means an insurance policy or other arrangement by which amounts or premiums are received as consideration for any person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

"(F) SELF-INSURED HEALTH PLAN.—For purposes of this subsection, the term ‘self-insured health plan’ means any policy or arrangement described in paragraph (B), (C), or (E) of section 1181(b) of the Social Security Act for purposes of sections 1181(b) of the Social Security Act for purposes of part D of title XI of the Social Security Act for purposes of part D of title XI of the Social Security Act.
(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).  

(c) TREATMENT AS TAX.—For purposes of paragraph (1) of section 501(d) of the Internal Revenue Code of 1986, all amounts collected under this subchapter shall be considered to be taxes imposed under this chapter.  

(d) No COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be considered to be in possession of any officer of the United States.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES"

"SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS"

"SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS"

"Subchapter A—Policies Issued by Foreign Insurers"

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES"

(iii) Tax-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

Subsection 501(i) of the Internal Revenue Code of 1986 is amended by adding at the end of such subsection the following new paragraph:

"(v) New PROVIDERS OF SERVICES AND SUPPLIERS.—The Secretary shall determine the level of screening appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, which may include:

(I) fingerprinting;

(II) a background check; and

(III) information on current and past Medicare or Medicaid enrollment.

(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.

SEC. 6302. FEDERAL COORDINATING COUNCIL FOR COMPARITIVE EFFECTIVENESS RESEARCH.

Notwithstanding any other provision of law, the Federal Coordinating Council for Comparative Effectiveness Research established under section 802 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b-8), including the requirement under subsection (a)(2) of such section, shall terminate on the date of enactment of this Act.

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

SEC. 6401. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) MEDICARE.—Section 1868(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following:

"(v) Other PROVIDERS.—A provider of medical or other items or services or supplier who submits an application for enrollment or re-enrollment of a program under this title, title XIX, or title XXI as of such date of enrollment, or who is enrolled in the program under this title, title XIX, or title XXI as of such date of enrollment, shall provide the Secretary with any financial information requested by the Secretary, in accordance with paragraph (5), and the Secretary may adjust payments to the applicable program under this title, title XIX, or title XXI on or after the date that is 1 year after such date of enrollment.

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

"(2) PROVIDER SCREENING.—

(A) PROCEDURE.—Not later than 180 days after the date of enactment of this paragraph and in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted for providers of medical or other items or services and suppliers under the program under this title, the Medicare program under title XIX, and the CHIP program under title XXI.

(B) LEVEL OF SCREENING.—The Secretary shall establish the level of screening consistent with the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

(i) shall include a screening check, which may include such checks across States; and

(ii) may require such an appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, which may include:

(I) fingerprints;

(II) a background check; and

(III) information on current and past Medicare or Medicaid enrollment.

(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.

(c) APPLICABILITY.—

(1) INDIVIDUAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a hospital or a skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(i) for 2010, $200; and

(ii) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(2) PROVIDER SCREENING.—

(A) IN GENERAL.—Notwithstanding any provision of this title, in the case of an applicable provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enrollment, the Secretary may adjust payments to the applicable program under this title, title XIX, or title XXI on or after the date that is 2 years after such date of enrollment.

(III) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after the date of enactment of this paragraph and in accordance with paragraph (2), the Secretary may promulgate an interim final rule to carry out this paragraph.

(4) EXPIRED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

(d) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

(4) INCREASED DISCLOSURE REQUIREMENTS.—

(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or re-enrollment of a program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner as determined by the Secretary) any current or previous affiliation with a Federal health care program (as defined in section 1128B(f)), has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges revoked, in the enrollment form for the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner as determined by the Secretary) any current or previous affiliation with a Federal health care program, any current or previous suspension under a Federal health care program, or any current or previous exclusion from participation under a Federal health care program, in the enrollment form for the program under this title, title XIX, or title XXI as of such date of enrollment, or who is enrolled in the program under this title, title XIX, or title XXI as of such date of enrollment, shall provide the Secretary with any financial information requested by the Secretary, in accordance with paragraph (5), and the Secretary may adjust payments to the applicable program under this title, title XIX, or title XXI.

(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(5) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.

(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of medical or other items or services or supplier, the Secretary may make any necessary adjustments to payments to the provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enrollment, or who is enrolled in the program under this title, title XIX, or title XXI on or after the date that is 2 years after such date of enrollment.

(B) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.
past due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

(B) DEFINITIONS.—In this paragraph:

(1) the term ‘provider or supplier’ means a provider of services or supplier that has the same taxpayer identification number as assigned to the obligated provider of services or supplier under section 1396g of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable services or supplier is assigned a different billing number or national provider identification number under the program where title than is assigned to the obligated provider of services or supplier.

(2) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term ‘obligated provider of services or supplier’ means a provider of services or supplier that owes a past due obligation under the program under this title.

(3) Moratorium is necessary to prevent or comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or, otherwise, temporary moratorium imposed under subparagraph (A).

(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall establish core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(D) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(E) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

(F) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry sector or category.

(G) COMPLIANCE PROGRAMS.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry sector or category.

(H) Reporting of adverse provider actions through the Integrated Data Repository.—The Secretary shall establish, within 90 days after the date of enactment of this Act, a national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary through a collaborative effort of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

(I) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—(A) All ordering or referring physicians or other professionals to be enrolled under the program shall be enrolled as a participating provider; and

(B) The Secretary shall establish a national identifier for any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.

(II) OTHER STATE OVERTSIGHT.—Nothing in this section shall preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.

(II) DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATISTICAL AGENTS.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agencies with responsibility for administering a Medicare, or Medicaid plan or a national statistical agency, and other identifying information for any provider or medical or other items or services or supplier under the Medicare program or the Medicaid program under title XXI or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare program on the date of enactment of this Act, within 90 days of such date).

(III) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a), as amended by inserting before the semicolon at the end the following: ’’or by a provider or supplier to whom a moratorium under subsection (ii)(4) is applied during the period of such moratorium’’.

(IV) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2101(d), is amended—

(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (N) respectively; and

(2) by inserting after subparagraph (C), the following:

(D) Subsections (a)(7) and (ii) of section 1902 relating to provider and supplier screening, oversights, and reporting requirements.

SEC. 6402. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) DATA MATCHING.—

(1) INTEGRATED DATA Repository.—

(A) INCLUSION OF CERTAIN DATA.—

(B) DATA SHARING AND MATCHING.—

(C) TIMELINE FOR IMPLEMENTATION.—

(D) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraphs (E) through (M) as subparagraphs (E) through (N) respectively; and

(ii) by inserting after subparagraph (C), the following:

(1) the programs under titles XVIII and XIX, excluding parts A, B, C, and D of title XVIII,

(II) the program under title XXI,

(III) Health-related programs administered by the Secretary of Veterans Affairs,

(IV) Health-related programs administered by the Secretary of Defense,

(V) The program of oil-age, survivors, and dependents’ uncertainty insurance benefits established under title II,

(VI) The Indian Health Service and the Contract Health Service program,

(VII) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority.

(VIII) DATA SHARING AND MATCHING.—In general, the Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system with the data of such individuals with data in the system of records of the Department of Health and Human Services through the Integrated Data Repository as appropriate.
(2) DATA MATCHING.—Section 522(a)(8)(B) of title 5, United States Code, is amended—
(A) in clause (vii), by striking “or” at the end,
(B) in clause (viii), by inserting “or” after the semicolon; and
(C) by adding at the end the following new clause:
(2) MATCHES PERMITTED.—(A) The matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse including matches of a system of records with non-Federal records; and
(B) the matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services shall be reported and returned under paragraph (1) by the end of—
(1) the date which is 60 days after the date on which the overpayment was identified; or
(2) the date any corresponding cost report is due.
(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(2)(C) of title 31, United States Code) for purposes of section 3729 of such title.
(4) DISPOSITIONS.—In this subsection—
(A) KNOWING AND KNOWNLY.—The terms “knowing” and “knowingly” have the meaning given those terms in section 3729(b)(2) of title 31, United States Code.
(B) OVERPAYMENT.—The term “overpayment” means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.
(C) PERSON.—
(1) IN GENERAL.—The term “person” means a provider of services, supplier, Medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1933(a)(1)), or PDP sponsor (as defined in section 1860D–4(a)(13)).
(2) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term ‘system of records’ has the meaning given such term in section 552(a)(5) of title 5, United States Code.
(D) REPORTING AND RETURNING OF OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the Secretary or such Inspector General for the purpose of matching data in the system of records of the Secretary with the system of records of the Department of Health and Human Services; and
(1) enter into an agreement with the Secretary or such Inspector General for the purposes of matching data in the system of records of the Secretary with the system of records of the Department of Health and Human Services; and
(2) OIG AUTHORITY TO OBTAIN INFORMATION.—
(A) KNOWING AND KNOWINGLY.—The terms “knowing” and “knowingly” have the meaning given those terms in section 3729(b)(2) of title 31, United States Code.
(B) OVERPAYMENT.—The term “overpayment” means any funds that a provider of services or supplier, a beneficiary, or an entity that knowingly makes false statements, fails to report or returns an overpayment, or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, request, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1860D–1(f)(1)), including Medicaid and Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, Medicare managed care organizations under title XIX, and any other entity that the Secretary or such Inspector General determines shall be included in such an agreement.
(C) BY THE ATTORNEY GENERAL.—(1) IN GENERAL.—The Attorney General shall, upon the request of the Secretary or such Inspector General—
(A) by officers, employees, and contractors of the Department of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse including matches of a system of records with non-Federal records; and
(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.
(3) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—(1) PERMISSIVE EXCLUSIONS.—Section 1128A–2(a)(2)(B) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:
(E) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, request, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1860D–1(f)(1)), including Medicaid and Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, and any other entity that the Secretary or such Inspector General determines shall be included in such an agreement.
(2) CIVIL MONETARY PENALTIES.—(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—
(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.
from the Federal health care program (as defined in section 1128(f)) under which the claim was made pursuant to Federal law; “;”;

(ii) in paragraph (6), by striking “or” at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

“(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service was not permitted under such a program;”;

“(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, request for participation in, or as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plans under part D of title XVIII, Medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;”;

“(10) knows of an overpayment (as defined in section 1129(d)) and does not report and return the overpayment in accordance with such section;”;

“(iv) in the first sentence—

(I) by striking “or” after “‘prohibited relationship’;”;

(II) by striking “act)” and inserting “act;”

or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)”;

and

(2) in the second sentence, by striking “purpose)” and inserting “purpose; or”;

or in cases under paragraph (9), an assessment of not more than $100,000 for each false statement or misrepresentation of a material fact;”;

and

(3) by striking “in” and inserting “or”;

and

(iv) by adding at the end the following new subparagraphs:

“(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (including the Federal health care program (as defined in section 1128(h));

“(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

“(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

“(ii) the items or services are offered or transferred on equal terms available to the general public, regardless of health insurance status of a person, and the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part under title XVIII or a State health care program (as defined in section 1128(b));

“(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

“(i) the items or services are not offered as part of any other program or arrangement described in section 1128(k)(2);

“(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

“(iii) there is a reasonable connection between the items or services and the medical care of the individual;

“(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

“(D) effective as of January 1, 2011, the waiver by a PIP sponsor of a prescription drug plan under part D of title XVIII or an MA-PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA-PD plan, respectively.”;

(C) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-EXCLUSION-ONLY CASES.—Section 1128(h) of the Social Security Act (42 U.S.C. 1320a–7b(f)(7)) is amended by adding at the end the following new subsection:

“(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to section 1128(f) of chapter III of title XVIII of the Act.”;

(1) HEALTH CARE FRAUD.—

(1) KEEPER’S EXCLUSION.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

“(e) EXPENSES INCURRED IN COLLECTING—

“(1) IN GENERAL.—In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.”;

(2) REVISING THE INTENT REQUIREMENT.—

Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new paragraph:

“(b) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.”;

(2) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1890aa(a)(16)(B) of the Social Security Act (42 U.S.C. 1395aa(a)(16)(B)) is amended by inserting “that the Secretary determines is commensurate with the volume of the billing of the home health agency” before the semicolon at the end.

(2) REQUIREMENTS FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

“(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

“(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

“(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph of services or supplier the Secretary determines appropriate based on the level of risk associated with the services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).”;

(2) SUSPENSION OF MEDICAID AND MEDICARE PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICAID.—Section 1902 of the Social Security Act (42 U.S.C. 1396v), as amended by subsection (g)(3), is amended by adding at the end the following new subsection:

“(g) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

“(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, and the Secretary determines there is good cause not to suspend such payments.

“(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

(3) PROVISO.—That part of section 1902(c) of such Act (42 U.S.C. 1396v(c)(2)) is amended—

(A) in subparagraph (A), by striking “or” at the end; and

(B) by inserting after subparagraph (B), the following:

“(C) by any individual or entity to whom the Secretary determines is in financial need; or

(4) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

(1) IN GENERAL.—Section 1871(k) of the Social Security Act (42 U.S.C. 1395l(k)) is amended—

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

“(1) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) for and purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funds appropriated to the Account for each of fiscal years 2011 through 2016. The funds appropriated under this paragraph shall be available without further appropriation until expended and are hereby made available for use for the following purposes:

(A) To support State and local governments and businesses to fight health care fraud and abuse;

(B) To increase, by matching funds, the amount appropriated under paragraph (1) of section 1131(c) of the Social Security Act (42 U.S.C. 1395f(c)(1)) and to support such Section 1131 programs for the fiscal years 2011 through 2020;

(2) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) for and purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be allocated in the same proportion as the total funds appropriated to the Account for each of fiscal years 2011 through 2016. The funds appropriated under this paragraph shall be available without further appropriation until expended and are hereby made available for use for the following purposes:

(A) To support State and local governments and businesses to fight health care fraud and abuse;

(B) To increase, by matching funds, the amount appropriated under paragraph (1) of section 1131(c) of the Social Security Act (42 U.S.C. 1395f(c)(1)) and to support such Section 1131 programs for the fiscal years 2011 through 2020;
(2) Indexing of amounts appropriated.—
(i) in subsection (III), by inserting “and” at the end;
(ii) in subsection (IV)—
(1) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”; and
(2) by striking “;” and inserting a period; and
(i) in subsection (VIII), by inserting “and” at the end;
(ii) in subsection (IX)—
(1) by striking “for each of fiscal years 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2007”; and
(2) by striking “;” and inserting a period; and
(iii) by striking subsection (X).
(C) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1396u–2(k)(4)(C)) is amended—
(i) in clause (vii), by striking “and” at the end;
(ii) in clause (viii)—
(1) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”;
(2) by striking “;” and inserting a period; and
(iii) by striking clause (ix).
(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1396u–2(k)(4)(C)) is amended by adding at the end the following new clause:
“(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.”.
(E) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1396u–2(k)(4)(C)) is amended—
(i) by striking subsection (a) and inserting
“(1) MEDICARE INTEGRITY PROGRAM.—
(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—
(1) in paragraph (5), by striking “and” at the end;
(2) by redesignating paragraph (4) as paragraph (5); and
(3) by inserting after paragraph (3) the following new paragraph:
“(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in section (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).’’;
(B) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1120(c)(3)(B) of the Social Security Act (42 U.S.C. 1320c–7(c)(3)(B)) is amended by striking “under part A of title XVII or enrolled under part B of such title, or both” and inserting “beneficiaries (as defined in section 1128A(c)(5)) of that program’’.

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND FRAUD INTERDICT SYSTEM AND THE NATIONAL PRACTITIONER DATA BANK.
(A) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1122E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—
(1) by striking subsection (a) and inserting the following:
“(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).’’;
(B) FEES FOR DISCLOSURE.—The Secretary may collect a fee for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and the costs of furnishing such information. Such fees shall be available to the Secretary to cover such costs.”;

(3) by striking subsection (f) and inserting the following:
“(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall coordinate the maximum use of the coordinated system with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921.”

(A) in paragraph (1)(A)—
(1) by striking “or State” and inserting “or otherwise;”; and

(B) in paragraph (2) (A) through (D) as so redesignated, by striking “by a State law or regulation” and inserting “by a State licensing or certification agency or State law or fraud enforcement agency.”

(2) MEDICAID INTEGRITY PROGRAM.—Section 1841, to carry out this section, the Secretary shall—
(1) make available to each State such information as the Secretary deems appropriate concerning any adverse actions, but only with respect to information provided pursuant to subsection (a)(1)(A) before the comma at the end;
(C) by striking paragraph (5) and inserting the following:

"(5) To State law or fraud enforcement agencies;"

(D) in redesigning paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

"(7) To health plans (as defined in section 1128(c));";

(3) by redesigning subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

"(d) Disclosure and Correction of Information. —

(1) Disclosure. — With respect to information obtained pursuant to subsection (a)(1), the Secretary shall—

(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

"(2) Corrections. — Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any health care practitioner, entity, or agent. Each State medical board shall report corrections of information as required under this section, with payment of costs related to the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

"(f) Protection from Liability for Reporting. — No person or entity, including any agent designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

"(g) References. — For purposes of this section:

(1) STATE LICENSING OR CERTIFICATION AGENCY. — The term 'State licensing or certification agency' includes any authority of a State (or of a political subdivision thereof) responsible for the licensing or certification of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners).

(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY. — The term 'State law or fraud enforcement agency' includes—

(A) a State law enforcement agency; and

(B) a State Medicaid fraud control unit.

"(3) ADVERSE ACTION. — Subject to subparagraph (B), the term 'adverse action' includes—

(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

(ii) State criminal convictions related to the delivery of a health care item or service;

(iii) exclusion from participation in State health care programs (as defined in section 1128b);"

(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

(v) any discipline or actions or decisions that the Secretary shall establish by regulation.

"(3) DISCLOSURE AND CORRECTION OF INFORMATION. —

(a) REQUIREMENT. — The Secretary shall provide for the maximum appropriate period that begins on the effective date specified in paragraph (2) and ends on the later of—

(A) the date that is 1 year after such date of enactment of this Act; or

(B) the date that is the effective date of the regulations promulgated under paragraph (2).

(b) EFFECTIVE DATE. — The Secretary shall provide for the maximum appropriate period that begins on the effective date specified in paragraph (2) and ends on the later of—

(A) the date that is 1 year after such date of enactment of this Act; or

(B) the effective date of the regulations promulgated under paragraph (2).

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION. —

(B) Section 1835(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended—

(A) by striking "within 12 months" and inserting "within 12 months", and

(B) by striking "closer of the calendar year following the year in which such service is furnished" and inserting "closer of the calendar year following the year in which such service is furnished".

(c) IN GENERAL. — The Secretary shall implement this section without regard to any other provision of law, and shall provide for the Secretary to implement this section without regard to any other provision of law.

(d) IN GENERAL. — In implementing this section, the Secretary shall provide for the maximum appropriate period that begins on the effective date specified in paragraph (2) and ends on the later of—

(A) the date that is 1 year after such date of enactment of this Act; or

(B) the effective date of the regulations promulgated under paragraph (2).

SEC. 6408. BANKS AND DEPOSITORY INSTITUTIONS EXEMPTED FROM THE EFFECT OF THE TRANSITION PERIOD.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION. —

(B) Section 1835(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended—

(A) by striking "within 12 months" and inserting "within 12 months", and

(B) by striking "closer of the calendar year following the year in which such service is furnished" and inserting "closer of the calendar year following the year in which such service is furnished".

(c) IN GENERAL. — The Secretary shall implement this section without regard to any other provision of law, and shall provide for the Secretary to implement this section without regard to any other provision of law.

(d) IN GENERAL. — In implementing this section, the Secretary shall provide for the maximum appropriate period that begins on the effective date specified in paragraph (2) and ends on the later of—

(A) the date that is 1 year after such date of enactment of this Act; or

(B) the effective date of the regulations promulgated under paragraph (2).

EFFECTIVE DATE. — The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.
1806(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j).

(1) HOME HEALTH SERVICES.—
(a) Section 1835(a)(2) of such Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following paragraph:

"The Secretary may revoke enrollment of an individual enrolled under section 1866(j) if such physician or supplier fails to maintain, and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary."

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph:

"(i) The Secretary may revoke enrollment of a physician, a clinical nurse specialist, or an eligible professional under section 1866(j) if such physician or supplier fails to maintain, and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary."

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after January 1, 2010.

SEC. 6406. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE, FRAUD, OR ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1820(h) of the Social Security Act (42 U.S.C. 1395n(a)(2)) is amended by adding at the end the following new paragraph:

"(n) The Secretary may revoke enrollment of a physician, a clinical nurse specialist, or an eligible professional under section 1866(j) if such physician or supplier fails to maintain, and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary."

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph:

"(i) The Secretary may revoke enrollment of an individual enrolled under section 1866(j) if such physician or supplier fails to maintain, and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary."

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after January 1, 2010.

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR MEDICAL EQUIPMENT.—

(1) PART A.—Section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–44(a)) is amended in the matter preceding subparagraph (A) by inserting "in the case of services described in subparagraph (A), a physician enrolled under section 1848(k)(3)(B)," before "or, in the case of services described in subparagraph (B),".

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395u(h)) is amended in the matter preceding subparagraph (A) by inserting "in the case of services described in subparagraph (A), a physician enrolled under section 1848(k)(3)(B)," after "a physician.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended by inserting "(ii) in any conduct described in subparagraphs (A) through (J) of section 1128(c)(1)(A) to any other remedies authorized by law, for any of the remedies described in paragraphs (8) through (10) (including new paragraphs:

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1851(a)(2)(D) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by striking "timely" before "inspect"; and

(B) in subparagraph (B), by striking "timely" before "audit and inspect".

(2) MARKETING VIOLATIONS.—Section 1867(a)(1) of the Social Security Act (42 U.S.C. 1395w–27(t)(1)) is amended—

(A) in subparagraph (A), by striking or adding a "in any conduct described in subparagraphs (A) through (J) of this paragraph;

(b) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such conduct would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 6409. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended by inserting "(ii) in any conduct described in subparagraphs (A) through (J) of section 1128(c)(1)(A)" after "investigation".

(b) PROVIDER ADVANTAGE AND PART D PLANS.—

(2) BY INSERTING "(A) in subparagraph (A), by striking "timely" before "inspect" and "timely" before "audit and inspect"."
SEC. 6109. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, acting through the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The SRDP shall include direction to health care providers of services and suppliers—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP information related to the disclosure.

(b) PROVISION OF INSTRUCTION.—The Secretary of Health and Human Services, acting through the Inspector General of the Department of Health and Human Services, shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(c) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(d) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The Secretary may consider the following factors:

(1) the cooperation in providing additional information related to the disclosure;

(2) the timeliness of self-disclosure;

(3) the cooperation in providing additional information related to the disclosure;

(4) such other factors as the Secretary considers appropriate.

(e) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the number of violations reported under the SRDP;

(4) the number of violations reported under the SRDP that are pending appeal; and

(5) such other information as may be necessary to evaluate the impact of this section.
the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program and Medicaid and shall include such reports recommendations for expanding or improving the program.

Subtitle F—Additional Medicaid Program Integrity Provisions

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (38) the following:

"(39) terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to expansions under sections 1128(c)(3)(B) and 1128(d)(3)(B)) participation of such individual or entity is terminated under title XVIII or any other State plan under title X.

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following:

"(78) provide that the State agency described in paragraph (77) shall, in determining whether or not an entity is involved in a management affiliation, consider whether such entity is owned, controlled, or managed by an individual or entity that—

"(A) has been suspended or excluded from participation under the program, that is 30 days after the date on which a final determination of the amount of the overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to the State for such overpayment, and the payment (or portion thereof) before the date that is 30 days after the date on which a final judgment (including, if applicable, a final determination on appeal) is made.

"(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) CORRECTIVE ACTION.—The Secretary shall promulgate regulations that require all States to correct payments to incorrect payees or pay incorrect amounts, overpayments of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate methodologies for detecting and recovering such overpayments. Such guidance shall be made available by a date determined by the Secretary.

SEC. 6505. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1396b of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in paragraph (1)(A)—

(A) in clause (ii), by striking "3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of welfare arrangements described in section 3400, shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, the representative or agent of any such person, State, or the Secretary, concerning—"

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after October 1, 2010.

SEC. 6506. OVERPAYMENTS.

SEC. 6507. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

(a) IN GENERAL.—Section 1902(a)(2)(H)(ii) of the Social Security Act (42 U.S.C. 1396b(h)(2)(H)(ii)) is amended—

(1) in paragraph (1)(B)—

(A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of paragraph (A).

SEC. 6508. GENERAL EFFECTIVE DATE.

SEC. 519. PROHIBITION ON FALSE STATEMENTS

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this title, and any other Federal law, no person, in connection with a plan or arrangement, shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, the representative or agent of any such person, State, or the Secretary, concerning—

 SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

"SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

"No person, in connection with a plan or arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employee, any member of an employee organization, any beneficiary, any employer, any employee organization, the Secretary, or any State, the representative or agent of any such person, State, or the Secretary, concerning—

(1) the financial condition or solvency of such plan or arrangement;

(2) the benefits provided by such plan or arrangement;

(3) the regulatory status of such plan or arrangement, under any Federal or
State law governing collective bargaining, labor management relations, or intern union affairs; or

(4) the regulatory status of such plan or other arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).’’.

(b) CONFORMING AMENDMENT.—The table of sections, in section 654(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting ‘‘(a)’’ before ‘‘Any person’’; and

(2) by adding at the end the following:

‘‘(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 5 years for the offense described in title 18, United States Code, or both.’’;

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

‘‘Sec. 519. Prohibition on false statement and representations.’’

SEC. 6602. CLARIFYING DEFINITION.
Section 24(a)(2) of title 18, United States Code, is amended by inserting ‘‘or section 411, 510, or 511 of the Employee Retirement Income Security Act of 1974,’’ after ‘‘1954 of this title’’.

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.
Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

‘‘SEC. 2794. UNIFORM FRAUD AND ABUSE REFERAL FORMAT.
‘‘The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.’’.

SEC. 6604. APPLICABILITY OF STATE LAW TO PERSONAL COMFORT AND ABUSE.
(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

‘‘SEC. 520. APPLICABILITY OF STATE LAW TO COMBAT FRAUD AND ABUSE.
‘‘The Secretary, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1966, if the Secretary determines that the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).’’;

(b) CONFORMING AMENDMENT.—The table of sections, in section 654(b) of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

‘‘Sec. 520. Applicability of State law to combat fraud and abuse.’’

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDER OR SEIZURE ORDERS AGAINST PLANS THAT ARE IN FINANCIALLY HAZARDOUS CONDITION.
(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6604, is further amended by adding at the end the following:

‘‘SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.
‘‘(a) IN GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in subsection (g), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can reasonably be expected to cause significant, imminent, and irreparable public injury.

‘‘(b) HEARING.—A person that is adversely affected by the issuance of a cease and desist order under section 521(a)(1) may request a hearing by the Secretary regarding such order. The Secretary may require that a proceeding under this section, including all related information and evidence, be conducted in a confidential manner.

‘‘(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under section (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

‘‘(d) DETERMINATION.—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order may be affirmed, modified, or set aside by the Secretary in whole or in part.

‘‘(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears to the Secretary that a multiple employer welfare arrangement is in a financially hazardous condition.

‘‘(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

‘‘(g) EXCEPTION.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).’’;

SEC. 6606. PLAN REGISTRATION WITH DEPARTMENT OF LABOR.
Section 10(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(g)) is amended—

(1) by striking ‘‘Secretary may’’ and inserting ‘‘Secretary shall’’; and

(2) by inserting ‘‘register with the Secretary prior to operation in a State and may, by regulation, require such multiple employer welfare arrangements’’ after ‘‘not group health plans’’.

SEC. 6607. PREEMPTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.
Section 24(a)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

‘‘(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

(1) A State insurance department.
(2) A State attorney general.
(3) The National Association of Insurance Commissioners.
(4) The Department of Labor.
(5) The Department of the Treasury.
(6) The Department of Health and Human Services.
(7) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

‘‘(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.’’.

Subtitle H—Elder Justice Act

SEC. 6701. SHORT TITLE OF SUBTITLE.
This subtitle may be cited as the ‘‘Elder Justice Act of 2009’’.

SEC. 6702. DEFINITIONS.
Except as otherwise specifically provided, any term that is defined in section 201(b) of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.
(a) ELDER JUSTICE.
(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) by inserting ‘‘AND ELDER JUSTICE’’ after ‘‘SOCIAL SERVICES’’; and

(B) by inserting before section 201 the following:

‘‘Subtitle A—Block Grants to States for Social Services’’;

and

(C) by adding at the end the following:

‘‘Subtitle B—Elder Justice’’

SEC. 201. DEFINITIONS.
‘‘In this subtitle:

(1) ABUSE.—The term ‘‘abuse’’ means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

(2) ADULT PROTECTIVE SERVICES.—The term ‘‘adult protective services’’ means such services provided to adults as the Secretary may specify and includes services such as—

(A) receiving reports of adult abuse, neglect, or exploitation;

(B) investigating the reports described in subparagraph (A);

(C) case planning, monitoring, evaluation, and other case work and services; and

(D) providing, arranging for, or facilitating the provision of medical, social services, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

(3) CAREGIVER.—The term ‘‘caregiver’’ means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law,

November 19, 2009
and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

"(4) DIRECT CARE.—The term ‘direct care’ means care by an employee or contractor who performs in-person or long-term care services to a recipient.

"(5) ELDER.—The term ‘elder’ means an individual age 60 or older.

"(6) ELDER JUSTICE.—The term ‘elder justice’ means—

(A) from a societal perspective, efforts to—

(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(ii) protect elders with diminished capacity while maximizing their autonomy; and

(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

"(7) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

"(8) EXPLOITATION.—The term ‘exploitation’ means the fraudulent or otherwise illegal, unauthorized, or improper action or inaction of a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

"(9) FIDUCIARY.—The term ‘fiduciary’—

(A) means a person or entity with the legal responsibility—

(i) to make decisions on behalf of and for the benefit of another person; and

(ii) to act in good faith and with fairness; and

(B) includes a trustee, a guardian, a conservator, an executor, an attorney under a financial power of attorney or health care power of attorney, or a representative payee.

"(10) GRANT.—The term ‘grant’ includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

"(11) GUARDIANSHIP.—The term ‘guardianship’—

(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker.

(B) in manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

"(12) INDIAN TRIBE.—

(A) IN GENERAL.—The term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term ‘Indian tribe’ includes any Pueblo or Rancheria.

"(13) LAW ENFORCEMENT.—The term ‘law enforcement’ means the full range of potential responses to elder abuse, neglect, and exploitation including—

(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

(B) public safety; and

(C) medical examiners; and

(D) investigators; and

(E) coroners.

"(14) LONG-TERM CARE.—

(A) IN GENERAL.—The term ‘long-term care’ means supportive and health services specifically designed for individuals who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

(B) LONG-TERM CARE SERVICES.—For purposes of subparagraph (A), the term ‘loss of capacity for self-care’ means an inability to engage in 1 or more activities of daily living including eating, dressing, bathing, management of one’s financial affairs, and other activities the Secretary determines appropriate.

"(15) LONG-TERM CARE FACILITY.—The term ‘long-term care facility’ means a residential care provider that arranges for, or directly provides, long-term care.

"(16) NEGLECT.—The term ‘neglect’ means—

(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

(B) self-neglect.

"(17) NURSING FACILITY.—

(A) IN GENERAL.—The term ‘nursing facility’ has the meaning given such term under section 1919(a).

(B) INCLUSION OF NEEDED SKILLED NURSING FACILITY.—The term ‘nursing facility’ includes a nursing facility (as defined in section 1919(a)).

"(18) SELF-NEGLECT.—The term ‘self-neglect’ means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

(A) obtaining essential food, clothing, shelter, and medical care;

(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

(C) managing one’s own financial affairs.

"(19) SERIOUS BODILY INJURY.—

(A) IN GENERAL.—The term ‘serious bodily injury’ means an injury—

(i) involving extreme physical pain; or

(ii) involving substantial risk of death; or

(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury has occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

(C) SOCIAL.—The term ‘social’, when used with respect to a service, includes adult protective services.

"(20) STATE LEGAL ASSISTANCE DEVELOPER.—The term ‘State legal assistance developer’ means an individual described in section 721 of the Older Americans Act of 1965.

"(21) STATE LONG-TERM CARE OMBUDSMAN.—The term ‘State long-term care ombudsman’ means an individual described in section 712(a)(2) of the Older Americans Act of 1965.

"SEC. 201. ELDER JUSTICE COORDINATING COUNCIL.

(‘(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the ‘Council’).

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Council shall be composed of the following members:

(A) The Secretary (or the Secretary’s designee).

(B) The Attorney General (or the Attorney General’s designee).

(2) REQUIREMENTS.—Each member of the Council shall be an officer or employee of the Federal Government.

(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

(f) DUTIES.—

(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Older Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

(A) describes the activities and accomplishments of, and challenges faced by—

(i) the Council; and

(ii) the entities represented on the Council; and

(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

(g) POWERS OF THE COUNCIL.—

(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2220 of the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair, the head of such department or agency shall furnish such information to the Council.
"(2) Postal services.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(b) Travel expenses.—(1) The members of the Advisory Board shall not receive compensation for the performance of services for the Council, except that, of the members first appointed, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

"(2) Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

"(3) Postal services.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

"(d) Authorization of appropriations.—There are authorized to be appropriated such sums as are necessary to carry out this section.

"SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

"(a) Establishment.—There is established a board to be known as the ‘Advisory Board on Elder Abuse, Neglect, and Exploitation’ (in this section referred to as the ‘Advisory Board’ to create short- and long-term multidisciplinary strategic plans for the development of the field of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

"(b) Composition.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

"(c) Solicitation of nominations.—The Secretary shall give notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

"(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

"(A) 9 shall be appointed for a term of 3 years;

"(B) 9 shall be appointed for a term of 2 years; and

"(C) 9 shall be appointed for a term of 1 year.

"(2) Vacancies.—

"(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

"(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

"(3) Expiration of terms.—The term of any member shall not expire before the date on which the member’s successor takes office.

"(e) Election of Officers.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

"(f) Duties.—

"(1) Enhance communication on promoting quality of, and preventing abuse, neglect, and exploitation in long-term care.—The Advisory Board shall develop collaborative multidisciplinary strategic plans to improve the quality of, including preventing abuse, neglect, and exploitation in long-term care.

"(2) Collaborative efforts to develop consensus.

"(3) ELECTION OF OFFICERS.—The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

"(4) Recommendations (including recommended priorities) regarding—

"(f) Powers of the Advisory Board.—

"(1) Information from Federal agencies.—Subject to the requirements of section 2023(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section.

"(2) Sharing of data and reports.—The Advisory Board may request from any entity conducting elder justice activities pursuant to the Elder Justice Act of 2009 or an amendment made by this Act, recommendations generated in connection with such activities.
funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and determine information on—

(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

(B) methods for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and what actions they should report to the case to law enforcement authorities.

(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General, shall use data made available by grant recipients under this section to develop standard forensic health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

(e) APPLICATION.—To be eligible to receive a grant under paragraph (A), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $1,000,000;

(2) for fiscal year 2012, $6,000,000; and

(3) for each of fiscal years 2013 and 2014, $8,000,000.

PART II—PROGRAMS TO PROMOTE ELDER justice

SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives to train and retain long-term care staff and to promote long-term care staffing.

(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives to train and seek employment providing direct care in long-term care.

(B) CAREER LADDERS AND WAGE OR BENEFIT INCENTIVES TO INCREASE STAFFING IN LONG-TERM CARE.—

(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing care training and varying levels of certification, based on observed clinical care practices and the amount of time the employees spend providing care;

(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program;

(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence that the entity is located in a State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(1) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection shall be used for other purposes determined appropriate by the Secretary.

(b) FINANCING STAFF.—

(1) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence that the entity is located in a State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(2) DEVELOPMENT OF FORENSIC EXPERTISE AND MANAGEMENT PRACTICES.—

(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

(B) PROVIDING EDUCATION AND TRAINING.—

(i) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

(I) providing mentors who have been trained in the use of human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

(ii) the establishment of motivational and thoughtful work organization practices;

(iii) the creation of a workplace culture that respects and values caregivers and their needs;

(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents of such an entity;

(v) the development of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

(C) USE OF GRANT FUNDS.—Funds provided under this paragraph shall be used for other purposes determined appropriate by the Secretary.

(3) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence that the entity is located in a State in which the eligible entity is located with respect to carrying out activities funded under the grant).

(4) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

(5) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.

(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under paragraph (4) of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1866D–4, standards adopted under section 3002 of the Public Health Service Act, and general health information technology standards.

(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

(B) ROLE OF CONSTITUTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

(C) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a
There are authorized to be appropriated to carry out this section—

(1) [in paragraph (1), $10,000,000];

(2) for fiscal year 2012, $17,500,000; and

(3) for each of fiscal years 2013 and 2014, $15,000,000.

**SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONs AND GRANT PROGRAMS.**

‘‘(a) Secretarial Responsibilities.—

‘‘(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

‘‘(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

‘‘(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

‘‘(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

‘‘(D) conducts research related to the provision of adult protective services; and

‘‘(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsection (b) and (c).

‘‘(2) Authorization of Appropriations.—

There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

(b) Grants To Enhance the Provision of Adult Protective Services.—

‘‘(1) Establishment.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

‘‘(2) Amount of Payment.—

‘‘(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year shall equal 50 percent of the amount determined under subsection (b) and (C) for the year.

‘‘(B) Guaranteed Minimum Payment Amount.—

‘‘(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such purpose for such fiscal year, the amount for such fiscal year shall be increased such amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount determined under subparagraph (A) for such year.

‘‘(ii) TERRITORIES.—In the case of a State other than one of the 50 States, clause (i) shall be applied as if each reference to ‘0.75’ were a reference to ‘0.1’.

‘‘(C) Pro rata Reductions.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

‘‘(3) Authorized Activities.—

‘‘(A) Adult Protective Services.—Funds made available pursuant to this subsection shall only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

‘‘(B) Use by Agency.—Each State receiving funds pursuant to this subsection shall provide funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

‘‘(C) Payment Not Supplant.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

‘‘(d) State Reports.—Each State receiving funds pursuant to this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

‘‘(e) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

**SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.**

‘‘(a) Grants To Support the Long-term Care Ombudsman Program.—

‘‘(1) IN GENERAL.—The Secretary shall make grants to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

‘‘(2) Authorized Activities.—A recipient of grants described in paragraph (1) shall—

‘‘(A) evaluate the effectiveness of the activities funded under each program carried out under this part.

‘‘(B) report the results of the evaluation conducted under paragraph (1) to the Secretary.

‘‘(C) certify to the Secretary that such evaluations were conducted consistent with guidance issued by the Secretary.

‘‘(D) report to the Secretary that such evaluations were conducted pursuant to such guidance.

‘‘(E) other matters relating to the detection or prevention of elder abuse.

‘‘(2) Authorized Activities.—A recipient of grants described in paragraph (1) shall—

‘‘(A) establish a culture of continuous improvement in the provision of long-term care ombudsman programs and such other long-term care ombudsman programs and responsibilities, for the purpose of—

‘‘(i) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

‘‘(ii) conducting pilot programs with State units of government to conduct demonstration programs that test—

‘‘(I) training modules developed for the purpose of detecting or preventing elder abuse;

‘‘(II) methods to detect or prevent financial exploitation of elders;

‘‘(III) methods to protect elder abuse;

‘‘(IV) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government;

‘‘(V) other matters relating to the detection or prevention of elder abuse.

‘‘(B) Authorized Activities.—A recipient of grants described in paragraph (1) shall—

‘‘(i) establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

‘‘(ii) Other Matters.—The Secretary may require in order to conduct such evaluation; or

‘‘(C) Authorized Activities.—There are authorized to be appropriated to carry out this subsection, $10,000,000.

**SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.**

‘‘(a) Provision of Information.—To be eligible to receive a grant under this part, an applicant shall agree—

‘‘(i) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the Secretary may require in order to conduct such evaluation; or

‘‘(ii) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

‘‘(b) Use of Eligible Entities to Conduct Evaluations.—

‘‘(1) Evaluations Required.—Except as provided in paragraph (2), the Secretary shall—

‘‘(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

‘‘(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

‘‘(2) Authorized Activities.—A recipient of grants described in paragraph (1)(B) shall—

‘‘(A) establish a culture of continuous improvement in the program funded under section 2041(b).

‘‘(B) report to the Secretary that such evaluations were conducted consistent with guidance issued by the Secretary.

‘‘(C) certify to the Secretary that such evaluations were conducted pursuant to such guidance.

‘‘(D) Other Matters.—The Secretary may require, including a proposal for the evaluation.

‘‘(3) Authorized Activities.—A recipient of grants described in paragraph (1)(B) shall—

‘‘(A) conduct an evaluation of the effectiveness of the activities funded under a program carried out under this part.

‘‘(B) report to the Secretary that such evaluations were conducted consistent with guidance issued by the Secretary.

‘‘(C) certify to the Secretary that such evaluations were conducted pursuant to such guidance.

‘‘(D) other matters relating to the detection or prevention of elder abuse.

‘‘(E) Authorized Activities.—The Secretary may require in order to conduct such evaluation; or

‘‘(F) Authorized Activities.—The Secretary may require in order to conduct such evaluation.

**TWO-HUNDRED-THIRTY-FOURTH CONGRESSIONAL SESSION, FIRST SESSION S11792**
the funding provided under the grant is expended only for the purposes for which it is made.

(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

SEC. 2045. REPORT.

"Not later than October 1, 2014, the Secretary of the Re- 

directs the Coordination Council established under section 

2021, the Committee on Ways and Means and the 

30,000,000). The Coordination Council shall be in- 

subdivision in which the facility is located 

and law enforcement entities for the political 

(9) IN GENERAL.—Each covered individual 

(10) IN GENERAL.—If a covered individual 

(c) PENALTIES.—

(1) IN GENERAL.—If a covered individual 

(2) INCREASED HARM.—If a covered indi- 

(3) EXCLUDED INDIVIDUAL.—During any pe- 

(4) EXTENUATING CIRCUMSTANCES.—

(A) PENALTIES.—

(1) IN GENERAL.—If a covered individual 

(2) INCREASED HARM.—If a covered indi- 

(3) EXCLUDED INDIVIDUAL.—During any pe- 

(4) EXTENUATING CIRCUMSTANCES.—

(A) IN GENERAL.—The Secretary may take 

(1) DETERMINATION.—The owner or oper- 

(IV) advocacy and consumer organizations; 

(V) State agencies of conducting complaint 

investigations of such complaints.

(III) General results of Federal and State 

investigations and complaints of abuse, neglect, and misappropriation of property.

(II) Sample results of Federal and State 

investigations and complaints of abuse, neglect, and misappropriation of property.

(I) Preliminary results of Federal and 

State investigations and complaints of abuse, neglect, and misappropriation of property.

HARM/photos of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State com- 

plaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including hol- 

days).

(Vi) To the extent approved by the Sec- 

retary of Health and Human Services, pro- 

vide a national 24 hours per day, 7 days a week (including holidays), back-up system to 

State complaint intake systems in order to 

ensure that prompt and responsive responses to complaints of abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the follow- 

(1) The total number and sources of com- 

plaints of such abuse, neglect, and misappro- 

riation of property.

(II) The extent to which such complaints are re- 

ferred to law enforcement agencies.

(III) General results of Federal and State 

investigations of such complaints.

(IV) Sample results of Federal and State 

investigations of such complaints.

(V) Preliminary results of Federal and 

State investigations of such complaints.

(IV) advocacy and consumer organizations; 

(V) State agencies of conducting complaint 

investigations of such complaints.

(III) General results of Federal and State 

investigations and complaints of abuse, neglect, and misappropriation of property.

(II) Sample results of Federal and State 

investigations and complaints of abuse, neglect, and misappropriation of property.

(I) Preliminary results of Federal and 

State investigations and complaints of abuse, neglect, and misappropriation of property.
“(ii) racial and ethnic minority populations; and
“(iii) populations underserved because of special needs (such as language barriers, disabilities, or access to care).
“(d) ADDITIONAL PENALTIES FOR RETALIATION.—
“(1) IN GENERAL.—A long-term care facility may not—
“(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or
“(B) file a complaint or report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for making steps in furtherance of making a report pursuant to subsection (b)(1).

“(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

“(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in the location accessible to patients a notice of the Secretary specifying the rights of employees under this section. The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a nationwide program for national and State demonstration programs to evaluate alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

“(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(1) in subsection 2001(a), by inserting “subtitle 1 of” before “title XX”;

(2) in subsection 2391(a), by inserting “subtitle 1 of” before “title XX”;

and

(3) in section 242(b), by inserting “subtitle 1 of” before “title XX”;

(4) by striking “such title” and inserting “such subtitle”;

and

(5) in section 1128A(1), by inserting “subtitle 1 of” before “title XX.”

Title I—Sense of the Senate Regarding Medical Malpractice

SEC. 8601. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES

Subtitle A—Biologics Price Competition and Innovation

SEC. 7001. SHORT TITLE.

(a) IN GENERAL.—This subtitle may be cited as the “Biologics Price Competition and Innovation Act of 2009”.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that a biosimilars pathway has the potential to increase consumer and patient interests should be established.

SEC. 7002. APPROVAL PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting “subsection this subsection or subsection (k)” after “biologics license”; and

(2) by adding at the end the following:

“(k) LICENSURE OF BIOLOGICAL PRODUCTS AS BIOSIMILAR OR INTERCHANGEABLE.—

“(1) IN GENERAL.—Any person may submit an application for licensure of a biological product under this subsection.

“(2) CONTENT.—

“(A) IN GENERAL.—

“(i) REQUIRED INFORMATION.—An application submitted under this subsection shall include information demonstrating that—

“(I) the biological product is biosimilar to a reference product based upon data derived from—

“(aa) analytical studies that demonstrate that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components;

“(bb) animal studies (including the assessment of toxicity); and

“(cc) a clinical study or studies (including the assessment of immunogenicity and pharmacokinetics or pharmacodynamics)

that...
are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which a purpose is sought for the biological product;

(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanisms or mechanisms of action are known for the reference product;

(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

(V) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

(VI) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(II) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection—

(I) shall contain information demonstrating that the biological product meets the standards described in paragraph (4);

(II) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(B) the applicant (or other appropriate person) retains the inspection of the facility that is the subject of the application, in accordance with subsection (c).

(4) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall license the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that the biological product—

(i) is biosimilar to the reference product; or

(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved for the reference product;

(IV) the route of administration, the dosage form, and the strength of the biological product are the same as those of the reference product; and

(V) the facility in which the biological product is manufactured, processed, packed, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

(VI) may include any additional information in support of the application, including publicly-available information with respect to the reference product or another biological product.

(A) USE OF PREVIOUS DETERMINATION.—The Secretary may, on the basis of a previous determination under this subsection or any supplement thereto, license the biological product to be interchangeable with the reference product.

(II) EVALUATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsection (a).

(4) EVALUATION BY SECRETARY.—Upon review of an application submitted under this subsection or any supplement thereto, the Secretary will use the information described in paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use of the reference product until the earlier of—

(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product; or

(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(C) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has not been sued under subsection (l)(6).

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court which may not be reversed in a court of appeals (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

(5) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection or any supplement thereto, the Secretary will use the information described in paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use of the reference product.

(B) EXCLUSIVE USE.—The Secretary shall not make a determination under paragraph (4) if—

(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

(ii) the criteria, if available, that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class.

(C) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

(6) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues product class-specific guidance under subparagraph (A), such guidance shall include a description of—

(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class; and

(ii) the criteria, if available, that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class.

(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 years after the date on which the reference product was first licensed under subsection (a).

(B) FILING PERIOD.—An application submitted under this subsection may not be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

(i) a supplement for the biological product that is the reference product; or

(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) (for a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosage form, delivery system, device, or strength; or

(iii) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.}

(8) GUIDANCE DOCUMENTS.—

(A) IN GENERAL.—The Secretary may, after opportunity for public comment, issue guidance in accordance, except as provided in subparagraph (B)(i), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

(B) PUBLIC COMMENT.—

(i) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance.

(ii) DETERMINATION OF INTERCHANGEABILITY.—The Secretary will use the information described in paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use of the reference product until the earlier of—

(A) 1 year after the first commercial marketing of the first interchangeable biosimilar biological product; or

(i) a final court decision on all patents in suit in an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(6) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(C)(i) 42 months after approval of the first interchangeable biosimilar biological product; or

(ii) 18 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(6) and such litigation is still ongoing within such 42-month period; or

(D) NO REQUIREMENT FOR APPLICATION CONSIDERATION.—The issuance (or non-issuance) of guidance under subparagraph (A) shall not preclude the review of, or action on, an application submitted under this subsection.

(9) DETERMINATION OF INTERCHANGEABILITY.—The Secretary may make a determination as described in paragraph (4) if—

(A) the biological product—

(i) is biosimilar to the reference product; and

(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

(B) for a biological product that is administered to individual patients, the risk in terms of safety or diminished efficacy of alternating or switching between use of

(B) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanisms or mechanisms of action are known for the reference product;
“(I) Provision of Confidential Information.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in subparagraph (A) of this paragraph, confidential access to the information required to be produced pursuant to paragraph (2) and any other information that is an employee of the reference product sponsor, whether a claim of patent to or exclusively licensed by the reference product sponsor, or a person not licensed by the reference product sponsor, but in no case later than 60 days after the receipt of the list and statement under subparagraph (A), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6), the provisions of paragraph (5) shall apply to the parties.

“(II) Exchange of Patent Lists.—In general.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, but in no case later than 5 days after the subsection (k) applicant notifies the reference product sponsor of the number of patents that subsection (k) applicant shall provide to the reference product sponsor under subparagraph (A) the subsection (k) applicant and the reference product sponsor shall simultaneously exchange—

“(I) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

“(II) the list of patents, in accordance with clause (I), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).

“(III) Number of Patents Listed by Reference Product Sponsor.—

“(I) In General.—Subject to subclause (II), the number of patents listed by the reference product sponsor under subparagraph (A) may not exceed the number of patents listed by the subsection (k) applicant under clause (i)(I),
(ii) not included, as applicable, on—
(1) the list of patents described in paragraph (4); or
(II) the lists of patents described in paragraph (5)(B).

(C) REASONABLE COOPERATION.—If the reference product sponsor has sought a preliminary injunction under subparagraph (B), the reference product sponsor shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

(A) SUBSECTION (K) APPLICATION PROVIDED.—If a subsection (k) applicant provides the application and information required under paragraph (2)(A), neither the reference product sponsor nor the subsection (k) applicant may, prior to the date notice is received under paragraph (8)(A), bring any action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (i) and (II) of paragraph (8)(B).

(B) SUBSEQUENT FAILURE TO ACT BY SUBSECTION (K) APPLICANT.—If a subsection (k) applicant fails to complete an action required of the subsection (k) applicant under paragraph (3)(B)(i), paragraph (5), paragraph (6)(C)(i), paragraph (7), paragraph (8)(A), the reference product sponsor, but not the subsection (k) applicant, may bring an action under section 2201 of title 28, United States Code, for a declaration of infringement, validity, or enforceability of any patent included in the list described in paragraph (3)(A), including as provided under paragraph (7).

(C) SUBSECTION (K) APPLICATION NOT PROVIDED.—If a subsection (k) applicant fails to provide the application and information required under paragraph (3)(B)(i), paragraph (5), paragraph (6)(C)(i), paragraph (7), paragraph (8)(A), the reference product sponsor shall reasonably cooperate to expedite such further discovery as is needed in connection with the preliminary injunction motion.

(D) COURT ORDER.—If a court, upon a finding that the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application, not later than 30 days after such issuance or licensing, the reference product sponsor shall provide to the subsection (k) applicant a list of patents described in section 351(l)(5)(B) of the Public Health Service Act as an amendment to the list provided by the subsection (k) applicant as provided under paragraphs (3)(A) and (3)(B), the court may, to the extent that the court determines is necessary to protect the rights of the parties, enter an order prohibiting the making, using, offering to sell, selling, or importing into the United States of the biological product that is the subject of the subsection (k) application.

(E) NOTICE OF COMMERCIAL MARKETING AND PRELIMINARY INJUNCTION.—

(A) NOTICE OF COMMERCIAL MARKETING.—The subsection (k) applicant and subsection (k) applicant shall jointly provide notice to the reference product sponsor not later than 180 days before the date of the first commercial marketing of the biological product that is the subject of the subsection (k) application.

(B) PRELIMINARY INJUNCTION.—After receiving the notice under subparagraph (A) and before such date of the first commercial marketing of such biological product, the reference product sponsor may seek a preliminary injunction prohibiting the subsection (k) applicant from engaging in the commercial manufacture or sale of such biological product until the court decides the issue of patent validity, enforceability, and infringement with respect to any patent that is—

(1) included in the list provided by the reference product sponsor under paragraph (3)(A); or

(2) included in the list provided by the reference product sponsor under paragraph (3)(B); and

(3) the term ‘biological product’ means—

(a) a biological product that is the same as or structurally chemically synthesized polypeptide of a single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k); or

(b) a biological product that is the same as or structurally chemically synthesized polypeptide of a single biological product licensed under subsection (a) against which a biological product is evaluated in an application submitted under subsection (k).
using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringes the patent, shall be a reasonable royalty.

"(C) The owner of a patent that should have been included in the list described in section 355(i)(3)(A) of the Public Health Service Act (as prescribed) shall be paid by the Secretary, in a period at the end of the first sentence, the sum of the amount of the royalty determined and the costs of securing a judgment in a civil action against the person performing the infringing act, pursuant to section 271(b) of the Act."

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, as amended by inserting before the period at the end of the first sentence the following: "', or section 351 of the Public Health Service Act'."

(d) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period at the end of the first sentence the following: "or, with respect to an applicant for approval of a biological product under section 351 of the Public Health Service Act, any necessary clinical study or studies'."

(2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following: "(1) NEW ACTIVE INGREDIENT.—(A) NON-INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is biosimilar to a reference product under section 351 of the Public Health Service Act, and that has not previously been approved under such section, the term ''biological product'' has the meaning given such term under section 351(a)."

(3) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section."

(4) INTERCHANGEABLE BIOSIMILAR BIOLOGICAL PRODUCT.—A biological product that is interchangeable with a reference product under section 351 of the Public Health Service Act shall not be considered to have a new active ingredient under this section."

(5) REQUIREMENT TO FOLLOW SECTION 351.—Except as provided in paragraph (2), an application for a biological product that has not previously been approved under section 351 of the Public Health Service Act, and that has not previously been approved under such section, and that has not previously been approved under such section, the term 'biological product' has the meaning given such term under section 351(a).

(A) such biological product is in a product class for which a biological product in such product class is the subject of an application approved under such section 356 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this subsection as the 'Secretary') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act."

(3) LIMITATION.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that is biosimilar to the biological product with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(4) DEEMED APPROVED UNDER SECTION 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 18 years after the date of enactment of this Act.

(5) DEFINITIONS.—For purposes of this subsection, the term "biological product" has the meaning given such term under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act)."

(1) FOLLOW-UP FEES.—(1) DEVELOPMENT OF USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) IN GENERAL.—Beginning not later than October 1, 2011, the Secretary shall develop recommendations to present to Congress with respect to the goals, and plans for meeting the goals, for the process for the review of biosimilar biological product applications submitted under section 351(k) of the Public Health Service Act (as added by this Act) for the first 5 fiscal years after fiscal year 2012. In developing such recommendations, the Secretary shall consult with:

(i) the Committee on Health, Education, Labor, and Pensions of the Senate;

(ii) the Committee on Energy and Commerce of the House of Representatives;

(iii) scientific and academic experts;

(iv) health care providers;

(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(1) present the recommendations developed under subparagraph (A) to the appropriate committees specified in such subparagraph;

(2) publish such recommendations in the Federal Register; and

(3) provide for a period of 30 days for the public to provide written comments on such recommendations; and

(iv) hold a meeting at which the public may present its views on such recommendations; and

(v) after consideration of such public views and comments, revise such recommendations as necessary.

(C) TRANSMITTAL OF RECOMMENDATIONS.—Not later than January 15, 2012, the Secretary shall transmit such recommendations to Congress."

(2) ESTABLISHMENT OF USER FEE PROGRAM.—

(A) APPLICATION OF CERTAIN PROVISIONS.—Section 355a(a) of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following: "(1) APPLICATION OF CERTAIN PROVISIONS.—Section 355a(a) of the Public Health Service Act (42 U.S.C. 262) applies to the amount of the user fee applicable to such applications under such section 351(a)."

(B) USER FEE APPLICABILITY.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.

(g) PEDICULAR STUDIES OF BIOLOGICAL PRODUCTS.—

(1) IN GENERAL.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended by adding at the end the following: "(3) TRANSITIONAL PROVISIONS FOR USER FEES.—During the period beginning on October 1, 2010, the Secretary shall collect and evaluate data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(2) AUDIT.—(A) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), and on a biennial basis thereafter until October 1, 2013, the Secretary shall perform an audit of the costs of reviewing such applications under such section 351(k). Such an audit—

(i) the costs of reviewing such applications under such section 351(k) to the amount of the user fee applicable to such applications; and

(ii) such ratio determined under subclause (I) to (bb) the ratio of the costs of reviewing applications for biological products under sections 351(a) of such Act (as amended by this Act) to the amount of the user fee applicable to such applications under such section 351(a).

(3) MARKET EXCLUSIVITY FOR NEW BIOLOGICAL PRODUCTS.—If, prior to approval of an application that is submitted under subsection (a), the Secretary determines that information relating to the use of a new biological product in the pediatric population may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include a timeframe for completing such studies), the applicant agrees to the request, such studies are completed using appropriate formulae, and the results thereof are submitted and accepted in accordance with section 506A of the Federal Food, Drug, and Cosmetic Act—

(A) the periods for such biological product referred to in subsection (k)(7) are deemed to begin at the earlier of such timeframes; and

(B) the Secretary shall perform a market exclusivity review of such biological product based on the results of such studies described by the Comptroller General of the United States under section 3511 of title 31, United States Code, to ensure the validity of any potential variability.
"(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years and 6 months rather than 7 years and 6 months rather than 7 years and 6 months rather than 7 years and 6 months rather than 7 years.

(3) Market exclusivity for already-marketed biological products.—If the Secretary determines that information relating to the safety and effectiveness of a biological product for the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application under section (a) for pediatric studies (which shall include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using appropriate formulations for each group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 9 months prior to the expiration of such period.

(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years and 6 months rather than 7 years and 6 months rather than 7 years and 6 months rather than 7 years.

(4) Subsection (a) shall not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made by at the end of the following:

"(A) a hospital's children's hospital excluded from the Medicare prospective payment system pursuant to section 1888(d)(1)(B)(ii) of the Social Security Act, or a free-standing cancer hospital excluded from the Medicare prospective payment system pursuant to section 1888(d)(1)(B)(v) of the Social Security Act, that would meet the requirements of subparagraph (L)(i) if the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.

"(B) An entity that is a critical access hospital (as defined under section 1820(c)(2) of the Social Security Act) that meets the requirements of subparagraph (L)(i).

(5) Other definitions.—In this section, unless the context otherwise requires, the term 'covered drug'—

(A) means a covered outpatient drug (as defined in section 340B of the Public Health Service Act (42 U.S.C. 256b(a)(4))) and that meets the following:

(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking "outpatient" each place it appears.

(2) in subsection (b)—

(A) by striking "other definition" and all that follows through "in this section" and inserting the following: "other definitions.

1. IN GENERAL.—In this section; and

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

"(2) Covered Drug.—In this section, the term 'covered drug'—

(3) Medicaid credits on inpatient drugs.—Section 340B of the Public Health Service Act (42 U.S.C. 256b(a)) is amended by adding at the end the following:

"(c) Medicaid Credit.—Not later than 90 days after the date of filing of the hospital's application filed under this paragraph, the hospital shall issue a credit as determined by the Secretary to the State Medicaid program for inpatient covered drugs provided to Medicaid recipients.

(e) Effective dates.—

1. In general.—The amendments made by this section and section 7102 shall take effect on January 1, 2010, and shall apply to drugs purchased on or after January 1, 2010.

2. Effectiveness.—The amendments made by this section and section 7102 shall be effective and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B of the Public Health Service Act (42 U.S.C. 256b(a)), notwithstanding any other provision of law.

SEC. 7102. IMPROVEMENTS TO 340B PROGRAM INCLUDING INTEGRITY.

(a) Integrity improvements.—Section (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended to read as follows:

"(4) Improvements in program integrity.—

1. Manufacturer compliance.—
“(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section and to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

(i) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, with the following:

(I) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(II) Oversight by the Secretary to ensure that a system is in place which limits such access to covered entities and adequately assures security and protection through the use of password protection that is periodically reviewed and verified by the Secretary in accordance with the Department of Health and Human Services, or other Federal agencies for compliance with the goals of fairness and economy of resources; and

(iv) The establishment of procedures for gathering pricing data that is reported by manufacturers that violations of subsection (a)(1) as a prerequisite to initiating enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that they have been charged prices for covered drugs in excess of the applicable price which are not as a result of a violation of subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(E) have occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(ii) permit the official or body designated under clause (i), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer’s product have exceeded the applicable ceiling price under subsection (a)(1), and may submit such documents and information to the administrative official or body responsible for adjudicating such claims.

(C) FORMALIZING ADMINISTRATIVE RESOLUTION PROCESS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal year 2010 and each succeeding fiscal year.”.

(b) CONFORMING AMENDMENTS.—Section 360a(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: “Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the ‘ceiling price’); and shall require that the manufacturer annually furnish each covered entity covered drugs for purchase at or below the applicable ceiling price if such drug is made available to any other purchasers by the manufacturer.”

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 710i(c),
by inserting ‘‘after audit as described in subparagraph (D) and after ‘ finds.’’. 

SEC. 7103. GAO STUDY TO MAKE RECOMMENDATIONS ON IMPROVING THE 340B PROGRAM

(a) Report.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that exam- ines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 294e) (referred to in this section as the ‘‘340B program’’) are receiving optimal health care services.

(b) Recommendations.—The report under subsection (a) shall include recommendations on the following:

(1) Whether the 340B program should be expanded since it is anticipated that the 47,000 individuals who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is imple- mented.

(2) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

(3) Whether income from the 340B program is being used by the covered entities under the program to further the program objec- tives.

TITLE VIII.—CLASS ACT

SEC. 8001. SHORT TITLE OF TITLE.

This title may be cited as the ‘‘Community Living Assistance Services and Supports Act’’ or the ‘‘CLASS Act’’.

SEC. 8002. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

(a) Establishment of CLASS Program.—

(1) in general.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 3204(a), is amended by adding at the end the following:

‘‘TITLE XXXII.—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

‘‘SEC. 3201. PURPOSE.

‘‘The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

‘‘(1) establish programs with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for com- munity living assistance services and sup- ports;

‘‘(2) establish an infrastructure that will help address the Nation’s community living assistance services and supports needs;

‘‘(3) alleviate burdens on family caregivers; and

‘‘(4) address institutional bias by providing a financing mechanism that supports per- sonal choice and independence to live in the community.

‘‘SEC. 3202. DEFINITIONS.

‘‘In this title:

‘‘(1) active enrollee.—The term ‘active enrollee’ means an individual who is enrolled in the CLASS program in accordance with section 3204(a) who has paid any premiums due to maintain such enrollment.

‘‘(2) actively employed.—The term ‘ac- tively employed’ means an individual who—

‘‘(A) is reporting for work at the individ- ual’s usual place of employment or at an- other location to which the individual is re- quired to travel because of the individual’s employment or the case of an individual who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual’s position; and

‘‘(B) is able to perform all the usual and customary duties of the individual’s employ- ment on the individual’s regular work sched- ule.

‘‘(3) activities of daily living.—The term ‘activities of daily living’ means each of the following activities specified in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986:

‘‘(A) Eating

‘‘(B) Dressing

‘‘(C) Transferring

‘‘(D) Bathing

‘‘(E) Grooming

‘‘(4) CLASS program.—The term ‘CLASS program’ means the program established under this title.

‘‘(5) Eligibility Assessment System.—The term ‘Eligibility Assessment System’ means the entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.

‘‘(6) Eligible beneficiary.—

‘‘(A) in general.—The term ‘eligible bene- ficiary’ means any individual who is an ac- tive enrollee or an eligible enrollee and, as of the date described in subparagraph (B)—

‘‘(i) has paid premiums for enrollment in such program for at least 6 months;

‘‘(ii) has paid premiums for enrollment in such program for at least 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individ- ual’s enrollment and ends on the date of such determination.

‘‘(B) date described.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the indi- vidual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous pe- riod of more than 90 days.

‘‘(C) Regulations.—The Secretary shall promulgate regulations specifying excep- tions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

‘‘(D) Hospital; nursing facility; inter- mediate care facility for the mentally re- tarded; institution for mental dis- eases.—The terms ‘hospital’, ‘nursing facil- ity’, ‘intermediate care facility for the men- tally retarded’, and ‘institution for mental diseases’ have the meanings given such terms for purposes of Medicaid.

‘‘(E) CLASS independence benefit plan.—The term ‘CLASS independence Benefit Plan’ means the benefit plan developed and designed by the Secretary in accordance with section 3206.

‘‘(F) CLASS independence fund.—The term ‘CLASS Independence Fund’ or ‘Fund’ means the fund established under section 3206.

‘‘(G) Medicaid.—The term ‘Medicaid’ means the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

‘‘(12) poverty line.—The term ‘poverty line’ has the meaning given that term in sec- tion 4302(a) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

‘‘(13) protection and advocacy system.—The term ‘Protection and Advocacy System’ means the system for core funding established under section 143 of the Developmental Dis- abilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 1594a).

‘‘SEC. 3203. CLASS INDEPENDENCE BENEFIT PLAN

‘‘(a) Process for Development.—In general.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actu- arially sound benefit plans as alternatives for consideration for designation by the Sec- retary as the CLASS Independence Benefit Plan under which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3205 consistent with the following requirements:

‘‘(1) Premiums.—

‘‘(i) in general.—Beginning with the first year of the CLASS program, and for each subsequent year thereafter, and (iii), the Secretary shall establish all pre- miums to be paid by enrollees for the year based on an actuarial analysis of the 75-year cash flow of the program that ensures solvency throughout such 75-year period.

‘‘(ii) nominal premium for poorest indi- viduals and full-time students.—

‘‘(I) in general.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—

‘‘(aa) any individual whose income does not exceed the poverty line; and

‘‘(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

‘‘(II) applicable dollar amount.—The ap- plicable dollar amount described in this sub- clause is the amount equal to $3, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for a calendar year occurring after 2009 and before such year.

‘‘(iii) class independence fund res-erves.—At such time as the CLASS pro- gram has been in operation for 10 years, the Secretary shall establish all premiums to be paid by enrollees for the year based on an ac- tuarial analysis that accumulated reserves under the CLASS Independence Fund would not decrease in that year. At such time as the Secretary determines the CLASS program demonstrates a sustained ability to finance expected yearly expenses with expected year-ly premiums and interest credited to the CLASS Independence Fund, the Secretary may decrease the required amount of CLASS Independence Fund reserves.

‘‘(b) Vesting Period.—A 5-year vesting pe- riod for eligibility for benefits.

‘‘(C) Benefit Triggers.—A benefit trigger for provision of benefits that requires a de- termination that an individual has a func- tional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

‘‘(i) The individual is determined to be un- able to perform at least the minimum num- ber of activities of daily living as are required under the plan for the provision of benefits without substan- tial assistance (as defined by the Secretary) for a continuous period of more than 90 days.

‘‘(ii) The individual requires substantial supervision to protect the individual from
threats to health and safety due to substantial cognitive impairment.

“(iii) The individual has a level of functional limitation similar to (as determined under the Department of Health and Human Services) to the level of functional limitation described in clause (i) or (ii).

(D) Cash Benefit.—Payment of a cash benefit that satisfies the following requirements:

“(i) Minimum Required Amount.—The benefit amount provides an eligible beneficiary with sources of income that exceed by an average of $50 per day the (as determined based on the reasonably expected distribution of beneficiaries receiving benefits at various benefit levels).

“(ii) Periodic Pay.—The benefit is paid on a monthly or quarterly basis.

“(iii) No lifetime or aggregate limit.—The benefit is not subject to any lifetime or aggregate limit.

(E) Coordination with Supplemental Coverage Obtained through the Exchange.—In coordination with any supplemental coverage purchased through an Exchange established under section 1111 of the Patient Protection and Affordable Care Act.

(F) Review and Recommendation by the Class Independence Advisory Council.—The Class Independence Advisory Council shall:

“(A) evaluate the alternative benefit plans developed under paragraph (1); and

“(B) recommend for designation as the Class Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees’ needs in an actuarially sound manner while optimizing the probability of the long-term sustainability of the Class program.

(G) Designation by the Secretary.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the Class Independence Advisory Council under paragraph (2), shall designate as the Class Independence Benefit Plan. The Secretary shall publish such designation, along with details of the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

(H) Additional Premium Requirements.—

“(1) Adjustment of Premium.

“(a) General.—Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual subject to a nominal premium in the Class program shall remain the same for as long as the individual is an active enrollee in the program.

“(b) Recalculated Premium if Required for Risk Adjustment.

“(i) In General.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the Class Independence Fund, the advice of the Class Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, that the Class program is not actuarially sound for each month, the Secretary shall project the amount that the program would have paid if the enrollment in the program was for each month, the amount equal to 3 percent of all premiums paid during the year.

“(ii) No Underwriting Requirements.—No underwriting requirement shall be based on an individual’s age in accordance with subparagraph (D) and (E) of paragraph (2).

“(2) Administrative Expenditures.—In determining the monthly premiums for the Class program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

“(3) No Underwriting Requirements.—No underwriting requirement shall be based on an individual’s age in accordance with subparagraphs (D) and (E) of paragraph (2).

“(B) Student.—An individual subject to a nominal premium for enrollment in the Class program.

“(C) Recalculated Premium if Required for Risk Adjustment.

“(1) In General.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual’s enrollment in the Class program shall be treated as an initial enrollment for purposes of age-adjusting the premium for enrollment in the program.

“(2) Penalties for Reenrollment after 5-Year Lapse.—In the case of an individual who reenrolls in the Class program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required to maintain the individual’s enrollment in the Class program in each month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

“(I) in General.—The reenrollment of an individual described in this paragraph is an individual who is subject to a nominal premium on the basis of being described in subsection (a)(1)(A)(i)(B) who ceases to be described in that subsection, beginning with the first month following the month in which the individual ceases to be so described, shall be subject to the same monthly premium as the monthly premium that applies to an individual of the same age who first enrolls in the program under the most similar circumstances as the individual (such as the first year of eligibility for enrollment in the program or in a subsequent year).

“(II) notwithstanding the total amount of any such credited months, required to satisfy section 3202(6)(A)(ii) before being eligible to receive benefits.

“(D) No Longer Status as a Full-Time Student.—An individual subject to a nominal premium who is an active enrollee in the Class program.

“(E) Penalty for Reenrollment after 5-Year Lapse.—In the case of an individual who reenrolls in the Class program after the end of the 5-year period described in subparagraph (C)(ii), the monthly premium required to maintain the individual’s enrollment in the Class program and ends with the enrollment in the program.

“(F) No Underwriting Requirements.—No underwriting requirement shall be based on an individual’s age in accordance with subparagraphs (D) and (E) of paragraph (2).

“(2) Administrative Expenditures.—In determining the monthly premiums for the Class program the Secretary may factor in costs for administering the program, not to exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the year.

“(3) No Underwriting Requirements.—No underwriting requirement shall be based on an individual’s age in accordance with subparagraphs (D) and (E) of paragraph (2).

“(B) Self-Attestation and Verification of Income.—The Secretary shall establish procedures for

“(i) permit an individual who is eligible for the nominal premium required under subsection (a)(1)(A)(ii) and automatic enrollment in the Class program, to self-attest that their income does not exceed the poverty line or that their status as a full-time student who is actively employed;

“(ii) verify, using procedures similar to the procedures used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii) of the Social Security Act and consistent with the requirements applicable to the conveyance of data and information under section 1942 of such Act, the validity of such self-attestation; and

“(iii) require an individual to confirm, at least annually, that their income does not exceed the poverty line or that they remain in school to maintain such status.

“SEC. 3204. Enrollment and Disenrollment Requirements.

“(1) Automatic Enrollment.

“(A) In General.—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the Class program by an employer of such individual in the same manner as an employer may elect to automatically enroll individuals in a plan in a plan under section 308(k), 403(b), or 401 of the Internal Revenue Code of 1986.

“(B) Alternative Enrollment Procedures.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the Class program by more than 1 employer.

“(C) Administration.—

“(a) In General.—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the Class program if an employer determines that the enrollment of the individual would be, or if the individual does, such as the first year of eligibility for enrollment in the program or in a subsequent year.

“(b) Election to Opt-Out.—An individual described in subsection (c) may elect to forgo enrollment in the Class program at any time in such form and manner as the Secretary and the Secretary of the Treasury shall prescribe.

“(C) Individual Described.—For purposes of enrolling an individual in the Class program, an individual described in this paragraph is an individual...

“(1) who has attained age 18;

“(2) who...

“(A) receives wages on which there is imposed a tax under section 1631(a) of the Internal Revenue Code of 1986; or

“(B) derives self-employment income on which there is imposed a tax under section 1631(a) of the Internal Revenue Code of 1986.

“(C) who is actively employed; and

“(D) who...

“(A) a patient in a hospital or nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases and receiving medical assistance under Medicaid; or

“(B) confined in a jail, prison, other penal institution or correctional facility, or by court order pursuant to conviction of a
criminal offense or in connection with a verdict or finding described in section 202(x)(1)(A)(ii) of the Social Security Act (42 U.S.C. 422(x)(1)(A)(ii)).

(d) ELIGIBILITY DETERMINATION.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subparagraph (B) or (C) of subsection (c)(1) in order to maintain enrollment in the CLASS program.

(e) PAYMENT.—

(1) PAYROLL DEDUCTION.—An amount equal to the monthly premium for the enrollment in the CLASS program of an individual shall be deducted from the wages of self-employed individuals in accordance with such procedures as the Secretary, in coordination with the Secretaries, shall establish for employers who elect to deduct and withhold such premiums on behalf of employed enrollees.

(2) ALTERNATIVE PAYMENT MECHANISM.—The Secretary, in coordination with the Secretaries, shall establish alternative procedures for the payment of monthly premiums by an individual enrolled in the CLASS program—

(A) who does not have an employer who elects to deduct and withhold premiums in accordance with paragraph (a); or

(B) who does not earn wages or derive self-employment income.

(1) TRANSFER OF PREMIUMS COLLECTED.—

During each calendar year the Secretary of the Treasury shall deposit into the CLASS Independence Fund a total amount equal to, in the aggregate, to 100 percent of the premiums collected during that year.

(2) TRANSFERS BASED ON ESTIMATES.—

The amount deposited pursuant to paragraph (1) shall be increased, in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of the amounts collected in accordance with subparagraphs (A) and (B) of paragraph (5). Proper adjustments shall be made in amounts subsequently transferred to the Fund to the extent prior estimates were in excess of, or were less than, actual amounts collected.

OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary, in coordination with the Secretaries, shall establish procedures under which—

(1) an individual who, in the year of the individual’s initial eligibility to enroll in the CLASS program, has elected to waive enrollment and is eligible to enroll in the program, in such form and manner and as the Secretaries shall establish, only during an open enrollment period established by the Secretaries that is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment; and

(2) an individual shall only be permitted to disenroll from the program (other than for nonpayment of premiums) during an annual disenrollment period established by the Secretaries and in such form and manner as the Secretaries shall establish.

SEC. 3206. BENEFITS.

(a) APPLICATION FOR ELIGIBILITY.—

(1) ELIGIBILITY DETERMINATION.—The Secretary shall establish procedures under which an active enrollee shall apply for eligibility to enroll in the CLASS Independence Benefit Plan.

(2) ELIGIBILITY ASSESSMENTS.—

(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance with the sliding scale established under the plan).

(B) REGULATIONS.—The Secretary shall promulgate regulations as expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance with the sliding scale established under the plan).

(C) PRESUMPTIVE ELIGIBILITY FOR CERTAIN INSTITUTIONALIZED PLANNING TO DISCHARGE.—An active enrollee shall be deemed presumptively eligible if the enrollee—

(i) has applied for, and attests is entitled to, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan;

(ii) is institutionalized (but only if the hospitalization is for long-term care), nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases that the Secretary determines is specific to the individual and that may not occur more frequently than biennially after the date on which the individual first elected to waive enrollment; and

(iii) in the process of, or about to begin the process of, planning to discharge from the hospital, facility, or institution, or within 60 days from discharge from the hospital, facility, or institution.

(D) APPEALS.—The Secretary shall establish procedures under which an applicant for a cash benefit under the CLASS Independence Benefit Plan shall be guaranteed the right to appeal an adverse determination.

(b) BENEFITS.—

(1) CASH BENEFIT.—A cash benefit established by the Secretary in accordance with the requirements of section 3203(a)(1) that—

(A) the first year in which beneficiaries receive the benefits under the plan, is not less than the amount of the premium specified in clause (i) of such section; and

(B) for any subsequent year, is not less than the average per day dollar limit applicable to such subparagraph for the preceding year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) over the previous year.

(2) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

(3) ADVICE AND ASSISTANCE COUNSELING.—

Advice and assistance counseling in accordance with subsection (e).

(4) ADMINISTRATIVE EXPENSES.—

Advocacy services and advice and assistance counseling services under paragraphs (2) and (3) of this subsection shall be included as administrative expenses under section 3203(b)(3).

(c) PAYMENT OF BENEFITS.—

(1) LIFE INDEPENDENCE ACCOUNT.—

(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under the CLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another resident setting or to provide advocacy services in accordance with subsection (d).

(d) TRANSFERS OF PREMIUMS COLLECTED.—

The Secretary shall establish procedures for—

(1) crediting an account established on behalf of a beneficiary with the beneficiary’s cash daily benefit;

(2) allowing the beneficiary to access such account through electronic cards; and

(3) accounting for withdrawals by the beneficiary from such account.

(E) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for—

(1) crediting an account established on behalf of a beneficiary with the beneficiary’s cash daily benefit;

(2) allowing the beneficiary to access such account through electronic cards; and

(3) accounting for withdrawals by the beneficiary from such account.

(F) PRIMARY PAYOR RULES FOR BENEFICIARIES WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

(1) PAYROLL DEDUCTION.—Cash benefits paid into a Life Independence Account of an eligible beneficiary who is enrolled in Medicaid shall be guaranteed the right to appeal an adverse determination.

(2) BENEFACTORS RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subsection (I), if a beneficiary is receiving medical assistance paid for by Medicaid for community-based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary’s personal needs allowance provided under Medicaid), and the remainder of such benefit shall apply toward the facility’s cost, providing the beneficiary’s care, and Medicaid shall provide secondary coverage for such care.

(II) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—

(1) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subsection (I), if a beneficiary is receiving medical assistance paid for by Medicaid for community-based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary’s personal needs allowance provided under Medicaid), and the remainder of such benefit shall apply toward the facility’s cost, providing the beneficiary’s care, and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary’s daily or weekly cash benefit under subsection (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n), or the State plan that is a Title XIX plan or a Title XIX plan under subsection (I) of such section does not include a waiver of the requirements of section 1902(a)(1) of the Social Security Act (relating to statewideness) or of section 2131 of the Social Security Act (relating to new comparability) and the State offers at a minimum case management services, personal.
care services, habilitation services, and respite care under such a waiver or State plan amendment.

"(III) AGENCY FOR HOMECARE OR FAMILY CARE SERVICES.—The term "agency for homecare or family care services" means any agency that offers services to the disabled or to the elderly that are provided in the home or community setting. Such agencies shall meet the requirements of the Federal Government, or the State Government in which the agency is located, that are applicable to such agencies.

"(IV) IN GENERAL.—Subject to subparagraph (I), if a beneficiary is receiving medical assistance under Medicaid for program services under section 1904 of the Social Security Act (42 U.S.C. 1396a–4), the beneficiary shall retain a portion equal to 50 percent of the beneficiary's daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost of the benefits. Such assistance shall be paid to, or on behalf of, the eligible beneficiary on whose behalf such benefits are paid.

"(V) QUALITY ASSURANCE AND PROTECTION AGAINST ABUSE.—The Secretary shall establish procedures to ensure that the benefits paid to the beneficiary are used in accordance with the applicable annual benefit period. Such benefits shall be paid in accordance with procedures established by the Secretary. Such benefits shall not be paid to the beneficiary more frequently than the applicable annual benefit period.

"(VI) INSTITUTIONALIZED RECIPIENTS OF PACE PROGRAMS.—In the case of an eligible beneficiary who is institutionalized in a long-term care facility, the benefits shall be paid to, or on behalf of, the eligible beneficiary on whose behalf such benefits are paid.

"(VII) IN GENERAL.—An eligible beneficiary may elect to have the Secretary, by regulation, may require the following:

"(A) recertify by submission of medical evidence of the beneficiary's continued eligibility for benefits; and

"(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary during the preceding year.

"(VIII) SUPPLEMENT, NOT SUPPLANT OTHER HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (1)(D), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federal or State plan that provides health care benefits.

"(IX) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the Protection and Advocacy System for the State to—

"(i) assign, as needed, an advocate or an attorney to the eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

"(I) information regarding how to access the appeals process established for the program;

"(II) assistance with respect to the annual recertification and notification required under subsection (c)(6); and

"(III) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

"(ii) ensure that the System and such counselors comply with the requirements of subsection (h).

"(X) ADVICE AND ASSISTANCE COUNSELING.—An agreement entered into under subsection (a)(2)(A)(iii) shall require the entity to assign, as needed, an advocate or an attorney to the eligible beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with information regarding—

"(i) accessing and coordinating long-term services and supports in the most integrated setting;

"(ii) such other assistance with obtaining services as the Secretary, by regulation, shall require; and

"(III) development of a service and support plan;

"(IV) information about programs established under the Technology Transfer Assistance Act of 1990 and the services offered under such programs;

"(V) available assistance with decision making, including individual advocates who shall provide the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, as such a living will or durable power of attorney for health care, in the case that an injury or illness leaves the individual unable to make health care decisions; and

"(VI) such other services as the Secretary, by regulation, may require.

"(X) EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles X, XVI, XVIII, XIX, or XXI of the Social Security Act (42 U.S.C. 301 et seq., 1381 et seq., 1396 et seq., 1396aa et seq.), under the laws administered by the Secretary of Veterans Affairs, under low-income housing assistance programs, or under the supplemental nutrition assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 1161 et seq.).

"(X) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community support services and supports to an eligible beneficiary.

"(X) PROTECTION AGAINST CONFLICT OF INTERESTS.—The Secretary shall establish procedures to ensure that the Protection and Advocacy System for the State, the advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

"(i) The entity providing counseling or planning services, such services are provided in a manner that fosters the best interests of the active enrollee or beneficiary.

"(ii) The entity has established operating procedures that are designed to avoid or minimize conflicts of interest between the entity and an active enrollee or beneficiary.

"(iii) The entity provides information about all services and options available to the active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

"(iv) The entity assigns the active enrollee or beneficiary to access desired services, regardless of the provider.

"(v) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries receive services from the entity or another entity.

"(vi) If the entity provides counseling or planning services, the entity ensures that an active enrollee or beneficiary is informed of any financial interest that the entity has in a service provider.

"(vii) The entity provides an active enrollee or beneficiary with a list of available service providers that can meet the needs of the active enrollee or beneficiary.

"SEC. 3208. CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the "CLASS Independence Benefit Plan Trust Fund." The Secretary shall serve as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under sections 3202(a)(1)(A) and 3207(b)(2)(A) following the first investment of such amounts under section 3207(b), including additional amounts derived from income from such investments. The amounts credited to such Fund shall remain available without fiscal year limitation.
CLASS Independence Fund is to be managed. Including necessary changes in the provisions under section 3203(b)(1)(B)(i).

The Board of Trustees shall meet not less frequently than once each calendar year. A member serving on the Board of Trustees shall not be from the same political party, who shall be nominated by the President for a term of 4 years and subject to confirmation by the Senate. A member of the Board of Trustees is a member designated and nominated to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of that term. An individual nominated and confirmed as a member of the public may serve in such position after the expiration of such member’s term until the earlier of the time at which the member’s successor takes office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member’s term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

"(2) DUTIES.—"

"(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

(ii) Report to the Congress not later than the first day of April of each year on the operation and status of the CLASS Independence Fund and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

(iii) Report immediately to the Congress whenever the Board is of the opinion that the amount of the CLASS Independence Fund is not actuarially sound in regards to the provisions under section 3203(b)(1)(B)(i).

(iv) Review the general policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including any needed changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

"(B) REPORT.—The report provided for in subparagraph (A)(i) shall—"

(1) include—

(I) a statement of the assets of, and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

(II) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

(III) a statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year, and

(IV) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable;

(ii) be printed as a House document of the session of Congress to which the report is made.

"(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projection under section 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determine to be appropriate, including whether to administratively or otherwise impose a temporary moratorium on new enrollments.

"SEC. 3207. CLASS INDEPENDENCE ADVISORY COUNCIL.

"(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the ‘CLASS Independence Advisory Council’.

(b) MEMBERSHIP.—"

(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of not more than 15 individuals, not otherwise in the employee service office or the time at which a report of the Board is first issued under paragraph (2) after the expiration of the member’s term. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(2) LIMITATION.—A member shall not be appointed to fill a vacancy occurring prior to the expiration of a term, in the case of any appointed to fill a vacancy occurring prior to the expiration of a term, in the case of any

(3) Term.—"

(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve for terms of 3 years unless appointed to fill a vacancy occurring prior to the expiration of a term, in the case of any

(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

(c) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

(d) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—"

(1) the development of the CLASS Independence Benefit Plan. For purposes of this subsection, the term ‘taxpayer funds’ means any Federal funds from a source other than the CLASS program. Such individuals may participate in the CLASS Independence Fund and any associated interest earnings.

(2) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with the regulations adopted by the program. Such regulations shall include provisions to prevent fraud and abuse under the program.

(3) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

(1) The total number of enrollees in the program.

(2) The total number of eligible beneficiaries.

(3) The total amount of cash benefits provided during the fiscal year.

(4) A description of instances of fraud or abuse observed during the reporting period.

(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program and ensure the solvency, or to prevent the occurrence of fraud or abuse.

"SEC. 3209. INSPECTOR GENERAL’S REPORT.

"(a) In General.—The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

(1) The eligibility determination process.

(2) The provision of benefits and services.

(3) Quality assurance and protection against waste, fraud, and abuse.

(4) Recoupment of unpaid and accrued benefits.

"SEC. 3210. TAX TREATMENT OF PROGRAM.

"(a) In General.—The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services."

"(b) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (80) the following:

"(81) "CLASS Independence Benefit Plan."

"SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

"(a) SOLVENCY.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS Independence Advisory Council, for purposes of ensuring that enrollee premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 20- and 75-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3203.

"(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.—No taxpayer funds shall be used for payment of benefits under the CLASS Independence Benefit Plan. For purposes of this subsection, the term ‘taxpayer funds’ means any Federal funds from a source other than the CLASS program. Such individuals may participate in the CLASS Independence Fund and any associated interest earnings.

"(c) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary for fiscal year 2011 and for each fiscal year thereafter.

"(d) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

(1) The total number of enrollees in the program.

(2) The total number of eligible beneficiaries.

(3) The total amount of cash benefits provided during the fiscal year.

(4) A description of instances of fraud or abuse observed during the reporting period.

(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program and ensure the solvency, or to prevent the occurrence of fraud or abuse.

"(e) AUTHORIZATION OF APPROPRIATIONS.—"

(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council to carry out its duties under this section, such sums as may be necessary for fiscal year 2011 and for each fiscal year thereafter.

"(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

"SEC. 3205. ELECTION OF TRUSTEES; REGULATIONS; ANNUAL REPORT.

"(a) ELECTION OF TRUSTEES.—The Trustees of the CLASS Independence Fund shall be elected by the participants in the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

(1) The eligibility determination process.

(2) The provision of benefits and services.

(3) Quality assurance and protection against waste, fraud, and abuse.

(4) Recoupment of unpaid and accrued benefits.

"SEC. 3210. TAX TREATMENT OF PROGRAM.

"(a) In General.—The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services."

"(b) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (80) the following:

"(81) "CLASS Independence Benefit Plan."

"SEC. 3208. SOLVENCY AND FISCAL INDEPENDENCE; REGULATIONS; ANNUAL REPORT.

"(a) SOLVENCY.—The Secretary shall regularly consult with the Board of Trustees of the CLASS Independence Fund and the CLASS Independence Advisory Council, for purposes of ensuring that enrollee premiums are adequate to ensure the financial solvency of the CLASS program, both with respect to fiscal years occurring in the near-term and fiscal years occurring over 20- and 75-year periods, taking into account the projections required for such periods under subsections (a)(1)(A)(i) and (b)(1)(B)(i) of section 3203.

"(b) NO TAXPAYER FUNDS USED TO PAY BENEFITS.—No taxpayer funds shall be used for payment of benefits under the CLASS Inde-
prove that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall determine.

(b) Assurance of Adequate Infrastructure for the Provision of Personal Care Attendants.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a), as amended by subsection (a)(2)), is amended by inserting after paragraph (81) the following:

"(82) design or create such entities to serve as fiscal agents for, employers of, and providers of employment-related benefits for, personal care attendant workers who provide personal care services receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;"

(c) Personal Care Attendants Workforce Advisory Panel.—(1) Establishment.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish a Personal Care Attendants Workforce Advisory Panel for the purpose of examining and advising the Secretary and Congress on workforce issues related to personal care attendant workers, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from receiving benefits under the CLASS program, including in rural and underserved areas; and

(2) Ensure that the designation or creation of such entities will not permit the creation or employment of workers or inhibit such individuals from receiving such benefits that are for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SUPPORTED HEALTH COVERAGE.

(a) In General.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

"Sec. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SUPPORTED HEALTH COVERAGE.

"(a) Imposition of Tax.—If—

"(1) an employer provides coverage under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

"(2) there is any excess benefit with respect to the coverage, there is hereby imposed a tax equal to 40 percent of the excess benefit.

"(b) Excess Benefit.—For purposes of this section—

"(1) In General.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage of an employer to an employee during any taxable period, the excess of the amounts determined under paragraph (2) for months during the taxable period.

"(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

"(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

"(B) an amount equal to 1/12 of the annual limitation which applies for the tax year in which the month occurs.

"(3) ANNUAL LIMITATION.—For purposes of this subsection—

"(A) In General.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

"(B) Replacement of Annual Limitation.—The annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subparagraphs (B) and (C)) to which the employee is covered by the employer as of the beginning of the month.

"(C) Applicable Dollar Limit.—Except as provided in paragraph (1), the dollar limit under this subparagraph is—

"(i) in the case of an employee with self-only coverage, $8,500, and

"(II) in the case of an employee with coverage other than self-only coverage, $23,000.

"(2) In the case of an individual who is a qualified retiree or who participates in a plan sponsored by an employer the majority of whose qualified employees are engaged in professions or employed to repair or install electrical or telecommunications lines—

"(I) the dollar amount in clause (i)(1) (determined after the application of subparagraph (D)) shall be increased by $1,350, and

"(II) the dollar amount in clause (i)(II) (determined after the application of subparagraph (D)) shall be increased by $3,000.

"(3) Subsequent Years.—In the case of any calendar year after 2015, each of the dollar amounts under clauses (1) and (2) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

"(I) such amount as in effect, multiplied by

"(II) the cost-of-living adjustment determined under section 11433(c) for such year (determined without regard to the calendar year for which such adjustment was determined).

"(4) TRANSITION RULE FOR STATES WITH HIGHEST COST SHARING.

"(I) In General.—If an employer is a resident of a high cost State on the first day of any month beginning after 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employer shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(iii)).

"(II) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.

"(III) HIGH COST STATE.—The term 'high cost State' means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates have the highest average premium paid in the State for health insurance coverage under health plans. The Secretary's estimate shall be made on the basis of aggregate premiums paid in the State for health insurance coverage in the most recent data available as of August 31, 2012.

"(4) LIABILITY TO PAY TAX.—

"(I) In General.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

"(2) Coverage Provider.—For purposes of this subsection, the term 'coverage provider' means each of the following:

"(A) Health Insurance Coverage.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health plan issuer.

"(B) HSA and MSA Contributions.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

"(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

"(3) Applicable Share.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the
which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

(B) HEALTH INSURANCE.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 125(e)(2)), the cost of the coverage shall be equal to the sum of—

(i) the amount of employer contributions under any such flexible spending election under the arrangement, plus

(ii) the amount determined under subparagraph (A) with respect to any reimbursements under the plan in excess of the contributions described in clause (i).

(C) ARCHER MSAS AND HSA.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be treated as having been made in a taxable period on such basis as the Secretary may prescribe.

(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4) of the excess, but no penalty shall be imposed on the employer with respect to such amount, and

(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which it is attributable and ending on the date of payment of the penalty.

(2) LIMITATIONS ON PENALTY.—

(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DUE TO INNOCENT DUPLICATION.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period to which it is attributable to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

(i) such failure was due to reasonable cause and not to willful neglect, and

(ii) such failure is corrected during the 30-day period beginning on the date the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1)(B) to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

(3) GENERAL DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) COVERAGE DETERMINATIONS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated as having self-only coverage with respect to any applicable employer-sponsored coverage of an employer if the employee is an employee of the employer.

(B) MINIMUM ESSENTIAL COVERAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee has coverage under a health insurance policy or plan other than self-only coverage in a group health plan which provides minimum essential coverage (as defined in section 9832A(e)(2)) to the employee and a minimum essential benefit is offered to the employee which is at least as generous as the benefits provided under such minimum essential coverage do not vary based on the individual who is covered under such coverage, the employee is in a grandfathered plan, and

(2) QUALIFIED RETIREE.—The term ‘qualified retiree’ means any individual who—

(A) is receiving coverage by reason of being a retiree.

(B) has attained age 55, and

(C) is not entitled to benefits or eligible for enrollment under the Medicare program under title XVIII of the Social Security Act.

(3) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSIONAL ACTIVITIES.—The term ‘employees engaged in high-risk professional activities’ means law enforcement officers (as such term is defined in section 1294 of the Omnibus Crime Control and Safe Streets Act of 1968), individuals who provide off-the-job emergency medical care (including emergency medical technicians, paramedics, and first-responders), and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries. Such term includes an employee who is retired from a high-risk profession other than the preceding sentence, if such employee satisfied the requirements of such sentence for a period of not less than 20 years during the employee’s employment.

(4) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning given such term by section 5000(b)(1).

(5) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

(A) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning given to such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

(B) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning given such term by section 9832(b)(2).

(6) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term ‘person that administers the plan benefits’ shall include the plan sponsor if the plan sponsor administers benefits under the plan.

(7) PLAN SPONSOR.—The term ‘plan sponsor’ has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

(8) TAXABLE PERIOD.—The term ‘taxable period’ means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.
amended by section 1513, is amended by adding at the end the following new item:

"(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SUPPORTED HEALTH COVERAGE ON W-2.

(a) In General.—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking "and"

and "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting a semicolon, and by adding after paragraph (13) the following new paragraph:

"(14) the aggregate cost (determined under rules similar to the rules of section 6080(a)(4) of applicable employer-supported coverage (as defined in section 6080(d)(1)), except that this paragraph shall not apply to—

(A) coverage to which paragraphs (11) and (12) apply, or

(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 1259).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. DETERMINATIONS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 (relating to health flexible reimbursement arrangements) is amended by adding at the end the following new subsection:

"(f) Reimbursements for Medicine Qualified Only If Prescribed Drug or Insulin.—(1) HSAS—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(2) Archer MSAs—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(c) Health Flexible Spending Arrangements and Health Reimbursement Arrangements.—Section 105 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) Determinations for Medicine Restricted to Prescribed Drugs and Insulin.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS—Subsections made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2010.

(2) REIMBURSEMENTS—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) HSAS.—Section 223(f)(3)(A) of the Internal Revenue Code of 1986 is amended by striking "10 percent" and inserting "20 percent".

(b) Archer MSAs.—Section 223(f)(3)(A) of the Internal Revenue Code of 1986 is amended by striking "15 percent" and inserting "20 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER COVERED EMPLOYERS.

(a) In General.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

"(i) Limitation on Health Flexible Spending Arrangements for a Facility.—The benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2011.

SEC. 9006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) In General.—Section 6041 of the Internal Revenue Code of 1986 (relating to furnishing statements prescribed by the Secretary before the date of the enactment of this section) is amended by adding at the end the following new subsections:

"(h) Application to Corporations.—Notwithstanding the requirements of subsection (a), the Secretary may prescribe regulations governing the furnishing of statements made by any corporation to which the requirements of this subsection apply.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting "amounts in consideration for property," after "wages,",

(2) by inserting "gross proceeds," after "emoluments, or other", and

(3) by inserting "proceeds, after setting forth the amount of such.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS.—Section 501(c)(3) Charitable Hospital Organization.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporate income) is amended by redesignating subsection (c)(3) as subsection (c)(4) unless the organization—

(1) meets the community health needs assessment requirements described in paragraph (3); and

(2) meets the financial assistance policy requirements described in paragraph (4).

(b) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

(1) establishes and applies a policy that describes, and the applicable policies of any such facility, and

(2) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility.

(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

(A) In general.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

(ii) is made widely available to the public.

(B) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

(1) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care;

(ii) the basis for calculating amounts charged to patients,

(iii) the method for applying for financial assistance;

(iv) in the case of an organization which does not have a separate billing and collection policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

(iv) measures to widely publicize the policy within the community to be served by the organization.

(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy of the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395d) to individuals regardless of their eligibility under the financial assistance policy described in paragraph (A).

(C) LIMIT ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

(A) limits amounts charged for emergency medical care to other medically necessary by care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

(B) prohibits the use of gross charges.
"(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection activity. To the organization including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (4)(A).

(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this section. The Secretary may also establish, in consultation with the Secretary of Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(8) EFFECTIVE DATES.—
(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(9) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to tax-exempt hospitals regarding costs incurred for community benefit activities.

SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.’’.

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of this Code is amended by adding at the end the following new item:

‘‘SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.’’.

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary’s delegate shall review at least once every 3 years the organization’s determination of the amount of its activities that constitute community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDIT ON FL STRATEGIES.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of subparagraph (B) of such section and by redesigning paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

With respect to a covered entity’s aggregate branded prescription drug sales during the calendar year that are:

- Not more than $5,000,000
- More than $5,000,000 but not more than $125,000,000
- More than $125,000,000 but not more than $225,000,000
- More than $225,000,000 but not more than $400,000,000
- More than $400,000,000

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity’s branded prescription drug sales on the basis of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under section (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ‘‘covered entity’’ means any manufacturer or importer with gross receipts from sales taken into account under paragraph (1) of section 501(r)(3) of the Internal Revenue Code of 1986.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under section (a) or (b) of section 52 of the Internal Revenue Code of 1986 are in a controlled group.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of paragraphs (2) and (3), the amendments made by subsection (a), shall apply to tax-exempt hospitals regarding costs incurred for community benefit activities.

(e) REPORTS.—

(1) STUDY.—The study submitted by the Secretary of the Treasury under section (e) bears to $2,300,000,000 as—

- 0 percent
- 10 percent
- 20 percent
- 30 percent
- 40 percent
- 50 percent
- 60 percent
- 70 percent
- 80 percent
- 90 percent
- 100 percent

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(g) GENERAL.—For purposes of paragraph (1), the term ‘‘branded prescription drug sales’’ includes sales of drugs to any specified government program or pursuant to coverage under such program.

(h) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term ‘‘branded prescription drug sales’’ includes sales of drugs to any specified government program or pursuant to coverage under such program.

(2) FEMALES.—The term ‘‘branded prescription drug sales’’ means—

(i) any prescription drug the application for which was submitted under section 595(b)
of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or
(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (22 U.S.C. 262(a)).

(2) Prescription drug.—For purposes of subparagraph (A)(i), the term “prescription drug” means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) Exclusion of orphan drug sales.—The term “prescription drug sales” shall not include sales of any drug or biological product with respect to which a credit was allowed or any rebate attributable under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) Specified government program.—The term “specified government program” means—
(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,
(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,
(C) the Medicaid program under title XIX of the Social Security Act,
(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,
(E) the TRICARE program under which branded prescription drugs are procured by the Department of Defense, or
(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(5) Tax treatment of fees.—The fees imposed by this section—
(A) the Medicare Part D program under part D of title XVIII of the Social Security Act, and
(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the fee imposed by this subsection for the purposes of paragraph (1) to the extent that such credit was allowed or any rebate attributable under section 45C of the Internal Revenue Code of 1986. Each such determination shall be made not later than the annual payment date of each calendar year beginning after 2009. A fee in an amount determined under subparagraph (A) is imposed by this section.

(a) Imposition of fee.—
(1) In general.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under section 3690B(c) of the Patient Protection and Affordable Care Act of 2009 after “this part”.

(b) Annual payment date.—For purposes of this section, the term “annual payment date” means with respect to any calendar year, the date determined under paragraph (1). The Secretary shall publish guidance necessary to carry out the purposes of this section.

(c) Application of section.—This section shall be considered to be a tax described in section 275 of such Code.

(d) Reporting requirement.—Not later than September 30 of each calendar year, each covered entity shall report to the Secretary the gross receipts from medical device sales taken into account during the preceding calendar year, in the following format:

<table>
<thead>
<tr>
<th>Gross Receipts from Sales Taken into Account</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not more than $5,000,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>More than $5,000,000 but not more than $25,000,000</td>
<td>50 percent</td>
</tr>
<tr>
<td>More than $25,000,000</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

The percentage of gross receipts taken into account is:

(3) Secretarial determination.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and subject to the use of any other source of information available to the Secretary.

(c) Covered entity.—

(1) In general.—For purposes of this section, the term “covered entity” means any manufacturer or importer with gross receipts from medical device sales.

(2) Controlled groups.—
(A) In general.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(b) Inclusion of foreign corporations.—
For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) Medical device sales.—For purposes of this section—

...
(1) IN GENERAL.—The term “medical device sales” means sales for use in the United States of any medical device, other than the sales of a medical device that—
(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or
(B) has been classified in class I under such section.

(2) UNITED STATES.—For purposes of paragraph (1), the term “United States” means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term “medical device” means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(4) REPORTING REQUIREMENT.—
(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—
(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—
(i) $10,000, plus
(ii) the lesser of—
(I) an amount equal to $1,000, multiplied by the number of days during which such failure continues, or
(II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—
(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,
(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and
(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(g) SECRETARY.—For purposes of this section, the term “Secretary” means the Secretary of the Treasury or the Secretary’s delegate.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another covered entity or to another entity by reason of the application of subsection (c)(2).

(i) APPLICATION OF SECTION.—This section shall apply to any medical device sales after December 31, 2008.

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—
(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(b) DETERMINATION OF FEE AMOUNT.—
(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $6,700,000,000 as—
(A) the sum of—
(I) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, plus
(ii) 200 percent of the covered entity’s third party administration agreement fees that are taken into account during the preceding calendar year, bears to
(B) the sum of—
(i) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year, plus
(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1) .
(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year shall be determined in accordance with the following table:

<table>
<thead>
<tr>
<th>Premiums Written</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not more than $25,000,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>More than $25,000,000 but not more than $50,000,000</td>
<td>50 percent</td>
</tr>
<tr>
<td>More than $50,000,000</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account for any calendar year with respect to any covered entity shall be determined in accordance with the following table:

<table>
<thead>
<tr>
<th>Fees</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not more than $5,000,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>More than $5,000,000 but not more than $10,000,000</td>
<td>50 percent</td>
</tr>
<tr>
<td>More than $10,000,000</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

(3) SECRETARIAT DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—
(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any entity which provides health insurance for any United States health risk.

(2) EXCLUSION.—Such term does not include—
(A) any employer to the extent that such employer self-insures its employees’ health risks, or
(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) CONTROLLED GROUPS.—
(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(B) thereof.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term “United States health risk” means the health risk of any individual who is—
(1) a United States citizen,
(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or
(3) located in the United States, with respect to the period such individual is so located.

(e) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—For purposes of this section, the term “third party administration agreement fees” means, with respect to any covered entity, amounts received from an employer which are in excess of payments made by such covered entity for health benefits...
under an arrangement under which such em-
ployer self-insures the United States health risk of its employees.

(7) TAX TREATMENT OF FEES.—The fees imposed
pursuant to paragraph (1) on the date pre-
scribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause (as established by the party failing to file such report), are deductible by such employer in computing the employer's income tax for the taxable year in which the failure occurred.

(g) REPORTING REQUIREMENT.—(1) IN GENERAL.—The Secretary shall report the results of the study to the Committee on Ways and Means of the House of Representa-
tives and to the Committee on Finance of the Senate not later than December 31, 2012.

SEC. 9012. ELIMINATION OF DEDUCTION FOR EX-
PENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Inter-
nal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9013. MODIFICATION OF DEDUCED DEDU-
CTION FOR MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of any taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer or such taxpayer's spouse has attained age 65 before the close of such taxable year.'.

(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "by substituting '10 percent' for '7.5 percent' and inserting "without regard to subsection (f) of such section'."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9014. LIMITATION ON EXCESSIVE REMU-
nERNATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Inter-
nal Revenue Code of 1986 is amended by adding at the end the following new subpara-
graph:

"(6) SPECIAL RULE FOR APPLICATION TO CER-
tAIN HEALTH INSURANCE PROVIDERS.—(A) IN GENERAL.—No deduction shall be allowed under this chapter—

"(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is paid by an applicable individual during such taxable year, to the extent that the amount of such remuneration exceeds $500,000, or

"(ii) in the case of deferred deduction remuneration for services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $2,000,000.

(B) APPLICABLE INDIVIDUAL REMUNERA-
tION.—The term 'applicable individual remuneration' means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

(C) APPLICABLE INDIVIDUAls.—For purposes of this paragraph, the term 'applicable individual' means—

"(i) who is an officer, director, or employee in such taxable year, or

"(ii) who provides services for or on behalf of any covered health insurance provider during such taxable year.

(D) REGULATORY AUTHORITY.—The Sec-
tary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.

(E) DISQUALIFIED DEDUCTION REMU-
nERNATION.—For purposes of this paragraph, the term 'disqualified deduction remuneration' means remuneration which would be disqualified deduction remuneration if such remuneration were paid by an applicable individual during a taxable year.

(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means remuneration which would be disqualified deduction remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of para-
graph (4) shall apply for purposes of this paragraph.

(H) REGULATORY AUTHORITY.—The Sec-
tary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.

(i) STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.

(a) IN GENERAL.—The Secretary of Vet-
era shall conduct a study on the ef-
fect (if any) of the provisions of sections 9008, 9009, and 9101 on—

"(1) the cost of medical care provided to veterans.

(b) REPORT.—The Secretary of Veterans Af-
fairs shall report the results of the study under subsection (a) to the Committee on Ways and Means of the House of Representa-

(c) ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—(1) IN GENERAL.—Section 3121(b) of the Inter-
nal Revenue Code of 1986 is amended—

"(A) by striking "In addition" and inserting the follow-
ing:

"(i) in General.—In addition to

"(ii) by striking the following percentages of the" and inserting "1.45 percent of the", and

"(iii) by striking "(as defined in section 3121(b))" and all that follows and inserting "(as defined in section 9832(b)(2))".

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

"(i) IN GENERAL.—The term 'covered health insurance provider' means—"
(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, trust, or executor or administrator) an amount equal to 0.5 percent of wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2011, and which are in excess of $200,000, and

(A) in the case of a joint return, $250,000, and

(B) in any other case, $200,000.

(2) EFFECTIVE DATE.—Section 3102 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(i) in the case of a joint return, $250,000,

(ii) in any other case, $200,000.

(B) COVERAGE WITH FICA.—The amounts under clauses (i) and (ii) of subparagraph (A) shall be reduced (but not below zero) by the amount of wages taken into account in determining the tax imposed under section 3121(b)(2) with respect to the taxpayer.

(2) REDUCTION FOR ADDITIONAL TAX.—

(A) IN GENERAL.—Section 1401(b) of such Code is amended by inserting "(other than the taxes imposed by section 1401(b)(2))" after "section 1401(b)".

(B) DEDUCTION FOR NET EARNINGS FROM SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting "(determined without regard to the rate imposed under paragraph (2) of section 1401(b))" after "for such year".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to taxable years beginning after December 31, 2011.

SEC. 9016. MODIFICATION OF SECTION 833 TREATMENT OF CERTAIN HEALTH INSURANCE PLANS.

(a) IN GENERAL.—Subsection (c) of section 833 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(7) NONAPPLICATION OF SECTION IN CASE OF LOW MEDICAL LOSS RATIO.—Notwithstanding the preceding paragraph, this section shall not apply to any organization unless such organization's percentage of total premium revenue expended on reimbursement for clinical services provided under its plans during such taxable year (as reported under section 2718 of the Public Health Service Act) is not less than 85 percent.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 9017. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

"(a) IN GENERAL.—Subsection (a) of section 5001A of the Internal Revenue Code is amended by inserting "(other than a corporation, estate, trust) for each taxable year beginning after December 31, 2012, and which are in excess of—"

"(1) IN GENERAL.—In addition to the tax imposed by section 3101(b)(2), subsection (a) shall apply only to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.

(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

"(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no way relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.

(b) SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting "(defined in section 3121(b))" after "wages" as so defined.

(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

"(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no way relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.

(c) DEFENDANT.—The term ‘dependent’ has the same meaning as when used in section 152.

(2) TRIBAL ORGANIZATION.—The term ‘tribal organization’ has the same meaning as when used in section 2718.

(3) MEDICAL CARE.—The term ‘medical care’ has the same meaning as when used in section 213.

(4) ACCIDENT OR HEALTH INSURANCE.—The term ‘accident or health insurance’ has the same meaning as when used in section 2718.

(5) NONAPPLICATION.—The term ‘nonapplication’ has the same meaning as when used in section 2718.

SEC. 9018. EXCISE TAX ON ELECTIVE COSMETIC MEDICAL PROCEDURES.

"(a) IN GENERAL.—Subsection (a) of section 5001A of the Internal Revenue Code is amended by inserting "(other than a corporation, estate, trust) for each taxable year beginning after December 31, 2012, and which are in excess of—"

"(1) IN GENERAL.—In addition to the tax imposed by section 3101(b)(2), subsection (a) shall apply only to the extent to which the taxpayer receives wages from the employer in excess of $200,000, and the employer may disregard the amount of wages received by such taxpayer's spouse.

(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

"(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no way relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.

(b) SELF-EMPLOYMENT.—Subparagraph (B) of section 1402(a)(12) is amended by inserting "(defined in section 3121(b))" after "wages" as so defined.

(2) COLLECTION OF AMOUNTS NOT WITHHELD.—To the extent that the amount of any tax imposed by section 3101(b)(2) is not collected by the employer, such tax shall be paid by the employee.

"(3) TAX PAID BY RECIPIENT.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereafter the tax is paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no way relieve the employer from liability for any penalties or additions to tax otherwise applicable in respect of such failure to deduct and withhold.

(c) DEFENDANT.—The term ‘dependent’ has the same meaning as when used in section 152.

(2) TRIBAL ORGANIZATION.—The term ‘tribal organization’ has the same meaning as when used in section 2718.

(3) MEDICAL CARE.—The term ‘medical care’ has the same meaning as when used in section 213.

(4) ACCIDENT OR HEALTH INSURANCE.—The term ‘accident or health insurance’ has the same meaning as when used in section 2718.

(5) NONAPPLICATION.—The term ‘nonapplication’ has the same meaning as when used in section 2718.

SEC. 9019. ESTABLISHMENT OF SIMPLE CAFE-TERIA PLANS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to sections for part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 the following new item:

"(a) SIMPLE CAFE-TERIA PLANS FOR SMALL BUSINESSES.—"
amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (k) the following new subsection:

"(l) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

"(1) IN GENERAL.—An eligible employer maintaining a cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement of that plan for such year.

"(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—

"(A) which is established and maintained by an eligible employer, and

"(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

"(3) CONTRIBUTION REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

"(i) 6 percent of the average of the employee's compensation for each year during either of the 2 preceding years, or

"(ii) an amount which is not less than the lesser of—

"(I) 6 percent of the employee's compensation for the plan year, or

"(II) twice the amount of the salary reduction contributions of each qualified employee.

"(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

"(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from providing contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

"(D) DEFINITIONS.—For purposes of this paragraph—

"(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includable in gross income by reason of this section.

"(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with respect to a cafeteria plan, any person who is not a highly compensated or key employee, and who is eligible to participate in the plan.

"(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 414(q).

"(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 416.

"(D) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

"(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

"(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

"(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an employee may elect to exclude under the plan employees—

"(i) who have not attained the age of 21 before the close of a plan year,

"(ii) who have attained the age of 70 and one half before the close of a plan year,

"(iii) who are covered under an agreement which the Secretary finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer,

"(iv) who are described in section 411(b)(3)(C) (relating to nonresident aliens working outside the United States). A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

"(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 200 or more employees on business days during any year preceding any such year.

"(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence during the preceding year, the term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 200 or more employees on business days during either of the 2 preceding years.

"(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

"(1) IN GENERAL.—If—

"(i) an employer was an eligible employer for any year (a 'qualified year'), and

"(II) such employer establishes a simple cafeteria plan for its employees for such year, then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

"(2) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

"(D) SPECIAL RULES.—

"(1) PREEXEMPTIONS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

"(2) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

"(E) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term 'applicable nondiscrimination requirement' means any requirement under subsection (b), section 79(h), section 415(h), section 1905(h), section 416(b)(4), or section 129(d).

"(F) COMPENSATION.—The term 'compensation' has the meaning given such term by section 414(s).

"(G) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2010."

"SECT. 9022. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

"(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 48C the following new section:

"SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

"(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

"(b) QUALIFIED INVESTMENT.—

"(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project.

"(2) LIMITATION.—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for credit under this section.

"(3) EXCLUSIONS.—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any cost—

"(A) for remuneration of an employee described in section 1252(b) of title 26, Code of Federal Regulations,

"(B) for interest expenses,

"(C) for facility maintenance expenses,

"(D) which is identified as a service cost under section 1263(c)(8) of title 26, Code of Federal Regulations, or

"(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.

"(4) CERTAIN PROGRESS EXPENDITURE RULES MADE APPLICABLE.—In the case of costs described in paragraph (1) that are paid for property of a character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

"(5) APPLICATION OF SUBSECTION.—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

"(c) DEFINITIONS.—

"(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—

"(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

"(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or clinical conditions, or carrying out research protocols, for the purpose of developing molecular diagnostics to guide therapeutic decisions, or

"(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

"(2) ELIGIBLE TAXPAYER.—

"(A) IN GENERAL.—The term 'eligible taxpayer' means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).

"(B) AGGREGATION.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection
(m) or (o) of section 414, shall be so treated for purposes of this paragraph.

"(3) FACILITY MAINTENANCE EXPENSES.—The term 'facility maintenance expenses' means costs paid or incurred to maintain a facility, including—

"(A) mortgage or rent payments,

"(B) insurance payments,

"(C) utility and maintenance costs, and

"(D) costs of employment of maintenance personnel.

"(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECTS.—

"(1) Establishment.—

"(A) In general.—Not later than 60 days after the date of the enactment of this section, the Secretary may require, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

"(B) Limitation.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

"(2) Certification.—

"(A) Application period.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

"(B) Time for review of applications.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

"(C) Multi-year applications.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

"(3) Selection criteria.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

"(A) shall take into consideration only those projects that show reasonable potential—

"(i) to result in new therapies—

"(I) to treat areas of unmet medical need, or

"(II) to prevent, detect, or treat chronic or acute diseases and conditions,

"(ii) to reduce long-term health care costs in the United States,

"(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

"(B) shall take into consideration which projects have the greatest potential—

"(i) to create and sustain (directly or indirectly) quality, high-paying jobs in the United States, and

"(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

"(4) Disclosure of allocations.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such application.

"(e) Special rules.—

"(1) Basis adjustment.—For purposes of this section, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

"(2) Denial of double benefit.—
such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year to which the qualified investment relates with respect to which such application is made.

3. TIME FOR PAYMENT OF GRANT.—
(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—
(i) the date of the application for such grant, or
(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of a nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

4. QUALIFIED INVESTMENT.—For purposes of this subsection, the term “qualified investment” means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

5. APPLICATION OF CERTAIN RULES.—
(A) IN GENERAL.—In making grants under this section, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986. In applying such rules, any increase in the amount allocable as a grant under this subsection, the term “qualified investment” means a qualified investment with respect to which such grant was made.

(B) SPECIAL RULES.—
(i) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allocable as a grant under subsection (A) of this section, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess relates had ceased to be a qualified investment immediately after such grant was made.

(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under subsection (A), the identity of the person to whom such grant was made, or a description of the investment with respect to which such grant was made be treated as return information for purposes of section 6103 of the Internal Revenue Code of 1986.

(C) EXCISE TAX PAYERS.—The Secretary of the Treasury shall not make any grant under this subsection to—
(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),
(B) any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code,
(C) any entity referred to in paragraph (4) of section 48D(d) of such Code, or
(D) any partnership or other pass-through entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B), or (C).

In the case of a partnership or other pass-through entity described in subparagraph (D), partners and other holders of any equity or profits interest shall provide to such partner or entity such information as the Secretary of the Treasury may require to carry out the purposes of this paragraph.

7. OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.

9. DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under section 56(b) of the Internal Revenue Code of 1986 by reason of section 48D of such Code for any investment for which a grant is awarded under this subsection.

10. APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.

11. Termination.—The Secretary of the Treasury shall not make any grant to any person under this subsection unless the application of such person for such grant is received before the end of the calendar year in which the grant was made. Such grants shall be made—
(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred in taxable years beginning after such date.

NOTICE OF HEARING
COMMITTEE ON ENERGY AND NATURAL RESOURCES
Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that the hearing has been delayed before the Senate Committee on Energy and Natural Resources. The hearing will be held on Thursday, December 3, 2009, at 10 a.m., in room SD-366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on H.R. 2276, the American Medical Isotopes Production Act of 2009.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510-6150, or by e-mail to Rosemarie Calabro @energy.senate.gov.

For further information, please contact Jonathan Epstein at (202) 224-3357 or Rosemarie Calabro at (202) 224-5039.

AUTHORITY FOR COMMITTEES TO MEET
COMMITTEE ON ARMED SERVICES
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on November 19, 2009, at 9:30 a.m.

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

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m.

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

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on November 19, 2009, in room 253 of the Russell Senate Office Building.

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

COMMITTEE ON ENERGY AND NATURAL RESOURCES
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session to conduct a hearing on November 19, 2009, at 10:30 a.m., in room SD-366 of the Dirksen Senate Office Building.

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

COMMITTEE ON FOREIGN RELATIONS
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on November 19, 2009, at 3:30 p.m.

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

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet, during the session of the Senate, to conduct a hearing entitled “Hearing on Taxitarian for Children and for General Counsel of the Equal Employment Opportunity Commission” on November 19, 2009. The hearing will commence at 10 a.m. in room 430 of the Dirksen Senate Office Building.

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

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m. to conduct a hearing entitled “The Fort Hood Attack: A Preliminary Assessment.”

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

COMMITTEE ON INDIAN AFFAIRS
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

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