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

**ADDITIONAL COSPONSORS**

S. 565

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

**AMENDMENT NO. 3065**

At the request of Mr. DURBIN, the name of the Senator from California (Mrs. BOXER) was added as a cosponsor of amendment No. 3065 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

**AMENDMENT NO. 3076**

At the request of Mr. DURBIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a co-sponsor of amendment No. 3076 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

**AMENDMENTS SUBMITTED AND PROPOSED**

SA 2376. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) proposed an amendment to amendment SA 2376 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SA 2377. Mr. REID proposed an amendment to amendment SA 2376 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SA 2381. Mr. REID proposed an amendment to amendment SA 2380 proposed by Mr. REID to the bill H.R. 3590, supra, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SA 2382. Mr. COBURN submitted an amended intented to be proposed to amendment SA 2381 proposed by Mr. REID to the bill H.R. 3590, supra, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SA 2386. Mr. ROCKEFELLER was added as a cosponsor of amendment No. 3065 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

SA 2390. Mr. REID proposed an amendment to amendment SA 2380 proposed by Mr. REID to the bill H.R. 3590, supra, 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.

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

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

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

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

"(D) the unlawful ownership, possession, or storage of a firearm or ammunition; or

"(E) the lawful ownership, possession, or storage of a firearm or ammunition; or

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

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

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

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

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

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

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

"(b) ENSURING THAT CONSUMERS RECEIVE VALUABLE PREMIUM PAYMENTS.—

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

"(A) REQUIREMENT.—Beginning not later than January 1, 2015, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, issue a rebate to each enrollee under such coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the issuer on costs described in paragraphs (1) and (2) of subparagraph (A) to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments for risk adjustment, risk corridors, and reinsurance under sections 1311, 1312, and 1343 of the Patient Protection and Affordable Care Act) for the plan year (except as provided in subparagraph (B)(ii)), is less than—

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

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

"(B) REBATE AMOUNT.—

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

"(I) the amount by which the percentage described in subparagraph (A) exceeds the ratio described in such subparagraph; and

"(II) the total amount of premium revenue (exclusive of, and after accounting for payments or receipt for risk adjustment, risk corridors, and reinsurance under sections 1311, 1312, and 1343 of the Patient Protection and Affordable Care Act) for such plan year.

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

"(2) CONSIDERATION IN SETTING PERCENTAGES.—

"(A) a group health plan, or a health plan that is included in a plan under subsection (a) and is subject to sections 1397cc or 1397d of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

"(B) a health insurance issuer offering individual health coverage, requires or provides an external review process that meets the requirements of paragraph (1); or

"(ii) the lawful ownership, possession, or storage of a firearm or ammunition; or

"(iii) the unlawful ownership, possession, or storage of a firearm or ammunition; or

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

"(D) if the plan is a self-insured plan that is subject to State laws that establishes an external review process (including a State law that establishes an external review process described in paragraph (1)); or

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

"(F) if the plan is a self-insured plan that is subject to State laws that establishes an external review process (including a State law that establishes an external review process described in paragraph (1)); or

"(2) INTERNAL CLAIMS APPEALS.—

"(i) 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, and in addition to—

"(A) have in effect an internal claims appeals process that initially incorporates the claims and appeals procedures (including the timeframes established by the Secretary) and the requirements of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary for such plans and issuers; and

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

"(2) CONSIDERATION IN SETTING PERCENTAGES.—

"(A) a group health plan, or a health plan that is included in a plan under subsection (a) and is subject to sections 1397cc or 1397d of title 29, Code of Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70256), and shall update such process in accordance with any standards established by the Secretary of Labor for such plans and issuers; and

"(B) a health insurance issuer offering individual health coverage, requires or provides an external review process that meets the requirements of paragraph (1); or

"(ii) the lawful ownership, possession, or storage of a firearm or ammunition; or

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

"(D) if the plan is a self-insured plan that is subject to State laws that establishes an external review process (including a State law that establishes an external review process described in paragraph (1)); or

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

"(F) if the plan is a self-insured plan that is subject to State laws that establishes an external review process (including a State law that establishes an external review process described in paragraph (1)); or

"(G) Section 2719 of the Public Health Service Act, as added by section 1001(5) of this Act, is amended by inserting after section 2719 the following:

"SEC. 2719A. PATIENT PROTECTIONS. —

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

"(b) COVERAGE OF EMERGENCY SERVICES.—Until December 31, 2014, a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides
or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

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

(3) PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.—

(a) GENERAL RIGHTS.—

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

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

(b) APPLICATION OF PARAGRAPH.—A group health plan, or health insurance issuer offering group or individual health coverage described in this paragraph is a group health plan, pursuant to the direct access described in paragraph (A), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

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

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

(B) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological procedures are provided by any participating health care professional or the plan or issuer of treatment decisions.

(c) Access to Public Health Services—

(1) in paragraph (1), by inserting ‘‘or other information specifically for small businesses in, any State to receive information on at least the following coverage options:’’;

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

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

(i) a single disease or condition; or

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

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

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

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

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

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 60H of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.

SEC. 10103. AMENDMENTS TO SUBTITLE C.

(a) Section 2701(a)(5) of the Public Health Service Act, as added by section 1201(b) of
this Act, as amended by inserting “other than self-insured group health plans offered in such market” after “such market.”

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

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

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

“(a) COVERAGE.—

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

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

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

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

“(2) ROUTINE PATIENT COSTS.—

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

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

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

“(ii) items and services that are provided solely for investigational purposes, and are necessary and that are not used in the direct clinical management of the patient; or

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

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

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

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

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

“(2) The individual is a participating health care provider and has concluded that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or

“(B) the participant or beneficiary providing evidence that the individual’s participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

“(c) LIMITATIONS ON COVERAGE.—This section shall not be construed to require a group health plan, or a health insurance issuer offering group or individual health insurance coverage, to provide benefits for routine patient costs (as defined in paragraph (1)) or the plan’s (or coverage’s) health care provider network unless out-of-network benefits are otherwise provided under the plan (or coverage).

“(d) APPROVED CLINICAL TRIAL DEFINED.—

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

“(i) Federally funded trials.—The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

“(ii) The National Institutes of Health.

“(iii) The Centers for Disease Control and Prevention.

“(iv) The Agency for Health Care Research and Quality.


“(vi) Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Veterans Affairs.

“(vii) A qualified non-governmental research and quality entity identified in the guidelines issued by the Secretary of Health and Human Services.

“(viii) Any of the following if the condition is interrupted.

“(A) The Food and Drug Administration.

“(B) The Secretary of Labor has determined the extent to which new investigational drugs have been reviewed and approved through a system of peer review that the Secretary determines.

“(C) To be comparable to the system of peer review of studies and investigations used by the Food and Drug Administration.

“(D) To be comparable to the system of peer review of studies and investigations used under the National Institutes of Health.

“(E) Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

“(f) LIFE-THREATENING CONDITION DEFINED.—In this section, the term ‘life-threatening condition’ includes any condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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

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

“(i) Section 1251(a) of this Act is amended—

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

“(2) by adding at the end the following:

“(3) APPLICATION OF CERTAIN PROVISIONS.—

“The provisions of section 2704 of the Public Health Service Act (as added by subsection A) shall apply to grandfathered health plans for plan years beginning on or after the date of enactment of this Act.

“(e) Section 1253 of this Act is amended insert before the period the following: ‘, except that section 1251 shall take effect on the date of enactment of this Act; and

“(2) the provisions of section 2704 of the Public Health Service Act (as amended by section 1251), as they apply to enrollees who are under 19 years of age, shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.’.

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

“(1) by redesignating section 1253 as section 1252; and

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

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

“(a) IN GENERAL.—The Secretary of Labor shall prepare an aggregate annual report, using data collected from the Annual Report/Return of Employee Benefit Plan (Department of Labor Form 5500), that shall include general information on self-insured group health plans (including plan type, number of participants, benefits offered, funding arrangements, and benefit arrangements) as well as data from the financial filings of self-insured employers (including information on assets, liabilities, contributions, investments, and expenses).

“The Secretary shall submit such reports to the appropriate committees of Congress.

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

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

“(2) claim denial rates, plan benefit fluctuations (to evaluate the extent that plans scale back health benefits during economic downturns); and

“(3) any potential conflict of interest as it relates to the health care needs of self-insured enrollees and self-insured employer’s ability to control costs and maintain financial contribution or profit margin, and the impact of such conflict on administration of the health plan.
"(c) Report.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a report on the results of the study conducted under subsection (a)."

SEC. 10104. AMENDMENTS TO SUBTITLE D.

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

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

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

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

(b) Subsection 1302 of this Act is amended—

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

(2) by adding at the end the following:

"(d) Federal qualified health center arrangements.—

"(A) Definition of qualified health center.—The term "qualified health center" means an organization that is certified by the Department of Health and Human Services, with respect to a particular area, as a qualified health center described in section 330G of the Public Health Service Act.

"(B) Requirements for arrangements.—Nothing in this Act shall prohibit the Secretary from entering into arrangements with qualified health centers to provide health care to individuals in the area of the qualified health center, if the Secretary determines that the arrangement is in the best interest of the individuals in the area.

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

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

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

"SEC. 1303. SPECIAL RULES.

"(a) State opt-out of abortion coverage.—

"(1) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange in such State if such State enacts a law to provide abortion coverage were included for the entire population covered; and

"(2) Termination of opt-out.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.

"(b) Special rules relating to coverage of abortion services.—

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

"(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

"(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(1) or (B)(ii) as part of its essential health benefits for any plan year; and

"(ii) the amount of the premium to be paid directly by the enrollee, per month cost, determined on an average, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care; and

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

"(2) Prohibition on the use of federal funds.—

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

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

"(II) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act.

"(B) Establishment of allocation accounts.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

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

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

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

"(ii) shall deposit into the allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

"(2) VARIATION BASED ON RATING AREA.—A qualified health plan may vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).

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

"(b) Special rules relating to coverage of abortion services.—

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

"(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

"(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(1) or (B)(ii) as part of its essential health benefits for any plan year; and

"(ii) the amount of the premium to be paid directly by the enrollee, per month cost, determined on an average, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care; and

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

"(2) Prohibition on the use of federal funds.—

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

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

"(II) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act.

"(B) Establishment of allocation accounts.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

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

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

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

"(ii) shall deposit into the allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

"(2) VARIATION BASED ON RATING AREA.—A qualified health plan may vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).

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

"(b) Special rules relating to coverage of abortion services.—

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

"(A) IN GENERAL.—Notwithstanding any other provision of this title (or any amendment made by this title)—

"(i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B)(1) or (B)(ii) as part of its essential health benefits for any plan year; and

"(ii) the amount of the premium to be paid directly by the enrollee, per month cost, determined on an average, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care; and

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

"(2) Prohibition on the use of federal funds.—

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

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

"(II) Any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act.

"(B) Establishment of allocation accounts.—In the case of a plan to which subparagraph (A) applies, the issuer of the plan shall—

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

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

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

"(ii) shall deposit into the allocation accounts described in clause (ii) for enrollees receiving amounts described in subparagraph (A).

"(2) VARIATION BASED ON RATING AREA.—A qualified health plan may vary premiums by rating area (as defined in section 2701(a)(2) of the Public Health Service Act).

"(3) TERMINATION OF OPT-OUT.—A State may repeal a law described in paragraph (1) and provide for the offering of such services through the Exchange.
section 1867 of the Social Security Act (popularly known as ‘EMTALA’).”.

(d) Section 1394 of this Act is amended by adding at the end the following:

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

(4) Non-profit entities.—In entering into contracts under paragraph (1), the Director shall ensure that at least one contract is entered into with a non-profit entity.

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

(c) The premiums to be charged; and

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

The Director may prohibit the offering of any multi-State health plan that does not consist of State solvency regulations and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such laws shall be repealed within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and other planning and financial note and security arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants.

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

(j) Section 1324(a) of this Act is amended by striking ‘‘, a community health center’’ and the following: ‘‘, or a multi-State qualified health plan under section 1334’’.

(k) Section 1331 of this Act is amended—

(1) in section 1331(b)(1), by striking ‘‘85” and inserting ‘‘95”; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: ‘‘,” or, in the case of an alien lawfully present in the United States, whose income is not greater than 135 percent of the poverty line for the size of the family involved but who is ineligible for the Medical Assistance program under title XIX of the Social Security Act by reason of such alien status’’;

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

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

S 1349

CONGRESSIONAL RECORD — SENATE

December 19, 2009

T H E CONGRESS OF THE UNITED STATES IN CONCILIATION

S 1349

DEPARTMENT OF HUMAN SERVICES

(1) in each of paragraphs (1), (2), (3), (4), (5), (6), (7), and (8), by striking ‘‘under this section’’ and inserting ‘‘under this section.’’

(2) in paragraph (9), by striking ‘‘under this section’’ and inserting ‘‘under this section.’’

(3) by adding at the end the following:

(4) Section 1323 of this Act is amended by striking ‘‘, a community health center’’ and the following: ‘‘, or a multi-State qualified health plan under section 1334’’.

(5) Section 1331 of this Act is amended—

(1) in subsection (d)(3), by striking ‘‘95” and inserting ‘‘95”; and

(2) in subsection (e)(1)(B), by inserting before the semicolon the following: ‘‘,” or, in the case of an alien lawfully present in the United States, whose income is not greater than 135 percent of the poverty line for the size of the family involved but who is ineligible for the Medical Assistance program under title XIX of the Social Security Act by reason of such alien status’’;

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

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

S 1334. MULTI-STATE PLANS.

(1) General.—The Director of the Office of Personnel Management shall, to the extent practicable, ensure, and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(2) Cost-sharing transparency.—The Exchange shall require health plans seeking certification as qualified health plans to permit individuals to learn the amount of cost-sharing (premiums, copayments, coinsurance, and out-of-pocket expenses) under the individual’s plan or coverage that the individual would be responsible for paying with respect to the furnishing of health care service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information shall be made available to such an individual through an Internet website and such other means for individuals without access to the Internet.

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

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

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

(2) in subparagraph (D), by striking the period and inserting ‘‘,” and’’;

(3) by adding at the end the following:

(4) the implementation of activities to reduce health and behavioral inequities, including through the use of language services, community outreach, and cultural competency trainings.

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

(i) Section 1312 of this Act is amended—

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

(2) in subsection (e)—

(A) in paragraph (1), by inserting ‘‘and employees’’ after ‘‘enroll individuals’’; and

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

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

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

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

'(4) A survey of the cost and affordability of health care insurance provided under the small business health care coverage program established under chapter 89 of title 5, United States Code, including data on enrollees in Exchanges for owners and employees, group coverage.

2. Section 1322(b) of this Act is amended—

(1) in paragraph (2), by striking ‘‘develop a plan that implements’’ and inserting ‘‘develop a plan’’;

(2) in paragraph (3), by striking ‘‘and’’ and inserting ‘‘, and’’;

3. Section 1325 of this Act is amended—

(A) the premiums to be charged; and

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

The Director may prohibit the offering of any multi-State health plan that does not
meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).

(6) ASSURED AVAILABILITY OF VARIOUS COVERAGE.—In entering into contracts under this subsection, the Director shall ensure that with respect to multi-State qualified health plans offered in an Exchange, there is at least one such plan that does not provide coverage of services described in section 1392(b)(1)(B).

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

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

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

(2) is licensed in each State and is subject to all requirements of State law that do not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement under title XXVII of the Public Health Service Act or a requirement of this title;

(3) otherwise complies with the minimum standards that the Director establishes for carriers offering health benefits plans under section 9802(e) of title 5, United States Code, to the extent that such standards do not conflict with a provision of this title; and

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

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

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

(A) the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in section 1392;

(B) the plan meets all requirements of this title with respect to a qualified health plan, including the rating requirements of part A of title XXVII of the Public Health Service Act and section (b)(5) of the Federal Employees Health Benefit Program under chapter 89 of the Public Health Service Act; and

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

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

(3) CREDITS.—

(A) IN GENERAL.—An individual enrolled in a multi-State qualified health plan under this section shall not be required to pay the amount in effect under this paragraph for coverage under a multi-State qualified health plan under paragraph (1)(A) if such issuer—

(B) is licensed in each State and is subject to all requirements of State law that do not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement under title XXVII of the Public Health Service Act or a requirement of this title; and

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

SEC. 10105. AMENDMENTS TO SUBTITLE E.

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

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

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

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

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

(4) Section 45R(d)(3) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by adding to the end the following:

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


(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $25,000, multiplied by the cost-of-living adjustment under section 1(f)(3) for the calendar year, determined by subtracting the calendar year 2012 for "calendar year 1992" in subparagraph (B) thereof.

"(5) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by stricking "2011" both places it appears and inserting "2012".

"(6) Section 280C(i) of the Internal Revenue Code of 1986, as added by section 1421(a) of this Act, is amended by stricking "2011" and inserting "2010".

(7) Section 1421(f) of this Act is amended by stricking "2010" both places it appears and inserting "2009".

(b) Amendment made by this subsection shall take effect as if included in the enactment of section 1421 of this Act.
Section 1416. Study of Geographic Variation of the Cost of Living

(a) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and impact of adjusting the application of the provisions of this Act (and the amendments made by this subtitle) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. If the Secretary determines that an adjustment is feasible, the study shall include a methodology to make such an adjustment. Not later than one year after the date the Secretary submits to Congress a report on such study, the Secretary shall provide Congress such recommendations as the Secretary determines appropriate.

(b) INCLUSION OF TERRITORIES.—

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

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

Section 10901. Amendments to Subtitle F

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

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

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

"(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to be $3.8 trillion in 2019, or 17.6 percent of the economy, in 2019 to $4.7 trillion in 2030.

"(C) The requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.

"(D) The requirement achieves near-universal coverage of health insurance, which was $90 billion in 2008 and pays for medical claims payments flow through interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

"(E) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

"(F) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176 million Americans nationwide. In Massachusetts, requiring employers to provide strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage increased.

"(G) The economy loses up to $500 billion a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.

"(H) The cost of providing uncompensated care to the uninsured was $43 billion in 2008. To pay for this cost, health care providers raise their costs in the form of higher premiums, which pass on the cost to families. This cost-shifting increases family premiums by an average of $1,000 a year. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will lower health insurance premiums.

"(I) 62 percent of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

"(J) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance. The requirement is essential to creating effective health care markets. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

"(K) The requirement, together with the other provisions of this Act, will improve financial security for families.

"(L) Administrative costs for private health insurance, which were $50 billion in 2008, are 28 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 on a large scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.

"(M) The requirement is essential to creating effective health care markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

"(N) Administrative costs for private health insurance, which were $90 billion in 2008, are 28 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 on a large scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.

"(O) The requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.

"(P) The requirement achieves near-universal coverage of health insurance, which was $90 billion in 2008 and pays for medical claims payments flow through interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

"(Q) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services, and will increase the number and share of Americans who are insured.

"(R) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176 million Americans nationwide. In Massachusetts, requiring employers to provide strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage increased.

"(S) The economy loses up to $500 billion a year because of the poorer health and shorter lifespan of the uninsured. By significantly reducing the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums.
(f) (1) Subparagraph (A) of section 4980H(d)(4) of the Internal Revenue Code of 1986, as added by section 1513(a) of this Act, is amended by inserting “, with respect to any month after “plans”.

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

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

“(i) subparagraph (A) shall be applied by substituting ‘who employed an average of at least 50 full-time employees on business days during the preceding calendar year’ for ‘who employed an average of at least 50 full-time employees on business days during the preceding calendar year’, and

“(ii) subparagraph (B) shall be applied by substituting ‘5’ for ‘50’.

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

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

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

SEC. 10107. AMENDMENTS TO SUBTITLE G.

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

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

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

(2) by inserting after section 1561 the following:

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

“(a) In General.—The Comptroller General of the United States (referred to in this section as the ‘Comptroller General’) shall conduct a study of the incidence of denials of coverage and the reasons therefor, in connection with applications to enroll in health insurance plans, as described in subsection (b), by group health plans and health insurance issuers.

“(b) Data.—

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

“(A) Denials of coverage for medical services to a plan enrollee, by the types of services for which such coverage was denied;

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

“(C) Reasons such applications are denied.

“(2) Scope of Data.—

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

“(B) All Health Plans.—The study under this section shall consider data from varied group health plans and health insurance plans offered by health insurance issuers, including qualified health plans and health plans that are not qualified health plans.

“(C) Enrollment of Exchange.—The study conducted under this section shall include data concerning the following:

“(1) the reasons such coverage was denied;

“(2) the reasons such applications are denied;

“(3) the extent that the amount of such voucher does not exceed the amount paid for a qualified health plan (as defined in section 1301 of such Act) by the taxpayer.’’

(b) Offerings employer.—For purposes of this section, the term ‘offering employer’ means any employer who—

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

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

(c) Qualified employer.—For purposes of this section—

“(1) In General.—The term ‘qualified employer’ means, with respect to any plan year of an offering employer, any employer—

“(A) whose required contribution (as determined under section 5000A(e)(13)(B)) for minimum essential coverage through an eligible employer-sponsored plan—

“(i) exceeds, in the case of such employer’s household income for the taxable year described in section 1412(b)(13)(B) which ends with or within the plan year; and

“(ii) is not more than 8 percent of such employer’s household income for such taxable year;

“(B) whose household income for such taxable year is greater than 400 percent of the poverty line for a family of the size involved; and

“(C) who does not participate in a health plan offered other than

“(1) indexing.—In the case of any calendar year beginning after 2014, the Secretary shall adjust the 8 percent under paragraph (1)(A)(i) and 9 percent under paragraph (1)(A)(ii) for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2015 over the rate of income growth for such period.

“(d) Free Choice Voucher.—

“(1) Amount.—

“(A) In General.—The amount of any free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee were covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer pays under paragraph (1) for an employee with self-only coverage unless such employee elects family coverage (in which case such amount shall be the amount the employer would pay for family coverage).

“(B) Determination of cost.—The cost of any health plan shall be determined under any program or other authority under subsection (a)(2), similar to the rules of section 2204 of the Public Health Service Act, except that such amount shall be adjusted for age and category of enrollment in accordance with regulations established by the Secretary.

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

“(3) Exception.—The amount of the premium of the qualified health plan in which the qualified employee is enrolled for such month, such excess shall be paid to the employee.

“(4) Other Definitions.—Any term used in this section which is also used in section 5000A of the Internal Revenue Code of 1986 shall have the meaning given such term under such section 5000A.

(5) Exclusion from Income for Employees.—In the case of any individual—

“(A) with respect to which the employer pays the amount of any free choice voucher under section 139C the following new section:

“SEC. 139D. FREE CHOICE VOUCHERS.

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

(2) Clerical Amendment.—The table of sections for part III of subtitle B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 139C the following new item:

“Sec. 139D. Free choice vouchers.”

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

(g) Deduction allowed to employer.—Section 5000A of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(4) Exception for individual receiving free choice voucher.—The term ‘coverage month’ shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.

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

(c) Qualified Employee.—For purposes of section 15 of the Small Business Act for the...
This is natural text, not a table or diagram.
January 1, 2011’ and inserting ‘‘April 1, 2010’’.

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

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

(2) in subsection (b), in the first sentence, by inserting ‘‘(ii)’’ before ‘‘(aa);’’

(i) in subparagraph (A), by inserting ‘‘(z),’’ before ‘‘and (aa)’’;

(ii) in subparagraph (B), by inserting in clause (42 U.S.C. 1396d), as amended by sections 2010’’.

(3) in subsection (a), by inserting ‘‘without regard to this subsection and subsection (aa)’’.

(4) in subparagraph (A), by striking ‘‘without regard to this subsection and subsection (aa)’’.

(5) in subsection (aa), is amended by striking ‘‘without regard to this subsection and subsection (aa)’’.

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

(‘‘(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), the Secretary shall—

(i) ALLOTMENT ADJUSTMENTS.—In the case of the State that—

(I) is an expansion State described in subsection (y)(1)(B)(i)(II); and

(ii) is the State with the highest percentage of its population living below the poverty line, that—

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

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

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

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

(2) in subsection (b), in the first sentence, by inserting ‘‘(ii)’’ before ‘‘(aa);’’

(i) in subparagraph (A), by inserting ‘‘(z),’’ before ‘‘and (aa)’’;

(ii) in subparagraph (B), by inserting in clause (42 U.S.C. 1396d), as amended by sections 2010’’.

(3) in subsection (a), by inserting ‘‘without regard to this subsection and subsection (aa)’’.

(4) in subparagraph (A), by striking ‘‘without regard to this subsection and subsection (aa)’’.

(5) in subsection (aa), is amended by striking ‘‘without regard to this subsection and subsection (aa)’’.

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

(‘‘(cc) REQUIREMENT FOR CERTAIN STATES.—Notwithstanding subsections (y), (z), and (aa), the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 27.5 percent;

(i) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 25 percent;

(ii) if the State is a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 50 percent; and

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

(B) in paragraph (2), by inserting ‘‘(ii)’’ before ‘‘(aa);’’

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

(‘‘(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to 12.5 percent.

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

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

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

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

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

(‘‘(I) if the State is a low DSH State described in paragraph (5)(B) and has spent not more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 27.5 percent;

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

(iii) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent.

(iii) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 25 percent.

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

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

(i) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(ii) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(iii) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(iv) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(v) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(iv) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(v) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(vi) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(vii) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’

(viii) in paragraph (2), by striking ‘‘(ii)’’ before ‘‘(aa);’’
“(IV) if the State is not a low DSH State described in paragraph (5)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2003 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year to the preceding fiscal year and 40 percent.”;

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

(Iv) in paragraph (2), by striking at the end the following: “For purposes of eligibility for premium assistance for the purchase of a qualified health plan under section 136b of the Internal Revenue Code of 1986 and reductions under section 1462 of the Patient Protection and Affordable Care Act, children described in the preceding sentence to be ineligible for coverage under the State child health plan.”;

(b) Clause (i) of subparagraph (C) of section 513(b)(2) of the Social Security Act, as added by section 2906(b) of this Act, is amended to read as follows:

“(1) Healthy relationships, including marriage and family interactions.”;

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

"(b)(1) a process for public notice and comment, including public hearings, sufficient to ensure a meaningful level of public input;"

"(b)(2) requirements relating to the goals of the program to be implemented or renewed under the demonstration project;"

"(i) the expected State and Federal costs and coverage projections of the demonstration project; and"

"(ii) the specific plans of the State to ensure that the demonstration project will be in compliance with the Social Security Act or statutes governing the State Medicaid program;"

“(C) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input;”;

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

“(E) a process for the periodic evaluation by the Secretary of the demonstration project;"

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

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

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

“(a) STUDY.—

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

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

“(A) Section 2701 (adverse health quality measures).

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

“(C) Section 3001 (Hospital Value-Based Purchasing).

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

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

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

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

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

“(I) Section 3014 (quality measurement).

“(J) Section 3021 (Establishment of Center for Medicare Improvement).

“(K) Section 3022 (Hospital readmission reduction program).

“(L) Section 3501 (health care delivery system research, demonstration).

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

“(N) Section 4001 (research to optimize delivery of public health services).

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

“SEC. 3502. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

“(a) STATE BALANCING INCENTIVE PAYMENT PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the medical assistance percentage determined for the State under section 1905(b) of such Act and, if applicable, increased under subsection (2) or (aa) shall be increased by the applicable percentage points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (c).

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

“(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for a fiscal year for long-term services and supports (as defined under section 1905(b) of such Act and, if applicable, increased under subsection (2)) shall be for long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes as of December 31, 2010.

“(2) TOTAL SPENDING PERCENTAGE.—In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for long-term services and supports under the State Medicaid program for fiscal year 2009 are for home and community-based services, the target spending percentage for the State to achieve by not later than October 1, 2015, is 50 percent of the total expenditures for long-term services and supports under the State Medicaid program for home and community-based services.

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

“(d) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionalized long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program in order to ensure access to those services for qualified individuals and families as a result of this section.

“(e) STRUCTURAL CHANGES.—The State submits an application under this section, the following:

“(A) "No wrong door - single entry point system", optional presumptive eligibility, case management services, and the use of core standard-based assessment tools that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services.

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

“(2) TARGET SPENDING PERCENTAGE.—In the case of a State that is selected by the Secretary to participate in the State balancing incentive payment program established under this section—

“(A) a proposed budget that details the expansion of the State’s plan to expand and diversify medical assistance under non-institutionalized long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period; and

“(B) exceed the target spending percentage established under paragraph (2), including through structural changes to how the State furnishes such assistance, as the State achieves the establishment of a “no wrong door - single entry point system”, optional presumptive eligibility, case management services, and the use of core standard-based assessment tools that includes a description of the new or expanded offerings of such services that the State will provide and the projected costs of such services.

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

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

“(A) a proposed budget that details the State’s plan to expand and diversify medical assistance under non-institutionalized long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period; and

“(B) that is more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes as of December 31, 2010.

“(4) USE OF ADDITIONAL FUNDS.—The State agrees to use the additional Federal funds paid to the State as a result of this section only for purposes of providing new or expanded offerings of non-institutionalized long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program that are more restrictive than the eligibility standards, methodologies, or procedures in effect for such purposes as of December 31, 2010.

“(5) STRUCTURAL CHANGES.—The State agrees to make to not later than the end of the fiscal year preceding that in which the State submits an application under this section:

“(A) "No wrong door - single entry point system", development of a statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or other system as the State shall establish and that shall provide information regarding the availability
of such services, how to apply for such services, referral services for services and supports otherwise available in the community, and determinations of financial and functional need for such services and supports, or assistance with assessment processes for financial and functional eligibility.

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

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

(D) DATA COLLECTION.—The State agrees to collect from providers of services and supports data as the State determines appropriate the following data:

(1) SERVICES DATA.—Services data from providers of non-institutionally-based long-term services and supports described in section 1915(b)(1) on a per-beneficiary basis and in accordance with such standardized coding procedures as the State shall establish in consultation with the Secretary.

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

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

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

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

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

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

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

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

(G) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

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

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

(1) DEFINITIONS.—In this section:

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

(i) Nursing facility services.

(ii) Services in an intermediate care facility for individuals with mental retardation, as described in subsection (a)(15) of section 1905 of such Act.

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

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

(ii) Home health care services.

(iii) Personal care services.

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

(v) Self-directed personal assistance services described in section 1915(b)(1) of such Act.

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

(3) POVERTY LINE.—The term "poverty line" has the meaning given that term in section 214(c)(5) of the Social Security Act (42 U.S.C. 1382c(c)(5)).

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

SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH DECEMBER 31, 2015 AND OTHER CHIP-RELATED PROVISIONS.

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

"(i) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1397dd(a) of such Act;"

(b) Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-148).

(1) Section 1906(e)(2) of the Social Security Act (42 U.S.C. 1396e(e)(2)) is amended by striking "(b)'' and inserting "(b)"; and

(2) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1397ee(c)(3)(A)), as amended by section 2109, is amended—

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

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

(3) Section 2015 of the Social Security Act (42 U.S.C. 1397ee(f)), as amended by section 2101, is amended—

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

(2) in subsection (d)(3)—

(a) in subparagraph (A)—

(i) in the first sentence, by inserting "as a condition of receiving payments under section 1903(a)," after "2013,'';

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

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

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

(c) In subparagraph (B), by striking "(2013)" and inserting "(2014)"; and

(d) by adding at the end the following:

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

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

(A) in paragraph (5), by striking "and" at the end; and

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

"(16) for fiscal year 2015, $17,406,000,000;"

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

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

"$2,850,000,000 for the period beginning on October 1, 2014, and ending on March 31, 2015, and"

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

(2) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2113, is amended—

(A) in the subsection heading, by striking "2013" and inserting "2015";

(B) by striking paragraph (2)—

(i) in the paragraph heading, by striking "2012" and inserting "2013"; and

(ii) by adding at the end the following:

"(C) FISCAL YEARS 2013 AND 2014.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (16) and (17) of subsection (a) for fiscal years 2013 and
2014, respectively, the Secretary shall compute a State allotment for each State (including the District of Columbia and each commonwealth and territory) for each such fiscal year as follows: “(I) REASSESSING IN FISCAL YEAR 2013.—For fiscal year 2013, the allotment of the State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State in fiscal year 2012 (including payments made to the State under subsection (n) for fiscal year 2012 as well as amounts redistributed to the State in fiscal year 2012), multiplied by the allotment increase factor under paragraph (5) for fiscal year 2013, and “(II) the amount of any payments made to the State under subsection (n) for fiscal year 2013, multiplied by the allotment increase factor under paragraph (5) for fiscal year 2014.”; “(iii) in paragraph (3)— “(I) in the paragraph heading, by striking “and inserting “2015”; “(II) in subparagraphs (A) and (B), by striking “paragraph (16)” each place it appears and inserting “paragraph (18)”; “(III) in subparagraph (C)— “(aa) by striking “2012” each place it appears and inserting “2014” and “by striking “2013” and inserting “2015”; and “(bb) by inserting “2015” and “in paragraph (4), by striking “2013” and inserting “2015”; “(v) in paragraph (6)— “(a) in subparagraph (A), by striking “2013” and inserting “2015”; and “(b) by striking “2012” and inserting “2015”; and “(II) in the flush language after and below subparagraph (B), by striking “or fiscal year 2012” and inserting “; fiscal year 2012, or fiscal year 2014”; and “(vi) in paragraph (8)— “(I) in the paragraph heading, by striking “2013” and inserting “2015”; and “(II) by striking “2013” and inserting “2015”. (B) Section 2104(n) of such Act (42 U.S.C. 1397dd(n)) is amended— “(I) in paragraph (3)— “(a) in subparagraph (A)— “(I) the amount of premiums and cost-sharing imposed for coverage of the child for any State fiscal year as follows: “(II) the amount of any payments made to the State under subsection (n) for fiscal year 2014,”; “(2) E LIGIBLE INSTITUTION OF HIGHER EDUCATION.— “(1) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funds available to eligible institutions of higher education to carry out any activities described in section 202(d) for the purposes described in this section to assist pregnant and parenting teens and women. (a) IN GENERAL.—A State shall use amounts received under a grant under section 202(d) for the purposes described in this section to assist pregnant and parenting teens and women. (b) INSTITUTIONS OF HIGHER EDUCATION.— “(1) ELIGIBLE INSTITUTION OF HIGHER EDUCATION.— “(A) GENERAL.—The term "eligible institution of higher education" means an institution of higher education that desires to receive funding under this subsection to make funds available to eligible institutions of higher education to enable the institution to establish and operate pregnant and parenting student services. Such funding shall be used to supplement, not supplant, existing funding for such services. “(B) ELIGIBILITY REQUIREMENT.—An eligible institution of higher education that desires to receive funding under this subsection shall contribute to the conduct of the pregnant and parenting student services supported by the funding an amount from non-Federal funds equal to 25 percent of the amount of
the funding provided. The non-Federal share may be in cash or in-kind, fairly evaluated, including services, facilities, supplies, or equipment.

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

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

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

(ii) to set goals for

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

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

(ii) Family housing.

(iii) Child care.

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

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

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

(vii) Postpartum counseling.

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

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

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

(i) Parents.

(ii) Prospective parents awaiting adoption.

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

(iv) Parenting or prospective parenting couples.

(B) REPORTING.—

(A) ANNUAL REPORT BY INSTITUTION.—

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

(A) documents the pregnant and parenting student services office’s expenditures for the fiscal year;

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

(C) includes the achievement of the office in meeting the needs listed in paragraph (4)(B) of the students served by the eligible institution, and the frequency of use of the office by such students;

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

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

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

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

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

(D) IMPROVING PREGNANT WOMEN WHO ARE VICTIMS OF DOMESTIC VIOLENCE, SEXUAL VIOLENCE, SEXUAL ASSAULT, AND STALKING.

(i) IN GENERAL.—A State may use amounts received under a grant under section 10212 to make funding available to pregnant women and, as appropriate, their children.

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

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

(iv) Maternity care.

(v) Maternal care and delivery, infant or foster care, or adoption, to a student who requests such information. An office shall make such referrals of service providers that serve the following types of individuals:

(A) Parents.

(B) Prospective parents awaiting adoption.

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

(D) Parenting or prospective parenting couples.

(E) Supportive social services for eligible pregnant women who are victims of domestic violence, sexual violence, sexual assault, or stalking.

(F) Technical assistance and training (as described in subsection (b)) relating to violence against eligible pregnant women to be made available to the following:

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

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

(iii) Nonprofit organizations.

(iv) Faith-based organizations.

(v) Findings under this subsection, including the frequency of use of the office by such students.

(E) EFFECT OF SECTION.—Nothing in this section shall apply for purposes of any other Federal Act (as amended by section 134(b) of the bill referred to in subsection (a)) is amended by—

(A) in section (d)—

(i) in paragraph (2), by striking “In establishing” and inserting “Subject to paragraph (3),”

(ii) by adding at the end the following:

“(3) SUPPORT FOR PREGNANT AND PARENTING TRENDS.—For purposes of paragraphs (1)(B), (C), and (D), technical assistance and training—

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

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

(C) the maintenance of complete medical and forensic records that include the documentation and nature of the pregnant woman’s injuries, and the establishment of mechanisms to ensure the confidentiality of these medical records; and

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

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

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

(G) AMENDMENTS.—

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

(A) in subsection (d)—

(i) in paragraph (2), by striking “In establishing” and inserting “Subject to paragraph (3),”

(ii) by adding at the end the following:

“(3) SUPPORT FOR PREGNANT AND PARENTING TRENDS.—For purposes of paragraphs (1)(B), (C), and (D), technical assistance and training—

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

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

(C) the maintenance of complete medical and forensic records that include the documentation and nature of the pregnant woman’s injuries, and the establishment of mechanisms to ensure the confidentiality of these medical records; and

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

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

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

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

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

“(i) HHS APPROPRIATIONS.—Any limitation;” and

(B) by adding at the end the following:
“(b) LIMITATIONS PERTAINING TO OTHER FEDERAL LAW.—Any limitation pursuant to other Federal laws on the use of Federal funds appropriated to the Service shall apply with respect to the performance or coverage of abortions.”.

(4) The bill referred to in subsection (a) is amended by striking section 301.

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

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

“(f) D EVELOPMENT OF OUTCOME MEASURES.—

(1) IN GENERAL.—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))).

“(2) IN GENERAL.—The Secretary shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for ambulatory surgical centers (as described in section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i))).

“(b) IDENTIFICATION.—

“(1) IN GENERAL.—

“(A) The ongoing development, selection, and modification process for measures (including, but not limited to, the determination of the threshold or boundaries for payment adjustments, the size of such payments, and the sources of funding for the value-based bonus payments).

“(B) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(C) The reporting, collection, and validation of quality data.

“(D) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would trigger a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

“(E) The ongoing development, selection, and modification process for measures (including, but not limited to, the determination of the threshold or boundaries for payment adjustments, the size of such payments, and the sources of funding for the value-based bonus payments).

“(F) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(G) Any other issues determined appropriate by the Secretary.

“(H) IN GENERAL.—

“(a) IN GENERAL.—

“(1) DEVELOPMENT OF OUTCOME MEASURES.—

“(A) IN GENERAL.—

“(b) IDENTIFICATION.—

“(1) IN GENERAL.—

“(b)(2) PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(1) IN GENERAL.—

“(f) D EVELOPMENT OF OUTCOME MEASURES.—

“(A) The ongoing development, selection, and modification process for measures (including, but not limited to, the determination of the threshold or boundaries for payment adjustments, the size of such payments, and the sources of funding for the value-based bonus payments).

“(B) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(C) The reporting, collection, and validation of quality data.

“(D) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would trigger a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

“(E) The ongoing development, selection, and modification process for measures (including, but not limited to, the determination of the threshold or boundaries for payment adjustments, the size of such payments, and the sources of funding for the value-based bonus payments).

“(F) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(G) Any other issues determined appropriate by the Secretary.

“(H)(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall—

“(A) consult with relevant affected parties; and

“(B) consider experience with such demonstrations that the Secretary determines are relevant to the value-based purchasing program described in paragraph (1).

“(4) HOSPITAL ACQUIRED CONDITIONS.—The Secretary shall—

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

“(B) include measures of services that comprise a cycle of care; and

“(C) include multiple dimensions.

“(5) TIMEFRAME.—

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

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

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

“(D) CLINICAL PRACTICE GUIDELINES.—Section 1890A of the Social Security Act, as amended by section 3015(b), is amended by adding at the end the following new subsection:

“(f) D EVELOPMENT OF OUTCOME MEASURES.—

“(1) IN GENERAL.—

“(a) IN GENERAL.—

“(B) IDENTIFICATION.—

“(1) IN GENERAL.—

“(2) PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(1) IN GENERAL.—

“(f) D EVELOPMENT OF OUTCOME MEASURES.—

“(A) The ongoing development, selection, and modification process for measures (including, but not limited to, the determination of the threshold or boundaries for payment adjustments, the size of such payments, and the sources of funding for the value-based bonus payments).

“(B) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(C) The reporting, collection, and validation of quality data.

“(D) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would trigger a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

“(E) The ongoing development, selection, and modification process for measures (including, but not limited to, the determination of the threshold or boundaries for payment adjustments, the size of such payments, and the sources of funding for the value-based bonus payments).

“(F) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

“(G) Any other issues determined appropriate by the Secretary.

“(H) IN GENERAL.—

“(a) IN GENERAL.—

“(b) IDENTIFICATION.—

“(1) IN GENERAL.—

“(b)(2) PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR AMBULATORY SURGICAL CENTERS.

(1) IN GENERAL.—
(A) in paragraph (1)(B), by striking “care and reduce spending; and” and inserting “patient care without increasing spending;”;

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

(C) by striking the following:

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

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

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

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

“(1) OPTION TO USE OTHER PAYMENT MODELS.—

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

“(2) SPECIAL RULES.—In pilot testing the continuing care hospital model under paragraph (1), the following rules shall apply: 

“(A) Such model shall be tested within the limitations selected under subsection (a)(2)(B).

“(B) Notwithstanding subsection (a)(2)(B), an episode of care shall be defined as the full period that a patient stays in the continuing care hospital plus the first 30 days following discharge from such hospital.

“(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term ‘continuing care hospital’ means an entity that demonstrates the ability to meet patient care and patient safety standards and that provides, under common management the medical and rehabilitation services provided in an inpatient rehabilitation facility (as defined in section 1886(d)(1)(B)(ii)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1886(d).”;

(b) TECHNICAL AMENDMENTS.—

(1) Section 3023 is amended by striking “2016” and inserting “2017”.

(2) Title XVIII of the Social Security Act is amended by redesignating section 1869B, as added by section 3024, as section 1866E.

SEC. 10309. REVISIONS TO HOSPITAL READMISSIONS REDUCTION PROGRAM.

Section 1886A of the Social Security Act, as added by section 3025, in the matter preceding subparagraph (C), is amended by striking the Secretary shall determine the eligibility for such services under subsection (d)(3), as the case may be, in an amount equal to the product of:

SEC. 10310. REPEAL OF PHYSICIAN PAYMENT UPDATE DATE.

The provisions of, and the amendment made by, section 10301 are repealed.

SEC. 10311. REVISIONS TO EXTENSION OF AMBULANCE PROVISION.

(a) GROUND AMBULANCE.—Section 1831(h)(13)(A) of the Social Security Act (42 U.S.C. 1395m(h)(13)(A), as amended by section 3105(a), is further amended—

(1) in the matter preceding clause (1)—

(A) by striking “2007, for” and inserting “2007, and for”;

(B) by striking “2010, and before April 1, 2011” and inserting “2010, and on or after April 1, 2011, and before January 1, 2011” each place it appears; and

(c) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), as amended by section 3105(b), is further amended by striking “December 31, 2010,” and during the period beginning on April 1, 2010, and ending on January 1, 2011” and inserting “December 31, 2010”,

(c) SUPPLEMENTARY AMBULANCE.—Section 1581(b)(12)(A) of the Social Security Act (42 U.S.C. 1395m(b)(12)(A), as amended by section 3105(c), is further amended by striking “2007, and before April 1, 2011” and inserting “2010, and on or after April 1, 2010, and before January 1, 2011”.

SEC. 10312. CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITALS AND MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AN D FACILITIES.

(a) CERTAIN PAYMENT RULES.—Section 11(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111–5) and section 3106(a) of this Act, is further amended by striking “2010, and on or after April 1, 2010, and before January 1, 2011” and inserting “2011”.

SEC. 10313. REVISIONS TO THE EXTENSION FOR THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) IN GENERAL.—Subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272), as added by section 3123(a) of this Act, is amended to read as follows:

“(g) Five-Year Extension of Demonstration Program.—

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall extend the demonstration program under this section for an additional 5-year period (in this section referred to as the ‘5-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

“(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine which States were included for purposes of the initial 5-year period.

“(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 5-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

“(4) HOSPITALS IN DEMONSTRATION PROGRAM ON DATE OF ENACTMENT.—In the case of a
rural community hospital that is participating in the demonstration program under this section as of the last day of the initial 5-year period, the Secretary—

(A) shall provide for the continued participation of such rural community hospital in the demonstration program during the 5-year extension period unless the rural community hospital fails to participate in the program, in the form and manner as the Secretary may specify, to discontinue such participation; and

(B) in calculating the amount of payment under subsection (b) to the rural community hospital for covered inpatient hospital services furnished by the hospital during such 5-year extension period, shall substitute, under paragraph (1)(A) of such subsection—

(i) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the first day of the 5-year extension period, for

(ii) the reasonable costs of providing such services for discharges occurring in the first cost reporting period beginning on or after the implementation of the demonstration program;

(2) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 260), by section 508 of this Act, is amended by striking “1-year extension” and inserting “5-year extension”.

SEC. 10314. ADJUSTMENT TO LOW-VOLUME HOSPITAL PROVISION.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12), as amended by section 3132, is amended—

(1) in subparagraph (C)(i), by striking “1,500 discharges and inserting “1,600 discharges”;

(2) in subparagraph (D), by striking “1,500 discharges and inserting “1,600 discharges”;

SEC. 10315. REVISIONS TO HOME HEALTH CARE PROVISIONS.

(a) REINSURING.—Section 1855(b)(3)(A)(ii) of the Social Security Act, as added by section 3131, is amended—

(1) in the clause heading, by striking “2013” and inserting “2014”;

(2) in subparagraph (D), by striking “2013” and inserting “2014”; and

(3) in subparagraph (I), by striking “2016” and inserting “2017”.

(b) VISION OF HOME HEALTH STUDY AND REPORT.—Section 3131(d) is amended to read as follows:

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income, uninsured beneficiaries or beneficiaries residing in medically underserved areas, and in treating beneficiaries with varying levels of severity of illness. In conducting the study, the Secretary may analyze items such as the following:

(A) Methods to potentially revise the home health prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395fff) to account for costs related to patient severity of illness or to improving beneficiary access to care, such as—

(i) changes to reflect resources involved with providing home health services to low-income or uninsured beneficiaries or beneficiaries residing in medically underserved areas;

(ii) changes to reflect resources involved with providing home health services to low-income, uninsured beneficiaries or beneficiaries residing in medically underserved areas;

(iii) ways outlier payments might be revised to reflect costs of treating Medicare beneficiaries with high levels of severity of illness; and

(iv) other issues determined appropriate by the Secretary,

(B) Operational issues involved with potential implementation of potential revisions to the home health payment system, including impacts for both home health agencies and administrative and systems issues for the Centers for Medicare & Medicaid Services, and any possible payment adjustments under subparagraph (A).

(C) Whether additional research might be needed.

(D) Other items determined appropriate by the Secretary.

(2) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary may consider whether patient severity of illness and access to care could be measured by factors, such as—

(A) population density and relative patient access to care;

(B) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;

(C) the presence of severe or chronic diseases, which might be measured by multiple, discontinuous home health episodes;

(D) poverty status, such as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act; and

(E) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2014, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislations and administrative actions as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1), the Secretary shall consult with appropriate stakeholders, such as groups representing home health agencies and groups representing Medicare beneficiaries.

(5) MEDICARE DEMONSTRATION PROJECT BASED ON THE RESULTS OF THE STUDY.—

(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), for purposes of implementing the demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for beneficiaries with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

(B) WAIVING BUDGET NEUTRALITY.—The Secretary may not reduce the standard prospective payment amount (or amounts) under section 1885 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished by providers of a demonstration project to test whether making payment adjustments for home health services under the Medicare program would substantially improve access to care for beneficiaries with high severity levels of illness or for low-income or underserved Medicare beneficiaries.

(C) NO EFFECT ON SUBSEQUENT PERIODS.—A payment adjustment resulting from the application of subparagraph (A) for a period—

(i) shall not apply to payments for home health services under title XVIII after such period; and

(ii) shall not be taken into account in calculating the payment amounts applicable for such services after such period.

(D) DURATION.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall prepare a report for a four year period beginning not later than January 1, 2015.

(E) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395ll) of $500,000,000 for the period of fiscal years 2015 through 2018. Such funds shall be made available for the study described in paragraph (1) and the design, implementation and evaluation of the demonstration described in this paragraph. Amounts available under this subparagraph shall be available until expended.

(3) EVALUATION AND REPORT.—If the Secretary determines it appropriate to conduct the demonstration project under this subsection, the Secretary shall—

(i) provide for an evaluation of the project; and

(ii) submit to Congress, by a date specified by the Secretary, a report on the project.

(G) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply with respect to this subsection.

SEC. 10316. MEDICARE DSH.

Section 3137(b)(3)(B) of the Social Security Act, as added by section 3131, is amended—

(1) in clause (i)—

(A) in the matter preceding subclause (I), by striking “(divided by 100)”;

(B) in subclause (I), by striking “2012” and inserting “2013”;

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

“and, for each of 2018 and 2019, minus 1.5 percentage points.”;

(2) in clause (ii)—

(A) in the matter preceding subclause (I), by striking “(divided by 100)”;

(B) in subclause (I), by striking “2012” and inserting “2013”;

(C) in subclause (II), by striking the period at the end and inserting a comma; and

(D) by adding at the end the following flush matter:

“and, for each of 2018 and 2019, minus 1.5 percentage points.”.

SEC. 10317. REVISIONS TO EXTENSION OF SECTION 508 HOSPITAL PROVISIONS.

Section 3131(a) is amended to read as follows:

(a) EXTENSION.—


(2) TEMPORARY RULE PROMPT YEAR 2010.—

(A) IN GENERAL.—Subject to subparagraph (B), for purposes of implementation of the amendment made by paragraph (1), including (notwithstanding paragraph (3) of section 117(a) of the Medicare, Medicaid and SCHIP Extension Act of 2007 (Public Law 110-173), as amended by section 124(b) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110-275)) for purposes of the implementation of paragraph (2) of such section 117(a), during fiscal year 2010, the Secretary of Health and Human Services (in this subsection referred to as the ‘Secretary’) shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.
“(B) EXCEPTION.—Beginning on April 1, 2010, in determining the wage index applicable to hospitals that qualify for wage index reclassification, the Secretary shall include the average hourly wage data of hospitals whose reclassification was extended pursuant to the amendment made by paragraph (1) only if including such data results in a higher applicable wage index.

“(3) ADJUSTMENT FOR CERTAIN HOSPITALS IN FISCAL YEAR 2010.—

“(A) IN GENERAL.—In the case of a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which—

“(i) a reclassification of its wage index for purposes of such section was extended pursuant to the amendment made by paragraph (1); and

“(ii) the average hourly wage index applicable for such hospital for the period beginning on October 1, 2009, and ending on March 31, 2010, was lower than for the period beginning on April 1, 2010, by reason of the application of paragraph (2)(B); the Secretary shall pay such hospital an additional payment that reflects the difference between the wage index for such periods.

“(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph (B) no later than January 31, 2010.

SEC. 10318. REVISIONS TO TRANSITIONAL EXTRA BENEFITS UNDER MEDICARE ADVANTAGE.

Section 1833(p)(3)(A) of the Social Security Act, as added by section 3201(h), is amended by inserting “in 2009” before the period at the end.

SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1833(p)(3)(B)(II) of the Social Security Act, as added by section 3401(a), is amended—

“(1) in subclause (I), by striking “and” at the end;

“(2) by redesignating subclause (II) as subclause (III); and

“(3) by inserting after subclause (II) the following new subclause:

“(II) for each of fiscal years 2012 and 2013, 0.1 percentage point; and”; and

“(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(b) LONG-TERM CARE HOSPITALS.—Section 1833(m)(4) of the Social Security Act, as added by section 3401(a), is amended—

“(1) in subparagraph (A)—

“(i) by striking “2010 and 2011” and inserting “rate year 2010”;

“(ii) by striking “and” at the end;

“(B) by redesignating clause (ii) as clause (iv); and

“(C) by inserting after clause (i) the following new clauses:

“(ii) for each of fiscal years 2012 and 2013, 0.1 percentage point; and”; and

“(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(c) INPATIENT REHABILITATION FACILITIES.—Section 1866(i)(3)(D)(i) of the Social Security Act, as added by section 3401(d), is amended—

“(1) in subclause (I), by striking “and” at the end;

“(2) by redesignating subclause (II) as subclause (III); and

“(3) by inserting after subclause (II) the following new subclause:

“(II) for each of fiscal years 2012 and 2013, 0.1 percentage point; and”; and

“(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(d) HOME HEALTH AGENCIES.—Section 1395f(i)(1)(C), as amended by section 3401(g), is amended—

“(1) in clause (iv), by striking “0.5” and inserting “0.3”; and

“(2) in clause (v), in the matter preceding subclause (I), by striking “0.5” and inserting “0.3”.

(e) PSYCHIATRIC HOSPITALS.—Section 1866(m)(3)(A) of the Social Security Act, as added by section 3401(g), is amended—

“(1) in clause (i), by striking “and” at the end;

“(2) by redesigning clause (ii) as clause (iii); and

“(3) by inserting after clause (ii) the following new clause:

“(II) for each of the rate years beginning in 2012 and 2013, 0.1 percentage point; and”; and

“(4) in clause (iii), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

(f) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3401(g), is amended—

“(1) in clause (iv), by striking “0.5” and inserting “0.3”;

“(2) in clause (v), in the matter preceding subclause (I), by striking “0.5” and inserting “0.3”.

(g) OUTPATIENT HOSPITALS.—Section 1833(p)(3)(A) of the Social Security Act, as added by section 3401(i), is amended—

“(1) in clause (i), by striking “and” at the end;

“(2) by redesigning subclause (II) as subclause (III); and

“(3) by inserting after subclause (II) the following new subclause:

“(II) for each of 2012 and 2013, 0.1 percentage point; and”; and

“(4) in subclause (III), as redesignated by paragraph (2), by striking “2012” and inserting “2014”.

SEC. 10320. EXPANSION OF THE SCOPE OF, AND ADDITIONAL IMPROVEMENTS TO, THE INDEPENDENT MEDICARE ADVISORY BOARD.

(a) IN GENERAL.—Section 1899A of the Social Security Act, as added by section 3403, is amended—

“(1) in subsection (c)—

“(A) in paragraph (1)(B), by adding at the end the following: “In any year (beginning with 2014) that the Board is not required to submit a proposal under this section, the Board shall submit to Congress an advisory report on matters related to the Medicare program.”;

“(B) in paragraph (2)(A)—

“(i) in clause (iv), by inserting “or the full premium subsidy under section 1860D-1(a)” before the period at the end of the last sentence; and

“(ii) by adding at the end the following new clause:

“(viii) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination (not effective immediately) in subsection (e)(3)(B)(i)(II) in the determination year, the proposal shall be designed to help reduce the growth rate described in paragraph (6) while maintaining the beneficiary access to quality care under this title.”;

“(C) in paragraph (2)(B)—

“(i) in clause (v), by striking “and” at the end;

“(ii) in clause (vi), by striking the period at the end and inserting “; and”;

“(iii) by adding at the end the following new clause:

“(vii) take into account the data and findings contained in the annual reports under subsection (n) in order to develop proposals that not only promote the delivery of efficient, high quality care to Medicare beneficiaries.”;

“(2) in subsection (e)—

“(A) in paragraph (3)—

“(i) in the heading, by striking “TRANSMISSION OF BOARD PROPOSAL TO PRESIDENT” and inserting “SUBMISSION OF BOARD PROPOSAL TO CONGRESS AND THE PRESIDENT”; and

“(ii) in subparagraph (A)(i), by striking “transmit a proposal under this section to the President” and inserting “submit a proposal pursuant to this section to Congress and the President”;

“(B) in subparagraph (A)(i)—

“(I) in subclause (I), by inserting “or” at the end;

“(II) in subclause (II), by striking “; or” and inserting a period; and

“(III) by striking “immediately” and inserting “within 2 days”;

“(F) in paragraph (5)—

“(i) by striking “to but” and inserting “but”;

“(ii) by inserting “Congress and” after “submit a proposal to”; and

“(G) in paragraph (6)(B)(i), by striking “per unduplicated enrollee” and inserting “(calculated as the sum of per capita spending under each of parts A and D)”;

“(2) in subsection (d)—

“(A) in paragraph (1)(A)—

“(i) by inserting “the Board or” after “a proposal is submitted by”;

“(ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”;

“(B) in paragraph (2)(A), by inserting “the Board or” after “a proposal is submitted by”;

“(3) in subsection (e)—

“(i) in paragraph (1), by inserting “the Board or” after “a proposal submitted by”;

“(ii) by inserting “subsection (c)(3)(A)(i) or” after “the Senate under”;

“(B) in paragraph (3)—

“(i) by striking “EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by” and inserting “EXCEPTIONS.—”;

“(A) IN GENERAL.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the Board or”; and

“(II) by redesigning subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting appropriately; and

“(iii) by adding at the end the following new subparagraph:

“(B) LIMITED ADDITIONAL EXCEPTION.—

“(1) IN GENERAL.—Subject to clause (ii), the Secretary shall not implement the recommendations contained in a proposal submitted in a proposal year by the Board or the President to Congress pursuant to this section in a proposal year (beginning with proposal year 2010) if—

“(I) the Board was required to submit a proposal to Congress under this section in the year preceding the proposal year; and

“(II) the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination in the determination year that the growth rate described in subsection (e)(6)(B) exceeded the growth rate described in subsection (e)(6)(A)(I).

“(2) LIMITED ADDITIONAL EXCEPTION MAY NOT BE APPLIED IN TWO CONSECUTIVE YEARS.—

“Under this subsection, the Board may not apply the provisions of this subparagraph in the same year that the Board or the President to Congress pursuant to this section in the year preceding the proposal year were not required to be implemented by reason of this subparagraph.

“(3) NO AFFECTION TO REQUIREMENT TO SUBMIT PROPOSALS OR FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—
the Board under subsection (c).

(3) A VAILABLE TO PUBLIC.—The Board shall make recommendations submitted to Congress and the President under this subsection available to the public.

(4) Rule of construction.—Nothing in the amendments made by this section shall preclude the Secretary from implementing the Independent Medicare Advisory Board, as established under section 1899A of the Social Security Act (as added by section 3403), from solely using data from public or private sources to carry out the amendments made by subsection (a)(4).

SEC. 10321. REVISION TO COMMUNITY HEALTH TEAMs

Section 3502(c)(2)(A) is amended by inserting "or other primary care providers" after "physicians".

SEC. 10322. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) In general.—Section 1886(s) of the Social Security Act, as added by section 3401(f), is amended by adding at the end the following new paragraph:

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(1) In general.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a psychiatric hospital or psychiatric unit that does not submit data to the Secretary for a corresponding calendar year with respect to such a rate year, any annual update to a standard Federal rate for discharges for the hospital during the rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

"(ii) SPECIAL RULE.—The application of this subparagraph may result in such annual update being less than 0.0 for a rate year, and may result in payment rates under the system described in paragraph (1) for a rate year being less than the median payment rates for the preceding rate year.

(b) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the rate year involved and the Secretary shall not take into account such reduction in computing the payment amount under the system described in paragraph (1) for a subsequent rate year.

(c) SUBMISSION OF QUALITY DATA.—For rate year 2014 and each subsequent rate year, each psychiatric hospital or psychiatric unit described in paragraph (1) shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

(d) QUALITY MEASURES.—

"(i) In general.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph must have been endorsed by an entity with a contract under section 1899A(a).

"(ii) Exclusion.—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 contract under section 1899A(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 by a consensus organization identified by the Secretary.

(iii) Time frame.—Not later than October 1, 2012, the Secretary shall publish the measures described in this subparagraph that, in the opinion of the Secretary, will be applicable with respect to rate year 2014.

(e) Public availability of data submitted.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a psychiatric hospital or psychiatric unit has the opportunity to review the data that is to be made public with respect to the hospital or unit prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in psychiatric hospitals and psychiatric units on the Medicare website of the Centers for Medicare & Medicaid Services.

(b) CONFORMING AMENDMENT.—Section 1806(b)(7)(B)(i)(I) of the Social Security Act, as added by section 3403, is amended by inserting "1886(s)(4)(D)," after "1886(o)(2),".

SEC. 10323. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

(a) In general.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1801 the following new section:

"SEC. 1881A. MEDICARE COVERAGE FOR INDIVIDUALS EXPOSED TO ENVIRONMENTAL HEALTH HAZARDS.

"(a) Deeming of individuals as eligible for Medicare benefits.—

"(1) In general.—For purposes of eligibility for benefits under this title, an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) shall be deemed to meet the conditions specified in section 1226(a).

"(2) Discretionary deeming.—For purposes of eligibility for benefits under this title, the Secretary may deem an individual determined under subsection (c) to be an environmental exposure affected individual described in subsection (e)(2) to meet the conditions specified in section 1226(a).

"(3) EFFECTIVE DATE OF COVERAGE.—An Individual who is deemed eligible for benefits under this title under paragraph (1) or (2) shall—

"(A) entitled to benefits under the program Part A as of the date of such deeming; and

"(B) eligible to enroll in the program under Part B beginning with the month in which such deeming occurs.

(b) Pilot Program for Care of Certain Individuals Residing in Emergency Declaration Areas.—

"(1) PROGRAM; PURPOSE.—

"(A) PRIMARY PILOT PROGRAM.—The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this title to individuals described in paragraph (2)(A), in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

"(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

"(3) FLEXIBLE BENEFITS AND SERVICES.—A pilot program under this subsection may—

"(i) is deemed under subsection (a)(2); and

"(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

"(4) Pilot Program for Care in Geographic Areas Subject to an Emergency Declaration other than the Emergency Declaration of June 17, 2009; or

"(5) Pilot Program for Care in Geographic Areas Subject to an Emergency Declaration other than the Emergency Declaration of June 17, 2009; or

"(b) Pilot Program for Care of Certain Individuals Residing in Emergency Declaration Areas.—

"(1) PROGRAM; PURPOSE.—

"(A) PRIMARY PILOT PROGRAM.—The Secretary shall establish a pilot program in accordance with this subsection to provide innovative approaches to furnishing comprehensive, coordinated, and cost-effective care under this title to individuals described in paragraph (2)(A), in part B, submits to the Secretary an application to participate in the applicable pilot program under this subsection, and—

"(i) is deemed under subsection (a)(2); and

"(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.

"(3) FLEXIBLE BENEFITS AND SERVICES.—A pilot program under this subsection may—

"(i) is deemed under subsection (a)(2); and

"(ii) meets such other criteria or conditions for participation in a pilot program under paragraph (1)(B) as the Secretary specifies.
provide for the furnishing of benefits, items, or services not otherwise covered or authorized under this title, if the Secretary determines that furnishing such benefits, items, or services pursuant to paragraph (1) of this subsection will further the purposes of such program, including pursuant to the Medicare, Medicaid, and the Children's Health Insurance Programs.

(2) I NNOVATIVE REIMBURSEMENT METHODOLOGIES.—For purposes of the pilot program under this section, the Secretary shall—

(A) develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this title, if such benefits, items, or services are furnished pursuant to paragraph (1) of this subsection;

(B) may develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection;

(3) LIMITATION.—Consistent with section 1862, no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefits plan or local agreement.

(4) WAIVER AUTHORITY.—The Secretary may waive any of the provisions of this title and title XI as are necessary to carry out pilot programs under this subsection.

(5) FUNDING.—For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under title XVIII and the Federal Supplemental Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Federal Hospital Insurance Program and the Medicare Program Management Account.

(6) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not require that pilot programs under this subsection be budget neutral with respect to expenditures under this title.

(c) DETERMINATIONS.—

(1) BY THE COMMISSIONER OF SOCIAL SECURITY.—For purposes of this section, the Commissioner of Social Security, in consultation with the State and using the cost allocation method prescribed in section 20(g), shall determine whether individuals are environmental exposure affected individuals.

(2) BY THE SECRETARY.—The Secretary shall determine eligibility for pilot programs under subsection (b).

(d) EMERGENCY DECLARATION DEFINED.—For purposes of this section, the term ‘emergency declaration’ means a declaration of a public health emergency under section 104(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

(e) ENVIRONMENTAL EXPOSURE AFFECTED INDIVIDUAL DEFINED.—

(1) IN GENERAL.—For purposes of this section, the term ‘environmental exposure affected individual’ means—

(A) an individual described in paragraph (2); and

(B) an individual described in paragraph (3).

(2) INDIVIDUAL DESCRIBED.—

(A) IN GENERAL.—An individual described in this paragraph is any individual who—

(i) is diagnosed with 1 or more conditions described in subsection (b); and

(ii) as demonstrated in such manner as the Secretary determines appropriate, has been present for an aggregate total of 6 months in the geographic area subject to an emergency declaration specified in subsection (b)(2)(A), during a period ending—

(1) not less than 10 years prior to such diagnosis; and

(2) developing and disseminating public information and education concerning—

(A) the availability of screening under the program under this section;

(B) the detection, prevention, and treatment of environmental health conditions; and

(C) the availability of Medicare benefits for certain individuals diagnosed with environmental health conditions under section 1881.

(3) ELIGIBLE ENTITIES.—

(i) IN GENERAL.—For purposes of this section, an eligible entity is an entity described in paragraph (2) which submits an application to the Secretary in such form and manner, and containing such information and assurances, as the Secretary determines appropriate.

(ii) TYPES OF ELIGIBLE ENTITIES.—The entities described in this paragraph are the following:

(A) A hospital or community health center.

(B) A Federally qualified health center.

(C) A facility of the Indian Health Service.

(D) A National Cancer Institute-designated cancer center.

(E) An agency of any State or local government.

(F) A nonprofit organization.

(G) Any other entity the Secretary determines appropriate.

(3) DEFINITIONS.—In this section:

(i) AT-RISK INDIVIDUAL.—The term ‘at-risk individual’ means an individual who—

(A) is diagnosed with 1 or more conditions described in subsection (b)(2)(A); and

(B) is an individual described in paragraph (3).

(ii) DIAGNOSIS.—The term ‘diagnosis’—

(A) as used in this section, means—

(i) a diagnosis of 1 or more medical conditions, diagnoses, symptoms, or disabilities;

(ii) in the case of a disease, includes a diagnosis of such disease;

(iii) includes a diagnosis described in subchapter III of Part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 5507, is amended in such manner as the Secretary determines appropriate.

(iii) MEASURES.—The Secretary, in consultation with the Commissioner of Social Security, determines that furnishing such benefits, items, or services pursuant to paragraph (1) of this subsection is necessary—

(A) to make competitive grants to eligible entities specified in subsection (b) for environmental health hazards.

(a) PROGRAM ESTABLISHMENT.—The Secretary shall establish a program in accordance with this subsection to make competitive grants to eligible entities specified in subsection (b) for environmental health hazards.

(i) screening at-risk individuals (as defined in subsection (c)(3)); and

(ii) cytopathology of bronchioalveolar lavage.

(b) PROGRAM FOR EARLY DETECTION OF CERTAIN MEDICAL CONDITIONS RELATED TO ENVIRONMENTAL HEALTH HAZARDS.

(1) AT-RISK INDIVIDUAL.—The term ‘at-risk individual’ means an individual who—

(A) is diagnosed with 1 or more conditions described in subsection (b)(2)(A); and

(B) is an individual described in paragraph (3).

(c) DEFINITIONS.—In this section:

(i) pathologic examination of biopsy tissue;

(ii) cytopathology of bronchioalveolar lavage.

(iii) other diagnostic standards as the Secretary specifies.

(B) May develop and implement innovative approaches to reimbursing providers for any benefits, items, or services furnished under this subsection.

(C) The Secretary shall determine eligibility for pilot programs under this subsection.

(D) The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplemental Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Medicare and Medicaid Services Program Management Account.

(E) The Secretary shall determine eligibility for pilot programs under subsection (b).

(F) The Secretary shall determine eligibility for pilot programs under subsection (b).

(G) Any other entity the Secretary determines appropriate.

(H) The term ‘environmental exposure affected individual’ means an individual who—

(i) is diagnosed with 1 or more conditions described in subsection (b);

(ii) is an individual described in paragraph (3).

(iii) meets such other criteria as the Secretary specifies.

(C) Determinations.—In this section:

(i) ‘at-risk individual’ means an individual who—

(ii) ‘diagnosis’ means—

(i) a diagnosis of 1 or more medical conditions, diagnoses, symptoms, or disabilities;

(ii) in the case of a disease, includes a diagnosis of such disease;

(iii) includes a diagnosis described in subchapter III of Part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 5507, is amended in such manner as the Secretary determines appropriate.

(D) Measures.—The Secretary, in consultation with the Commissioner of Social Security, determines that furnishing such benefits, items, or services pursuant to paragraph (1) of this subsection is necessary—

(i) to make competitive grants to eligible entities specified in subsection (b) for environmental health hazards.

(a) Program Establishment.—The Secretary shall establish a program in accordance with this subsection to make competitive grants to eligible entities specified in subsection (b) for environmental health hazards.

(1) At-Risk Individual.—The term ‘at-risk individual’ means an individual who—

(A) is an individual described in paragraph (3); and

(B) is an individual described in paragraph (3).

(ii) ‘diagnosis’ means—

(i) a diagnosis of 1 or more medical conditions, diagnoses, symptoms, or disabilities;

(ii) in the case of a disease, includes a diagnosis of such disease;

(iii) includes a diagnosis described in subchapter III of Part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 5507, is amended in such manner as the Secretary determines appropriate.

(i) pathologic examination of biopsy tissue;

(ii) cytopathology of bronchioalveolar lavage.

(iii) other diagnostic standards as the Secretary specifies.

(b) Program for Early Detection of Certain Medical Conditions Related to Environmental Health Hazards.

(1) At-Risk Individual.—The term ‘at-risk individual’ means an individual who—

(A) is described in paragraph (3); and

(B) is an individual described in paragraph (3).

(ii) ‘diagnosis’ means—

(i) a diagnosis of 1 or more medical conditions, diagnoses, symptoms, or disabilities;

(ii) in the case of a disease, includes a diagnosis of such disease;

(iii) includes a diagnosis described in subchapter III of Part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 5507, is amended in such manner as the Secretary determines appropriate.
“(c) Any other medical condition which the Secretary determines is caused by exposure to a hazardous substance or pollutant or contaminant at a Superfund site to which an emergency or medical need applies, based on such criteria and as established by such diagnostic standards as the Secretary specifies.

(4) HAZARDOUS SUBSTANCE; POLLUTANT; CONTAMINANT.—Conditions as authorized under this section shall not apply to grants awarded under paragraph (2), the preceding sections of this title shall not apply to grants awarded under paragraph (5)(H).”.

(5) SUPERFUND SITE.—The term ‘Superfund site’ includes—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(3) FUNDING.—

(A) $23,000,000 for the period of fiscal years 2010 through 2014; and

(B) $20,000,000 for each 5-fiscal year period thereafter.
“(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements at the end of the following paragraph:

(i) The eligible professional shall—

(1) satisfactorily submit data on quality measures for purposes of paragraph (1) for a year;

(ii) have such data submitted on their behalf through a Maintenance of Certification Program as defined in subparagraph (C)(i) that measures the following:

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) a form and manner determined appropriate by the Secretary.

(iii) Eligible professionals, more frequently than is required to qualify for or maintain their Medicare or Medicaid enrollment status:

(1) participates in such a Maintenance of Certification program for a year; and

(2) successfully completes a qualified Maintenance of Certification Program practice assessment as defined in subparagraph (C)(i) for such year.

(iv) A Maintenance of Certification program described in subparagraph (A) includes the following:

(aa) the criteria for a registry (as described in subsection (k)(4)); or

(bb) a form and manner determined appropriate by the Secretary.

(v) The eligible professional, more frequently than is required to qualify for or maintain their Medicare or Medicaid enrollment status:

(1) submits to the Secretary, on behalf of the eligible professional, information—

(aa) in a form and manner specified by the Secretary, that the eligible professional has successfully completed a Maintenance of Certification Program practice assessment, including the following:

(i) a review of the eligible professional's practice that is designed to demonstrate the physician's use of evidence-based medicine;

(ii) a survey of patient experience with care (as determined by the Secretary);

(iii) an assessment of a physician's practice that—

(aa) is consistent with board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills and professionalism. Such a program shall include the following:

(1) a program that requires the physician to maintain a valid, unrestricted medical license in the United States;

(2) a program that requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned;

(3) a program that requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, judgment, and practice that allow quality care in their respective specialty.

(iv) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (i).

(2) requires a program that—

(i) includes an initial assessment of an eligible professional's practice that is determined to demonstrate the eligible physician's use of evidence-based medicine;

(ii) includes a survey of patient experience with care; and

(iii) requires a physician to implement a quality improvement intervention to address a practice weakness identified in the initial assessment under subclause (I) and then to remeasure to assess performance improvement after such intervention;

(b) AUTHORITY.—Section 3002(c) of this Act is amended by inserting at the end the following new subparagraph:

“(3) AUTHORITY.—For years after 2014, if the Secretary determines to be appropriate, the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician qualification program described in section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).”.

(c) ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.—(1) IN GENERAL.—Section 1858 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (e).

(2) TRANSITION.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 10328. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.

(a) IN GENERAL.—Section 1860D–4(c)(2) of the Social Security Act (42 U.S.C. 1395w–106(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraph:

“(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

(1) an annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

(I) shall include a review of the individual's medication history in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

(II) shall include providing the individual with a written or printed summary of the results of the review;

(b) RULE OF CONSTRUCTION.—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

SEC. 10329. DEVELOPING METHODOLOGY TO ASSESS HEALTH PLAN VALUE.

(a) DEVELOPMENT.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”), in consultation with relevant stakeholders including health insurance issuers, health care providers, and other entities determined appropriate by the Secretary, shall develop a methodology to measure health plan value.

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning the methodology developed under subsection (a).

SEC. 10330. MODERNIZING COMPUTER AND DATA SYSTEMS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES TO SUPPORT IMPROVEMENTS IN CARE DELIVERY.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall modernize the computer and data systems of the Centers for Medicare & Medicaid Services (in this section referred to as “CMS”) to—

(1) improve the efficiency of the plan in providing care;

(2) improve the quality of the care provided for under the plan;

(3) improve the efficiency of the plan in providing care;

(4) improve the quality of the care provided for under the plan;

(5) the actuarial value or other comparative measure of the benefits covered under the plan; and

(6) other factors determined relevant by the Secretary.

(b) CONSIDERATIONS.—In developing the plan, the Secretary shall consider how such modernized computer system could be used to support integrated care delivery systems and programs as described in subsection (a).

(c) FILING OF PLAN.—Not later than 9 months after the date of enactment of this Act, the Secretary shall post on the website of the Centers for Medicare & Medicaid Services the plan described in subsection (b).

SEC. 10331. PUBLIC REPORTING OF PERFORMANCE INFORMATION.

(a) IN GENERAL.—
(1) DEVELOPMENT.—Not later than January 1, 2011, the Secretary shall develop a Physician Compare Internet website with information on physicians enrolled in the Medicare program (under section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j))) and other eligible professionals who participate in the Physician Quality Reporting Initiative under section 1848 of such Act (42 U.S.C. 1395w–4).

(2) PLAN.—Not later than January 1, 2013, and with respect to reporting periods that begin no earlier than January 1, 2012, the Secretary shall implement a plan for making publicly available through Physician Compare, consistent with subsection (c), information on physician quality and performance feedback is provided to physicians concerning the data reported under section 1866(j). To the extent scientifically sound measures that are developed consistent with the requirements of this section are available, such information, to the extent practicable, shall include—

(A) measures collected under the Physician Quality Reporting Initiative;

(B) an assessment of patient health outcomes and the functional status of patients;

(C) an assessment of the continuity and coordination of care and care transitions, including episodes of care and risk-adjusted resource use;

(D) an assessment of efficiency;

(E) an assessment of patient experience and patient, caregiver, and family engagement;

(F) an assessment of the safety, effectiveness, and timeliness of care; and

(G) other information as determined appropriate by the Secretary.

(b) OTHER REQUIRED CONSIDERATIONS.—In developing the plan described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that data made available by the Secretary provide a robust and accurate portrayal of a physician’s performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians as described in subparagraph (B); and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) ENHANCING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration feedback from multi-stakeholder groups, consistent with sections 1890(b)(3) and 1890A of the Social Security Act, as amended by section 1848(l)(4) of such Act, in selecting quality measures for use under this section.

(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PAYING.—In developing the plan under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, compare the transition to a value-based purchasing program for physicians and other practitioners developed under section 131 of the Medicare Improvement Act of 2008 (Public Law 110–117).

(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit to Congress a report on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include information on the methodologies that such qualified entity requests data under parts A, B, and D for items and services furnished under such parts for one or more specified periods and time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the privacy of individuals entitled to, or enrolled for, benefits under such parts.

(4) REQUIREMENTS.—

(A) USE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited in the Supplementary Medical Insurance Trust Fund under section 1801.

(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data;

(ii) except as provided in subparagraph (C), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 501 of the Public Health Service Act; or

(iii) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iv) include data made available under this subsection with claims data from sources other than the data described in this subsection, in the evaluation of the performance of providers of services and suppliers; and

(v) only include information on the evaluation of providers of services and suppliers in reports described in subparagraph (C).

(vi) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vii) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(i), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and sponsors, so that such reports may be available to providers of services and suppliers, health plans, researchers, and other stakeholders who can assess such reports;

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public dissemination of such report; and

(iii) include data made available under this subsection that are comparable to data made available in the Medicare program and, to the extent such data are available, to the extent practicable, other payers.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

"(v) AVAILABILITY OF MEDICARE DATA.—

"(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) data on the evaluation of the performance of providers of services and suppliers.

"(2) QUALIFIED ENTITIES.—For purposes of this subsection, the term ‘qualified entity’ means a public or private entity that—

"(A) is qualified (as determined by the Secretary) to use claims data described in paragraph (3) for evaluating the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

"(B) agrees to meet requirements described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

"(3) DATA.—The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data made available to a qualified entity under this subsection. The Secretary shall take such actions as the Secretary deems necessary to protect the privacy of individuals entitled to, or enrolled for, benefits under such parts.

"(4) REQUIREMENTS.—

"(A) USE.—Data described in paragraph (3) shall be made available to a qualified entity under this subsection at a fee equal to the cost of making such data available. Any fee collected pursuant to the preceding sentence shall be deposited in the Supplementary Medical Insurance Trust Fund under section 1801.

"(B) SPECIFICATION OF USES AND METHODOLOGIES.—A qualified entity requesting data under this subsection shall—

(i) submit to the Secretary a description of the methodologies that such qualified entity will use to evaluate the performance of providers of services and suppliers using such data; and

(ii) except as provided in subparagraph (C), if available, use standard measures, such as measures endorsed by the entity with a contract under section 1890(a) and measures developed pursuant to section 501 of the Public Health Service Act; or

(iii) use alternative measures if the Secretary, in consultation with appropriate stakeholders, determines that use of such alternative measures would be more valid, reliable, responsive to consumer preferences, cost-effective, or relevant to dimensions of quality and resource use not addressed by such standard measures;

(iv) include data made available under this subsection with claims data from sources other than the data described in this subsection, in the evaluation of the performance of providers of services and suppliers; and

(v) only include information on the evaluation of providers of services and suppliers in reports described in subparagraph (C).

(vi) make available to providers of services and suppliers, upon their request, data made available under this subsection; and

(vii) prior to their release, submit to the Secretary the format of reports under subparagraph (C).

(C) REPORTS.—Any report by a qualified entity evaluating the performance of providers of services and suppliers using data made available under this subsection shall—

(i) include an understandable description of the measures, which shall include quality measures and the rationale for use of other measures described in subparagraph (B)(i), risk adjustment methods, physician attribution methods, other applicable methods, data specifications and limitations, and sponsors, so that such reports may be available to providers of services and suppliers, health plans, researchers, and other stakeholders who can assess such reports; and

(ii) be made available confidentially, to any provider of services or supplier to be identified in such report, prior to the public dissemination of such report; and

(iii) include data made available under this subsection that are comparable to data made available in the Medicare program and, to the extent such data are available, to the extent practicable, other payers.
release of such report, and provide an opportunity to appeal and correct errors;

"(iii) only include information on a provider of services or supplier in an aggregate form as determined appropriate by the Secretary; and

"(iv) except as described in clause (ii), be made available to the public.

"(D) LIMITATION OF USES.—The Secretary shall not make data described in paragraph (3) available to a qualified entity unless the qualified entity agrees to release the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and only in a form derived from such evaluation, for the reports under subparagraph (C). Data released to a qualified entity under this subsection shall not be subject to discovery or admissibility as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

"(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2012.

SEC. 10333. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title II of the Public Health Service Act (42 U.S.C. 330 et seq.) is amended by adding at the end the following new section:

"Subpart XI—Community-Based Collaborative Care Network Program

SEC. 3401H. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM.

"(a) IN GENERAL.—The Secretary may award grants to eligible entities to support community-based collaborative care networks that meet the requirements of subsection (b).

"(b) COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.—

"(1) DESCRIPTION.—A community-based collaborative care network (referred to in this section as a ‘network’) shall be a consortium of health care providers with a joint governance structure (including providers within a single entity) that provides comprehensive coordinated and integrated health care services (as defined by the Secretary) for low-income populations.

"(2) REQUIRED INCLUSION.—A network shall include the following providers (unless such providers are within the community, declines or refuses to participate, or places unreasonable conditions on their participation):

"(A) a hospital that meets the criteria in section 1923(b)(1) of the Social Security Act;

"(B) places unreasonable conditions on their participation, for the reports under subparagraph (C).

"(3) FUNDING.—

"(A) In general.—The Secretary may limit the percent of grant funds to HRSA grantees .—The Secretary may limit the percent of grant funds awarded to eligible entities under this subsection to the extent of the percent of grant funds provided by grantees of programs administered by the Health Resources and Services Administration or impose other requirements on such grantees deemed necessary.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 10334. MINORITY HEALTH.

"(a) Office of Minority Health.—

"(1) In general.—The Secretary may award grants, contracts, or cooperative agreements to eligible entities under the authority of the Office of Minority Health to establish within the agency an office to be known as the Office of Minority Health. The head of each such office shall be appointed by the head of the agency within which the Office is established, and shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

"(b) SPECIFIED AGENCIES.—The agencies referred to in subsection (a) are the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

"(c) DIRECTOR; APPOINTMENT.—Each Office of Minority Health established under this section is headed by a director, who is appointed by the Secretary, and is appointed by the Secretary, and shall report to the appropriate committees in both Houses of Congress.

"(d) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of Minority Health (in the Department of Health and Human Services) shall be a reference to the Office of Minority Health in the Office of the Secretary.

"(e) FUNDING.—

"(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities established in an agency that is being prepared. Not later than 1 year after the date of enactment of this section, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this subsection) during the period for which the report is being prepared. Not later than 1 year after the date of enactment of this section, the Secretary shall submit to the appropriate committees of Congress a report summarizing the minority health activities of each of the respective agencies.

"(2) Establishment of Office of Minority Health Within the Department of Health and Human Services.—

"(A) IN GENERAL.—The head of each agency specified in subsection (a) is the Secretary, which shall be a reference to the Office of Minority Health within the Department of Health and Human Services (as defined in subsection (a)).

"(B) by striking subsection (h) and inserting "(A) a hospital that meets the criteria in section 1861(aa) of the Social Security Act; and

"(C) Perform health outreach using neighborhood health workers or through other methods.

"(D) Provide transportation.

"(E) Expand capacity, including through telehealth, after-hours services or urgent care.

"(F) Provide direct patient care services.

"(2) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant funds awarded to eligible entities under this subsection to the extent of the percent of grant funds provided by grantees of programs administered by the Health Resources and Services Administration or impose other requirements on such grantees deemed necessary.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 1707A. INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN THE DEPARTMENT.

"(a) IN GENERAL.—The head of each agency specified in subsection (a) shall be the Director of the Office of Minority Health within the agency, which shall be a reference to the Office of Minority Health within the Department of Health and Human Services.

"(b) SPECIFIED AGENCIES.—The agencies referred to in subsection (a) are the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Agency for Healthcare Research and Quality, the Food and Drug Administration, and the Centers for Medicare & Medicaid Services.

"(c) DIRECTOR; APPOINTMENT.—Each Office of Minority Health established under this section is headed by a director, who is appointed by the Secretary, and shall report to the appropriate committees in both Houses of Congress.

"(d) REFERENCES.—Except as otherwise specified, any reference in Federal law to an Office of Minority Health (in the Department of Health and Human Services) shall be a reference to the Office of Minority Health in the Office of the Secretary.

"(e) FUNDING.—

"(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities established in an agency that is being prepared. Not later than 1 year after the date of enactment of this section, the Secretary of Health and Human Services shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under section 1707 of the Public Health Service Act (as amended by this subsection) during the period for which the report is being prepared. Not later than 1 year after the date of enactment of this section, the Secretary shall submit to the appropriate committees of Congress a report summarizing the minority health activities of each of the respective agencies.

"(2) Availability of funds for staffing.—The purposes for which amounts made available under paragraph may be expended and the amounts that otherwise would be available for each of the programs of the designated agency involved.
(3) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of minority health or Federal apportionment position with primary responsibility for minority health issues that is in existence in an office of agency of the Department of Health and Human Services on the date of enactment of this section shall not be terminated, reorganized, or, in any of its power or duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

(c) NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES.—

(1) REDESIGNATION.—Title IV of the Public Health Service Act (42 U.S.C. 291 et seq.) is amended by—

(A) redesignating section 291 as section 291A; and

(B) by inserting subsection 6 of part E as subpart 20, as so redesignated, after subsection 19 of such part C; and

(D) in subpart 20, as so redesignated—

(i) by redesignating sections 483E through 483H as sections 483E–3 through 483E–6, respectively;

(ii) by striking “National Center on Minority Health and Health Disparities” each place such term appears and inserting “National Institute on Minority Health and Health Disparities” each place such term appears;

(iii) by striking “Center” each place such term appears and inserting “Institute”.

(2) PURPOSE OF INSTITUTE; DUTIES.—Section 483E–2 of the Public Health Service Act, as so redesignated, is amended—

(A) in section (b)(1), by striking “research endowments at centers of excellence under” and inserting the following—

“research endowments—

(1) at centers of excellence under section 780; and

(2) at centers of excellence under section 484A–4;”;

(B) in subsection (2)(A), by striking “average” and inserting “median”;

and

(C) by adding at the end the following—

“(h) INTERAGENCY COORDINATION.—The Director of the Institute, as the primary Federal officials with responsibility for coordinating all research and activities conducted or supported by the National Institutes of Health on minority health and health disparities, shall plan, coordinate, review and evaluate all activities, and other activities conducted or supported by the Institutes of the National Institutes of Health.”

(3) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) Section 401(b)(24) of the Public Health Service Act (42 U.S.C. 291(b)(24)) is amended by striking “Center” and inserting “Institute”.

(B) Subsection (d)(1) of section 903 of the Public Health Service Act (42 U.S.C. 300a–1(d)(1)) is amended by striking “section 483E” and inserting “section 484A–3.”

SEC. 10335. TECHNICAL CORRECTION TO THE HOSPITAL VALUE-BASED PUBLISHING CHARGING PROGRAM.

Section 1886(o)(21A) of the Social Security Act, as added by section 3061, is amended, in the first sentence, by striking “and” and inserting “; other than measures of readmissions,” after “shall select measures”.

SEC. 10336. A STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO HIGH-QUALITY DIALYSIS SERVICES.

(a) STUDY.—

(I) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the impact on Medicare beneficiary access to high-quality dialysis services of including specified oral drugs that are furnished to such beneficiaries for the treatment of end stage renal disease in the bundled prospective payment system under section 1881(b)(14) of the Social Security Act (42 U.S.C. 1395rr(b)(14)) (pursuant to the proposed rule published by the Secretary of Health and Human Services in the Federal Register on September 29, 2009 (74 Fed. Reg. 49922 et seq.)). Such study shall include an analysis of—

(A) the ability of providers of services and renal dialysis facilities to furnish specified oral drugs or arrange for the provision of such drugs;

(B) the ability of providers of services and renal dialysis facilities to comply, if necessary, with applicable State laws (such as State pharmacy licensure requirements) in order to furnish such drugs; and

(C) whether appropriate quality measures exist to safeguard care for Medicare beneficiaries being furnished specified oral drugs by providers of services and renal dialysis facilities; and

(D) other areas determined appropriate by the Comptroller General.

(b) SPECIFIED ORAL DRUG DEFINED.—For purposes of paragraph (1), the term “specified oral drug” means a drug or biological for which there is no interchangeable (or other non-oral form of administration).

(c) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Subtitle D—Provisions Relating to Title IV

SEC. 10401. AMENDMENTS TO SUBTITLE A.

(a) Section (b)(1) of this Act is amended by striking “2010” each place such term appears and inserting “2020”.

(b) Section 403(c) of this Act is amended—

(1) by striking “research, health screenings” and inserting “research, health screenings, and initiatives”;

and

(2) by striking “for Preventive” and inserting “Regarding Preventive”.

(c) Section 404(a)(4) of this Act is amended by striking “a Gateway” and inserting “an Exchange”.

SEC. 10402. AMENDMENTS TO SUBTITLE B.

(a) Section 3902(1)(A)(1) of the Public Health Service Act, as added by section 410(b) of this Act, is amended by inserting “and vision” after “oral”.

(b) Section 1861(ii)(h)(4)(G) of the Social Security Act, as added by section 410(b), is amended to read as follows:

“(G) A beneficiary shall be eligible to receive only an initial preventive physical examination (as defined under subsection (w)(1)) during the 12-month period after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection each year thereafter provided that the beneficiary has not received either an initial preventive physical examination or personalized prevention plan services within the preceding 12-month period.”

Sec. 10403. AMENDMENTS TO SUBTITLE C.

Section 4201 of this Act is amended—

(1) in subsection (a), by adding before the period the following: “, with not less than 20 percent of such grants being awarded to rural and frontier areas”; and

(2) in subsection (b)(VII), by striking “both urban and rural areas” and inserting “urban, rural, and frontier areas”;

and

(3) in subsection (f), by striking “each fiscal years” and inserting “each of fiscal years.”

SEC. 10404. AMENDMENTS TO SUBTITLE D.

Section 399MM(2) of the Public Health Service Act, as added by section 4303 of this Act, is amended by striking “by ensuring” and inserting “and ensuring”.

SEC. 10405. AMENDMENTS TO SUBTITLE E.

Subtitle E of title IV of this Act is amended by struck section 461.

SEC. 10406. AMENDMENTS RELATING TO WAIVING COINSURANCE FOR PREVENTIVE SERVICES.

Section 1395l(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as added by section 4103(c)(1), is amended—

(1) by striking “(T)”, by inserting “(or 10 percent) if such services are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual” after “80 percent”; and

(2) by striking paragraph (W) and inserting “(W) by striking ‘80 percent’ and inserting ‘100 percent’;

(3) by striking paragraph (X) and inserting “(X) by striking before the semicolon at the end the following: ‘, and (Y) with respect to preventive services described in subparagraph (B) of paragraph (2)(i) of the Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of (i) except as provided in clause (ii), the lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part, and (ii) in the case of such services that are appropriate for the individual and in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent”;

and

(4) by inserting at the end the following:

“(Z) in subsection (t)(1)(B), the amount determined by providers of services and renal dialysis facilities to comply, if necessary, with applicable State laws (such as State pharmacy licensure requirements) in order to furnish such drugs; and

(2) S PECIFIED ORAL DRUG DEFINED.—For purposes of paragraph (1), the term “specified oral drug” means a drug or biological for which there is no interchangeable (or other non-oral form of administration).

(b) Section 4002(c) of this Act is amended—

(1) by striking “research and health screenings” and inserting “research, health screenings, and initiatives”; and

(2) by striking “for Preventive” and inserting “Regarding Preventive”.

(c) Section 4004(a)(4) of this Act is amended by striking “a Gateway” and inserting “an Exchange”.

SEC. 10407. BETTER DIABETES CARE.

(a) SHORT TITLE.—This section may be cited as the “Catalyst to Better Diabetes Care Act of 2009”.

(b) NATIONAL DIABETES REPORT CARD.—In GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the “Director”), shall prepare a biennial report card (referred to in this section as a “Report Card”) and, to the extent possible, for each State.

(1) CONTENTS.—

(A) IN GENERAL.—Each Report Card shall include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

(i) preventative care practices and quality of care;

(ii) risk factors; and

(iii) outcomes.

(B) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include trend analysis for the Nation and, to the extent possible, for each State, for the purpose of—

(i) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and

(ii) informing policy and program development.

(C) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each Report Card publicly available, including by posting the Report Card on the Internet.

SEC. 10408. IMPROVEMENT OF VITAL STATISTICS COLLECTION.—
(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(A) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete certificates, including the collection of such data for diabetes and other chronic diseases;

(B) encourage State adoption of the latest standards and revisions of birth and death certificates;

(C) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(2) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this subsection, the Secretary may promote improvements to the collection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

(d) STUDY ON APPROPRIATE LEVEL OF DIABETES MEDICAL EDUCATION.—

(1) IN GENERAL.—The Secretary shall, in collaboration with the Institute of Medicine and appropriate associations and councils, conduct a study of the impact of diabetes on the practice of medicine in the United States and the appropriateness of the level of diabetes medical education that should be required prior to licensure, board certification, and by recertification.

(2) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the study under paragraph (1) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, and Labor of the Senate.

(e) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out the grant program under this section, there is authorized to be appropriated $200,000,000 for the period of fiscal years 2011 through 2015. Amounts appropriated pursuant to this subsection shall remain available until expended.

SEC. 10408. GRANTS FOR SMALL BUSINESSES TO PROVIDE COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS.

(a) SHORT TITLE.—This section may be cited as the ‘‘Cures Acceleration Network Act of 2009.’’

(b) REQUIREMENT FOR THE DIRECTOR OF NIH TO ESTABLISH A CURES ACCELERATION NETWORK.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282(b)) is amended—

(1) in paragraph (22), by striking ‘‘and’’ at the end;

(2) in paragraph (23), by striking and inserting ‘‘;’’ and;

(3) by inserting after paragraph (23), the following:

‘‘(24) implement the Cures Acceleration Network described in section 402c.’’;

(c) ACCEPTING GIFTS TO SUPPORT THE CURES ACCELERATION NETWORK.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 282c) is amended—

(1) in paragraph (22), by striking ‘‘and’’ at the end;

(2) in paragraph (23), by striking and inserting ‘‘;’’ and;

(3) by inserting after paragraph (23), the following:

‘‘(24) establish the Cures Acceleration Network described in section 402c.’’;

(d) ESTABLISHMENT OF THE CURES ACCELERATION NETWORK.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 282c) is amended by adding at the end the following:

‘‘(B) The Cures Acceleration Network described in section 402c.’’;

(e) FUNCTION OF THE CURES ACCELERATION NETWORK.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 282c) is amended—

(1) in paragraph (22), by striking ‘‘and’’ at the end;

(2) in paragraph (23), by striking and inserting ‘‘;’’ and;

(3) by inserting after paragraph (23), the following:

‘‘(24) to implement the Cures Acceleration Network described in section 402c.’’;

(f) NAME.—Section 499(c)(1) of the Public Health Service Act (42 U.S.C. 282c) is amended by adding at the end the following:

‘‘(B) The Cures Acceleration Network established under this section as the ‘Cures Acceleration Network Review Board’, the following:

‘‘(1) ESTABLISHMENT.—There is established a Cures Acceleration Network Review Board (referred to in this section as the ‘Board’), which shall advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network.

‘‘(2) MEMBERSHIP.—

‘‘(A) IN GENERAL.—

‘‘(i) MEMBERS.—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

‘‘(ii) CHAIRPERSON AND VICE CHAIRPERSON.—

The Secretary shall designate, from among the 24 members appointed under clause (i), one Chairperson of the Board (referred to in this section as the ‘Chairperson’) and one Vice Chairperson.

‘‘(B) TERMS.—

‘‘(i) IN GENERAL.—Each member shall be appointed to serve a 4-year term, except that no member may serve more than 2 terms consecutively.

‘‘(ii) CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.—A member may be appointed to serve no more than 3 terms on the Board, and shall not serve more than 2 such terms consecutively.

‘‘(C) QUALIFICATIONS.—

‘‘(i) IN GENERAL.—The Secretary shall appoint individuals who have demonstrated a commitment to accelerating the development of new therapies and cures;

‘‘(ii) FUNDING.—The Board shall have the responsibilities described in subsection (e); and

‘‘(iii) TERMINATION.—The Board shall terminate on December 31, 2015.

‘‘(g) REPORT.—The Secretary shall submits a report to the Committees on Health, Education, Labor, and Pensions, the Committees on Ways and Means, and the Committees on Finance, Energy and Commerce of the House of Representatives and the Committees on Health, Education, Labor, and Pensions, the Committees on Health, Education, Labor, and Pensions, the Committees on Finance, Energy and Commerce of the Senate on the conduct of the activities of the Cures Acceleration Network Review Board.

SEC. 10409. CURES ACCELERATION NETWORK REVIEW BOARD.

(a) STUDY.—The Secretary, acting through the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as ‘CAN’), which shall—

(1) make recommendations to the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the ‘Board’), established under subsection (b), on the following:

‘‘(1) conduct and support research grants to eligible entities, as described in subsection (e), that may accelerate the development of new therapies and cures;

‘‘(2) award grants and contracts to eligible entities, as described in subsection (e), that may accelerate the development of new therapies and cures;

‘‘(3) define the terms ‘drug’ and ‘device’;

‘‘(4) conduct and support research grants to eligible entities, as described in subsection (e), that may improve the clinical safety, efficacy, and appropriateness of therapeutic and diagnostic products and services; and

‘‘(5) conduct and support research grants to eligible entities, as described in subsection (e), that may develop new therapies.

(2) REQUIREMENT.—The Board shall, in carrying out its responsibilities under this section, make recommendations to the Secretary.

(b) REQUIREMENT FOR THE SECRETARY TO ESTABLISH A CURES ACCELERATION NETWORK REVIEW BOARD.—Section 402(c)(1) of the Public Health Service Act (42 U.S.C. 282b(c)(1)) is amended by inserting after ‘‘Director’’ the following:

‘‘(c) ESTABLISHMENT.—The Secretary may require, which shall include a proposal for a comprehensive workplace wellness program that meet the criteria and requirements described under subsection (c).

‘‘(1) IN GENERAL.—The Secretary, acting through the Director of NIH, shall, in collaboration with the Office of the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as ‘CAN’), which shall—

(1) make recommendations to the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the ‘Board’), established under subsection (b), on the following:

‘‘(2) PREVENT AND TREAT.—The functions of the CAN are to—

‘‘(1) conduct and support research grants to eligible entities, as described in subsection (e), that may accelerate the development of new therapies and cures;

‘‘(2) award grants and contracts to eligible entities, as described in subsection (e), that may accelerate the development of new therapies and cures.

(2) MANAGEMENT OF THE BOARD.—The Board shall be comprised of 24 members appointed by the Secretary and who shall serve at the pleasure of the Secretary.

(3) CHAIRPERSON AND VICE CHAIRPERSON.—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

(4) TERMS.—Each member shall be appointed to serve a 4-year term, except that no member may serve more than 2 terms consecutively.

(5) CONSECUTIVE APPOINTMENTS; MAXIMUM TERMS.—A member may be appointed to serve not more than 3 terms on the Board, and shall not serve more than 2 such terms consecutively.

(6) QUALIFICATIONS.—The Secretary shall appoint individuals who have demonstrated a commitment to accelerating the development of new therapies and cures;

(7) TERMINATION.—The Board shall terminate on December 31, 2015.

(8) REPORT.—The Secretary shall submits a report to the Committees on Health, Education, Labor, and Pensions, the Committees on Ways and Means, and the Committees on Finance, Energy and Commerce of the House of Representatives and the Committees on Health, Education, Labor, and Pensions, the Committees on Finance, Energy and Commerce of the Senate on the conduct of the activities of the Cures Acceleration Network Review Board.
expertise described in clause (i). Each individual appointed to the Board shall be of distinguished achievement and have a broad range of disciplinary interests.

(ii) EXPERTISE.—The Secretary shall select individuals based upon the following requirements:

(I) For each of the fields of—

(a) basic research;

(b) medical science;

(c) biopharmaceuticals;

(dd) discovery and delivery of medical products;

(f) bioinformatics and gene therapy;

(g) medical instrumentation; and

(hh) regulatory review and approval of medical products,

the Secretary shall select at least 1 individual who is eminent in such fields.

(II) At least 4 individuals shall be recognized leaders in professional venture capital or governance of venture capital activities at all stages of development, manufacturing, review, approval, and safety surveillance of a medical product; and

(III) At least 8 individuals shall have demonstrated experience in private equity investing.

(iv) At least 8 individuals shall represent diseases of a 3-year term on the Board.

(3) EX-OFFICIO MEMBERS.—

(A) APPOINTMENT.—In addition to the 24 Board members described in paragraph (2), the Secretary shall appoint ex-officio members of the Board—

(i) a representative of the National Institutes of Health, recommended by the Secretary of Health and Human Services;

(ii) a representative of the Office of the Assistant Secretary for Defense for Health Affairs, recommended by the Secretary of Defense;

(iii) a representative of the Office of the Under Secretary for Health for the Veterans Health Administration, recommended by the Secretary of Veterans Affairs;

(iv) a representative of the National Science Foundation, recommended by the Chair of the National Science Board; and

(v) a representative of the Food and Drug Administration, recommended by the Commissioner of Food and Drugs.

(B) TERMS.—Each ex-officio member shall serve a 3-year term on the Board, except that the Chairperson may adjust the terms of the initial ex-officio members in order to provide for a staggered term of appointment for all such members.

(4) RESPONSIBILITIES OF THE BOARD AND THE DIRECTOR OF NIH.—

(A) RESPONSIBILITIES OF THE BOARD.—

(I) The Board shall advise, and provide recommendations to, the Director of NIH with respect to—

(i) policies, programs, and procedures for carrying out the duties of the Director of NIH under this section; and

(ii) significant barriers to successful translation of basic science into clinical application (including issues under the purview of other departments).

(ii) REPORT.—In the case that the Board identifies a significant barrier, as described in clause (i)(II), the Board shall submit to the Secretary a report regarding such barrier.

(B) RESPONSIBILITIES OF THE DIRECTOR OF NIH.—With respect to each recommendation provided by the Board under subparagraph (A)(i), the Director of NIH shall respond in writing to the Board, indicating whether such Director will implement such recommendation. In the case that the Director of NIH indicates a recommendation of the Board will not be implemented, such Director shall provide an explanation of the reasons for not implementing such recommendation.

(5) MEETINGS.—

(A) IN GENERAL.—The Board shall meet 4 times per calendar year, at the call of the Chairperson.

(B) QUORUM; REQUIREMENTS; LIMITATIONS.—

(i) QUORUM.—A quorum shall consist of a total of 13 members of the Board, excluding ex-officio members, with diverse representation as described in subparagraph (A)(i).

(ii) CHAIRPERSON OR VICE CHAIRPERSON.—Each meeting of the Board shall be attended by either the Chairperson or the Vice Chairperson.

(iii) DIVERSE REPRESENTATION.—At each meeting of the Board, there shall be not less than one scientist, one representative of a disease advocacy group, and one representative of a professional venture capital or private equity organization.

(C) COMPENSATION AND TRAVEL EXPENSES.—

(A) COMPENSATION.—Members shall receive compensation at a rate to be fixed by the Chairperson but not to exceed a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the performance of the duties of the Board. All members of the Board who are officers or employees of the United States shall receive compensation in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for persons employed intermittently by the Federal Government under section 7002(b) of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(6) GRANT PROGRAM.—

(A) SUPPORTING INNOVATION.—To carry out the purposes described in this section, the Director of NIH shall award contracts, grants, or cooperative agreements to the entities described in paragraph (2), to—

(i) promote innovation in technologies supporting the advanced research and development and production of high cure rates, including through the development of medical products and behavioral therapies;

(ii) accelerate the development of high need curative medical products;

(iii) develop in vitro models for high need medical products; and

(iv) develop biomarkers that demonstrate the safety or effectiveness of medical products;

(B) MATCHING FUNDS.—As a condition for receiving an award under this subsection, an eligible entity shall contribute to the project or Federal funds in the amount of $1 for every $2 awarded under clauses (i) and (ii), except that the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot be adequately carried out unless such requirement is waived.

(7) CURES ACCELERATION FLEXIBLE RESEARCH AWARDS.—If the Director of NIH determines that the goals and objectives of this section cannot be adequately carried out through a contract, grant, or cooperative agreement, the Director of NIH shall have flexible research authority to use other transactions to fund projects in accordance with the terms and conditions of this section. Awards made under such flexible research authority for a fiscal year shall not exceed 20 percent of the total funds appropriated under subsection (g)(1) for such fiscal year.

(8) SUSPENSION OF AWARDS FOR DEFAULTS, NONCOMPLIANCE WITH PROVISIONS AND PLANS, AND DIVERSION OF FUNDS; REPAYMENT OF FUNDS.—The Director of NIH may suspend the award to any entity upon noncompliance with the terms and conditions of the award. Awards made under this section may be suspended and, after a final determination, the entity may be required to repay any funds that were not used in accordance with this section.

(9) GRANTS AND CONTRACTS.—The Director of NIH may enter into agreements with any entity with periodic awards funded by grants or contracts awarded under this subsection.
(6) Closeout Procedures.—At the end of a grant or contract period, a recipient shall follow the closeout procedures under section 74.71 of title 45, Code of Federal Regulations (or analogous regulation).

(7) Review.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need cure (for purposes of subsection (a)(3)) shall not be subject to judicial review.

(f) Competitive Basis of Awards.—Any grant, cooperative agreement, or contract awarded under this section shall be awarded on a competitive basis.

(g) Authorization of Appropriations.—

(1) In general.—For purposes of carrying out this Act, other than funds appropriated under subsection (f) are appropriated $500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

(2) Limitation on Use of Funds Otherwise Appropriated.—No funds appropriated under this Act, other than funds appropriated under paragraph (1), may be allocated to the Aids Acceleration Network.

SEC. 10410. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) Short Title.—This section may be cited as the “Establishing a Network of Health-Advancing National Centers of Excellence for Depression” of the Public Health Service Act (42 U.S.C. 290bb et seq.) amended by inserting after section 520A the following:

SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

(1) General grant.—(A) Depressive Disorder Defined.—In this section, the term ‘depressive disorder’ means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

(B) Grant Program.—(1) In general.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as ‘Centers’) which shall engage in activities related to the treatment of depressive disorders.

(2) Allocation of Awards.—If the funds appropriated under this section (i) are appropriated $500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

(3) Grant Period.—(A) In general.—A grant awarded under this section shall be for a period of 5 years.

(B) Renewal.—A grant awarded under subparagraph (A) may be renewed, on a competitive basis, for 1 additional 5-year period, at the discretion of the Secretary. In determining whether to renew a grant, the Secretary shall consider the report cards issued under subsection (e)(2).

(4) Use of Funds.—Grant funds awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

(5) Evaluation.—

(A) Requirements.—To be eligible to receive a grant under this section, an entity shall—

(1) be an institution of higher education or a public or private nonprofit research institution; and

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

(B) Application.—An application described in subparagraph (A)(i) shall include—

(1) evidence that such entity—

(A) provides, or is capable of coordinating with other entities to provide, comprehensive health services with a focus on mental health services and specialty expertise for depressive disorders;

(B) collaborates with other mental health providers, as necessary, to address co-occurring mental and medical conditions;

(C) is capable of training health professionals about mental health; and

(D) other information, as the Secretary may require.

(C) Priorities.—In awarding grants under this section, the Secretary shall give priority to entities that meet or more of the following criteria:

(1) Demonstrated capacity and expertise to serve the targeted population.

(2) Existing infrastructure or expertise to provide culturally and linguistically competent services.

(3) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

(4) Innovative approaches for outreach to initial treatment services.

(5) Use of the most up-to-date science, practices, and interventions available.

(6) Demonstrated capacity to establish cooperative and collaborative agreements with community mental health centers and other community entities to provide mental health, social services, and support services to individuals with depressive disorders.

(6) National Coordinating Center.—

(A) In general.—The Secretary, acting through the Administrator, shall designate 1 recipient of a grant under this section to be the coordinating center of excellence for depression (referred to in this section as the ‘coordinating center’). The Secretary shall select such coordinating center on a competitive basis, based upon the demonstrated capacity of such center to perform the duties described in paragraph (B).

(B) Application.—A Center that has been awarded a grant under paragraph (1) may apply to the Secretary for establishment as a coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(C) Duties.—The coordinating center shall—

(1) develop, administer, and coordinate the network described under this section;

(2) oversee and coordinate the national database described in subsection (d);

(3) lead a strategy to disseminate the findings from the Centers through such database; and

(4) serve as a liaison with the Administration, the National Registry of Evidence-Based Programs and Practices of the Administration, and any Federal interagency or interagency forum on mental health.

(7) Matching Funds.—The Secretary may not award a grant as described under this subsection to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) contributions toward the activities to be carried out under the grant or contract in an amount equal to $1 for each $5 of Federal funds provided under such a grant or contract. Matching funds may be provided directly or through donations from public or private entities.

(8) National Database.—

(A) In general.—The coordinating center shall establish and maintain a national, publicly available database to improve preventive, educational, and dissemination of evidence-based interventions.

(B) Inclusion.—The coordinating center shall—

(1) include in the national database information on the effectiveness of interventions designed, tested, and evaluated;
PARTY REVIEW.—

(c) MENTOR.—The Director of the Institute, acting through the Administrator, shall—

(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the ‘National Congenital Heart Disease Surveillance System’; or

(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

(b) PURPOSE.—The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

(c) CONTENT.—The Congenital Heart Disease Surveillance System—

(1) may include information concerning the incidence and prevalence of congenital heart disease for individuals who are diagnosed with the disease;

(2) may be used to collect and store data on congenital heart disease, including data concerning:

(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

(B) risk factors associated with the disease;

(C) causation of the disease;

(D) treatment approaches; and

(E) outcomes, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients;

(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

(d) PUBLIC ACCESS.—The Congenital Heart Disease Surveillance System shall be made available to the public, as appropriate, including congenital heart disease researchers. The Director of the Institute—

(i) shall establish performance standards to which Centers are subject to rate the performance of such Center;

(ii) shall submit to the Secretary an application for a grant to be received by a Center; and

(iii) shall ensure that the Congenital Heart Disease Surveillance System is maintained in a manner that complies with the regulations of the Health Insurance Portability and Accountability Act of 1996.

(2) ELIGIBILITY FOR GRANT.—To be eligible to receive a grant under subsection (a)(2), an entity shall—

(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

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

(2) CONGENITAL HEART DISEASE RESEARCH.—

Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 245 et seq.) is further amended by adding at the end the following:

SEC. 425. CONGENITAL HEART DISEASE.

(a) IN GENERAL.—The Director of the Institute shall—

(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease; and

(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

(3) diagnosis, treatment, and prevention;

(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease;

(5) identifying barriers to life-long care for individuals with congenital heart disease.

(b) COORDINATION OF RESEARCH ACTIVITIES.—

The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

(c) MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES.—

In carrying out the activities described in this section, the Director of the Institute shall—

(1) enhance the Congenital Heart Disease Surveillance System to include data concerning—

(A) racial, ethnic, and cultural backgrounds;

(B) knowledge regarding—

(i) the incidence and prevalence of congenital heart disease among multiple racial, ethnic, and cultural backgrounds;

(ii) the availability of health information and other resources for young women diagnosed with breast cancer;

(iii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(iv) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(v) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(vi) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(vii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(viii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(ix) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(x) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xi) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xiii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xiv) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xv) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xvi) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xvii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xviii) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xix) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(xx) the availability of breast health information and other resources for young women diagnosed with breast cancer;

(2) in the first sentence of subsection (e), by striking “fiscal year 2003” and all that follows through “2006” and inserting “for each of fiscal years 2013 through 2014”.

SEC. 399NN. YOUNG WOMEN’S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) SHORT TITLE.—This section may be cited as the “Young Woman’s Breast Health Education and Awareness Requires Learning Young Act of 2009” or the “EARLY Act.”

(b) AMENDMENT.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by this Act, is further amended by adding at the end the following:

PART V—PROGRAMS RELATING TO BREAST HEALTH AND CANCER

SEC. 399NN. YOUNG WOMEN’S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) PUBLIC EDUCATION CAMPAIGN.—

(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

(A) conduct an educational campaign to increase early detection of breast cancer among young women;

(B) conduct educational campaigns to increase awareness of young women’s knowledge regarding—

(i) breast health in young women of all races, ethnic, and cultural backgrounds;

(ii) breast awareness and good breast health habits;

(iii) the occurrence of breast cancer and the rational and evidence-based risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

(iv) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancer.

(E) evidence-based, age-appropriate messages.—The campaign shall provide evidence-based, age-appropriate messages and materials as developed by the Centers for Disease Control and Prevention and the Advisory Committee established under paragraph (4).
“(3) MEDIA CAMPAIGN.—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented towards young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking Internet media, and any other medium determined appropriate by the Secretary.

“(4) ADVISORY COMMITTEE.—

“(a) ESTABLISHMENT.—Not later than 60 days after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee to assist in creating and conducting the education campaigns under paragraph (1) and subsection (b)(1).

“(B) MEMBERSHIP.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise on breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

“(b) HEALTH CARE PROFESSIONAL EDUCATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Administrator of the Health Resources and Services Administration, shall conduct an education campaign among physicians and other health care professionals to increase awareness:

“(1) of breast cancer symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women that may be at high risk for breast cancer, such as Ashkenazi Jewish population;

“(2) on how to provide counseling to young women about their breast health, including knowledge of their family cancer history and importance of providing regular clinical breast examinations;

“(3) on discussing the importance of discussing healthy behaviors, and increasing awareness of services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

“(4) on when to refer patients to a health care provider with genetics expertise;

“(5) on how to provide counseling that addresses long-term survivorship and health concerns of young women diagnosed with breast cancer; and

“(6) on when to provide referrals to organizations and institutions that provide credible health information and substantive assistance and support to young women diagnosed with breast cancer.

“(c) PREVENTION RESEARCH ACTIVITIES.—The Secretary, acting through—

“(1) the Director of the Centers for Disease Control and Prevention, shall conduct prevention research on breast cancer in younger women, including—

“(A) behavioral, survivorship studies, and other research on the impact of breast cancer diagnosis on young women;

“(B) formative research to assist with the development of educational messages and information for the public, targeted populations, and their families about breast health, breast cancer, and healthy lifestyles;

“(C) including existing and new social marketing strategies targeted at young women; and

“(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

“(2) the Director of the National Institutes of Health, shall conduct research to develop and validate new screening tests and methodologies for early detection of breast cancer in young women.

“(d) SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.—

“(1) IN GENERAL.—The Secretary shall award grants to organizations and institutions to provide health information from credible sources and substantive assistance directed towards women diagnosed with breast cancer and pre-neoplastic breast diseases.

“(2) PRIORITY.—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast diseases.

“(e) DUPLICATION OF EFFORT.—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

“(f) MEASUREMENT; REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

“(1) measure—

“(A) young women’s awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women’s proactive efforts at early detection;

“(B) the number and percentage of young women utilizing information regarding lifestyle interventions that foster healthy behavior;

“(C) the number or percentage of young women receiving regular clinical breast exams; and

“(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

“(2) not less than every 3 years, measure the impact of such activities and

“(3) submit reports to the Congress on the results of such measurements.

“(g) DEFINITION.—In this section, the term ‘young women’ means women 15 to 44 years of age.

“(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out subsections (a), (b), (c), and (d), there are authorized to be appropriated $9,000,000 for each of the fiscal years 2010 through 2014.

“Subtitle E—Provisions Relating to Title V

SEC. 10601. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT, THE SOCIAL SECURITY ACT, AND TITLE V OF THE INTERAGENCY TASK FORCE ACT

(a) Section 5101 of this Act is amended—

“(1) in subsection (c)(2)(B)(i)(II), by inserting ‘, including representatives of small business and self-employed individuals’ after ‘employment’;

“(2) in subsection (d)(4)(A)—

“(A) by redesignating clause (iv) as clause (v); and

“(B) by inserting after clause (iii) the following—

“(iv) an analysis of, and recommendations for, eliminating the barriers to entering and staying in the workforce, including provider compensation.”; and

“(3) in subsection (k)(2)(B), by inserting ‘ophthalmologists,’ after ‘occupational therapists,’.

(b) Title V of this Act is amended by adding at the end of the following:

“(1) The Secretary of Health and Human Services shall appoint one representative of each of the following:

“(A) The Department of Health and Human Services.

“(B) The Centers for Medicare and Medicaid Services.

“(C) The Indian Health Service.

“(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

“(3) The Secretary of the Army shall appoint one representative of the Army Medical Department.

“(4) The Secretary of the Air Force shall appoint one representative of the Air Force, from among officers at the Air Force performing medical service functions.

“(5) The Secretary of Veterans Affairs shall appoint one representative of each of the following:

“(A) The Department of Veterans Affairs.

“(B) The Veterans Health Administration.

“(C) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

“(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), from among the members appointed under paragraphs (1) and (2).

“(e) MEETINGS.—The Task Force shall meet at the call of the chairperson.

“(f) REPORT.—Not later than 180 days after the date of enactment of this Act, the Task Force shall submit to the Senate, the House of Representatives, and the Committee on Homeland Security and Governmental Affairs, and the Committee on Veterans’ Affairs, a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

“(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report described in subsection (f).”
SEC. 5316. DEMONSTRATION GRANTS FOR FAMILY NURSE PRACTITIONER TRAINING PROGRAMS.

(a) Establishment of Program.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’) shall establish a training demonstration program for community-based family nurse practitioners (referred to in this section as ‘FNPC’s’) to provide training for core examiners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as ‘FQHCs’) and nurse-managed health clinics (referred to in this section as ‘NMHCs’).

(b) Purpose.—The purpose of the program is to enable each grant recipient to—

(1) provide new nurse practitioners with core clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

(3) establish a model of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

(c) Award.—The Secretary shall award 3-year grants to eligible entities that meet the requirements established by the Secretary, for the purpose of operating the nurse practitioner programs described in subsection (a) in such entities.

(d) Eligible Entities.—To be eligible to receive a grant under this section, an entity shall—

(1) be a FQHC as defined in section 1861(aa) of the Social Security Act (42 U.S.C. 1395(aa));

(2) be a nurse-managed health clinic, as defined in section 339A-1 of the Public Health Service Act (as added by section 5285 of this Act); and

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

(e) Priority in Awarding Grants.—In awarding grants under this section, the Secretary shall give priority to eligible entities that—

(1) demonstrate sufficient infrastructure in size, scope, and capacity to undertake the requisite training of a minimum of 3 nurse practitioners, and to provide care to each awardee 12 full months of full-time, paid employment and benefits consistent with the benefits offered to other full-time employees of the entity;

(2) will assign not less than 1 staff nurse practitioner or physician to each of 4 or more precepted clinics;

(3) will provide to each awardee specialty rotations, including specialty training in prenatal care and women’s health, adult and child psychiatry, orthopedics, gynecology, and at least 3 other high-volume, high-burden specialty areas;

(4) provide sessions on high-volume, high-risk health problems and have a record of training health care professionals in the care of children, older adults, and underserved populations; and

(5) collaborate with other safety net providers, schools, colleges, and universities that provide health professions training.

(f) Eligibility of Nurse Practitioners.—

(1) In General.—To be eligible for acceptance to the demonstration program funded through a grant awarded under this section, an individual shall—

(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

(2) Preference.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

(3) Deferral of Certain Service.—The starting date of required service of individuals in the National Health Service Corps Nurse Practitioner program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) to which a grant recipient assigns a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

(4) Authorization of Appropriations.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

(5) Grant Amount.—Each grant awarded under this subsection shall be in an amount not to exceed $333,000.

(g) Technical Assistance Grants.—

(1) In General.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated the ability to establish a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

(2) Authorization of Appropriations.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

(h) Technical Assistance Grants.—

(1) In General.—To be eligible for acceptance to the demonstration program funded through a grant awarded under this section, an individual shall—

(A) be licensed or eligible for licensure in the State in which the program is located as an advanced practice registered nurse or advanced practice nurse and be eligible or board-certified as a family nurse practitioner; and

(B) demonstrate commitment to a career as a primary care provider in a FQHC or in a NMHC.

(2) Preference.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1)

(3) Deferral of Certain Service.—The starting date of required service of individuals in the National Health Service Corps Nurse Practitioner program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) to which a grant recipient assigns a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

(4) Authorization of Appropriations.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

(i) Grant Amount.—Each grant awarded under this subsection shall be in an amount not to exceed $333,000.
(ii) Payments in subsequent years.—Payment rates in years after the year of implementation of such system shall be the payment rates in the previous year increased—

(1) in the first year after implementation of such system, by the percentage increase in the MEI (as defined in section 1821(i)(3)) for the year involved;

(2) in subsequent years, by the percentage increase in a market basket of Federally qualified health center goods and services as promulgated through regulations, or if such an index is not available, by the percentage increase in the MEI (as defined in section 1821(i)(3)) for the year involved.

(2) Paragraph (3)(A) shall not apply to Federally qualified health center services for which payment is made under section 1834(o), the amount determined under such section shall be the lesser of the actual charge or the amount determined under such section.

(B) Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395la(a)(1)), as amended by section 4104, is amended—

(1) by striking “and” before “(Y);” and

(2) by inserting before the semicolon at the end of section (Y), and (Z) with respect to FQHCs established under section 1861(f)(9), by the percentage increase in a market basket of Federally qualified health center services for which payment is made under section 1834(o), the amount determined under such section shall be the lesser of the actual charge or the amount determined under such section.

(C) Section 1833(a) of the Social Security Act (42 U.S.C. 1395la(a)), as amended—

(1) in paragraph (3)(B)(i),—

(i) by inserting “(E)” after “other”; and

(ii) by inserting “; or (II) in the case of such services furnished on or after the implementation date of the prospective payment system under section 1834(o),” after “paid by the entity under subsection (b), a plan for similar facilities; or”;

(2) by inserting at the end of the section—

“(j) Section 5505 is amended by adding at the end the following:

“(2) demonstrate rural community institutions, or existence of training partners with interprofessional expertise in community health centers;”

(3) demonstrate that an existing academic medical school, or osteopathic medical school graduates who practice medicine in underserved rural communities, providing opportunities in underserved rural communities, or in local residency training programs, that support and train physicians to practice in underserved rural communities, or in local residency training programs, that support and train physicians to practice in underserved rural communities.

(2) by inserting at the end the following flush sentence:

“Paragraph (3)(A) shall not apply to Federally qualified health center services furnished on or after the implementation date of the prospective payment system under section 1834(o).”.

(D) Section 5505 is amended by adding at the end the following subsection:

“(d) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled cost report unless there is no administratively proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1866(d)(5)(B)(i) of the Social Security Act (42 U.S.C. 1395w(d)(5)(B)(i)) or for direct graduate medical education costs under section 1866(h) of such Act.”

(k) Subtitle G of title V of this Act is amended by adding at the end the following:

“SEC. 5606. STATE GRANTS TO HEALTH CARE PROVIDERS WHO PROVIDE SERVICES TO A HIGH PERCENTAGE OF MEDICALLY UNDERSERVED POPULATIONS OR OTHER SPECIAL POPULATIONS.

(a) IN GENERAL.—(1) An eligible entity receiving a grant under this section shall use the funds made available under such grant to establish, improve, or expand a rural-focused training program (referred to in this section as the ‘Program’) meeting the requirements described in this subsection and to carry out such program.

(2) STRUCTURE OF PROGRAM.—An eligible entity shall—

(A) develop eligibility criteria for admission to the Program that gives priority to students—

(i) who are employed in public or private non-profit hospital;
“(3) a State, local, or tribal health department; or
“(4) a consortium of 2 or more entities described in paragraphs (1) through (3).
“(b) FUNDING.—Amounts received under a grant or contract under this section shall be used to—
“(1) plan, develop (including the development of curricula), operate, or participate in an accredited residency or internship program in preventive medicine or public health;
“(2) defray the costs of practicum experiences, as required in such a program; and
“(3) establish, maintain, or improve—
“(A) administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health; or
“(B) programs that improve clinical teaching in preventive medicine and public health.
“(d) Repeal.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.
“(e) Authorization of Appropriations.—There are appropriated $250,000,000 for fiscal year 2011; $295,000,000 for fiscal year 2012; $300,000,000 for fiscal year 2013; $305,000,000 for fiscal year 2014; and $310,000,000 for fiscal year 2015.

SEC. 11002. INFRASTRUCTURE TO EXPAND ACCESS TO AFFORDABLE CARE.

(a) PROVISION.—There are authorized to be appropriated $8,000,000,000 to be used for the construction and renovation of community health centers.

(b) Authorization.—There are authorized to be appropriated under subsections (b) and (c) shall remain available until expended.

SEC. 11003. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.

(a) PURPOSE.—It is the purpose of this section to establish the National Health Service Corps Fund (referred to in this section as the “CHC Fund”), to be administered through the Office of the Secretary of the Department of Health and Human Services, to provide increased funding for the construction and renovation of community health centers.

(b) APPROPRIATIONS.—There are authorized to be appropriated, out of any monies in the Treasury not otherwise available, $800,000,000 for fiscal year 2012; $1,000,000,000 for fiscal year 2013; $1,600,000,000 for fiscal year 2014; and $2,900,000,000 for fiscal year 2015.

(c) USE OF FUNDS.—Amounts received under subsection (a) (i) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the National Health Service Corps—

(A) $290,000,000 for fiscal year 2011;
(B) $295,000,000 for fiscal year 2012;
(C) $300,000,000 for fiscal year 2013;
(D) $305,000,000 for fiscal year 2014; and
(E) $310,000,000 for fiscal year 2015.

SEC. 11004. DEMONSTRATION PROJECT TO PROVIDE ACCESS TO AFFORDABLE CARE.

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the “Secretary”), acting through the Health Resources and Services Administration, shall establish a 3-year demonstration project in up to 10 States to provide access to comprehensive health care services to the uninsured at reduced fees. The Secretary shall evaluate the feasibility of expanding the project to additional States.

(b) ELIGIBILITY.—To be eligible to participate in the demonstration project, an entity shall be a State-based, nonprofit, public-private partnership that provides access to comprehensive health care services to the uninsured at reduced fees. Each State in which a participant selected by the Secretary is located shall receive not more than $2,000,000 to establish and carry out the project for the 3-year demonstration period.

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

Subtitle F—Provisions Relating to Title VI

SEC. 11601. REVISIONS TO LIMITATION ON MEDICAL CARE EXCEPTION TO THE PROHIBITON ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 11817(1) of the Social Security Act, as added by section 601(a), is amended—

(1) in paragraph (1)(A)(i), by striking “February 1, 2010”, and inserting “January 1, 2010”;

(2) in paragraph (1)(A)—

(A) in clause (i), by striking “August 1, 2011” and inserting “August 1, 2012”; and

(B) in clause (iv), by striking “July 1, 2011” and inserting “January 1, 2012”.

(b) CONFORMING AMENDMENT.—Section 601(b)(2) of this Act is amended by striking “November 1, 2011” and inserting “May 1, 2012”.

SEC. 11602. CLARIFICATIONS TO PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Section 11817 of the Social Security Act (as added by section 601) is amended—

(1) in subsection (b)(2)—

(A) in clause (i), by striking “(A)” after “(i)”; and

(B) in clause (ii), by striking “(A)” after “(ii)”.

(2) in subsection (c)(2)—

(A) in subparagraph (A)(ii), by striking “annual basis” and inserting “on an annual basis to reflect inflation”.;

(B) in clause (B), by striking “$50,000” and inserting “$50,000, plus, beginning with fiscal year 2011, and such sums as may be necessary for the provision of greater access to health care;”.

(C) in clause (C), by striking “steps toward provider payment reform;” and

(D) in clause (D), by striking “steps toward” and inserting “steps toward”.

SEC. 11603. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS.

(a) PURPOSE.—It is the purpose of this section to establish the National Health Service Corps Fund (referred to in this section as the “CHC Fund”), to be administered through the Office of the Secretary of the Department of Health and Human Services, to provide increased funding for the construction and renovation of community health centers.

(b) APPROPRIATIONS.—There are authorized to be appropriated, out of any monies in the Treasury not otherwise available, $800,000,000,000 for fiscal year 2012; $1,000,000,000,000 for fiscal year 2013; $1,600,000,000,000 for fiscal year 2014; and $2,900,000,000,000 for fiscal year 2015.

(c) USE OF FUNDS.—Amounts received under subsection (a) (i) to be transferred to the Secretary of Health and Human Services to provide enhanced funding for the National Health Service Corps—

(A) $290,000,000,000 for fiscal year 2011;
(B) $295,000,000,000 for fiscal year 2012;
(C) $300,000,000,000 for fiscal year 2013;
(D) $305,000,000,000 for fiscal year 2014; and
(E) $310,000,000,000 for fiscal year 2015.
(a) FRAUD SENTENCING GUIDELINES.—

(1) DEFINITION.—In this subsection, the term "Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $100,000,000," means—

(1) a 2-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $1,000,000 and less than $7,000,000;

(2) a 3-level increase in the offense level for any defendant convicted of a Federal health care offense relating to a Government health care program which involves a loss of not less than $7,000,000 and less than $20,000,000;

(3) the sum of the amounts of the intended loss by the defendant; and

(b) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(1) by inserting "(a)" before "Whoever knowingly";

(b) by striking at the end the following:

(2) with respect to violations of this section, a person need not have actual knowledge of a violation in order to commit to commit a violation of this section.

(c) HEALTH CARE FRAUD OFFENSE.—Section 1349 of title 18, United States Code, is amended—

(1) in paragraph (1), by striking the semi-colon and inserting "or section 1123B of the Social Security Act (42 U.S.C. 1320a-7b);" or;

(2) in paragraph (2)—

(A) by inserting "1349," after "1343," and inserting "section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331)," after "title.";

(d) SUBPOENA AUTHORITY RELATING TO HEALTH CARE.—

(1) SUBPOENAS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking "to the grand jury";

(B) in paragraph (2)—

(i) in subparagraph (A), by striking "grand jury subpoena" and inserting "subpoena for records";

(ii) in the matter following subparagraph (B), by striking "to the grand jury".

(2) SUBPOENAS UNDER THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT.—The Civil Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by inserting after section 1346 the following:

SEC. 3A. SUBPOENA AUTHORITY.

"(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any documents, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

"(1) ISSUANCE.—Subpoenas issued under this section—

(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

"(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt of court.

SEC. 10607. PROHIBITION OF DATA USE AGREEMENTS WITH PRIVATE ENTITIES.

"(a) AUTHORITY.—The Attorney General, or at the direction of the Attorney General, any officer or employee of the Department of Justice may require by subpoena access to any institution that is the subject of an investigation under this Act and to any documents, record, material, file, report, memorandum, policy, procedure, investigation, video or audio recording, or quality assurance report relating to any institution that is the subject of an investigation under this Act to determine whether there are conditions which deprive persons residing in or confined to the institution of any rights, privileges, or immunities secured or protected by the Constitution or laws of the United States.

"(b) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

"(1) ISSUANCE.—Subpoenas issued under this section—

(A) shall bear the signature of the Attorney General or any officer or employee of the Department of Justice as designated by the Attorney General; and

(B) shall be served by any person or class of persons designated by the Attorney General or a designated officer or employee for that purpose.

"(2) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under this section, the United States district court for the judicial district in which the institution is located may issue an order requiring compliance. Any failure to obey the order of the court may be punished by the court as a contempt of court.

Security and efficiency measures may have inadvertently altered the formatting of the document, leading to some misinterpretations.
"(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

"(2) may not be transmitted by or within the Department of Justice for any purpose other than the protection of the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, have resided, or will reside in an institution; and

"(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner to disclose the content of any personally identifiable information.".

SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part D of title III of the Public Health Service Act (42 U.S.C. 290 et seq.), as amended by this Act, is further amended by adding at the end the following:

"SEC. 390V-4. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

"(a) In General.—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

"(b) Duration.—The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

"(c) Conditions for Demonstration Grants.—

"(1) Requirements.—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

"(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

"(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and quality of health care.

"(2) Alternative to Current Tort Litigation.—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative to current tort litigation described in paragraph (1) would—

"(A) make the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

"(B) encourage the efficient resolution of disputes;

"(C) encourage the disclosure of health care errors;

"(D) enhance patient safety by detecting, analyzing, and helping to reduce medical errors as part of an institution's quality improvement efforts;

"(E) improve access to liability insurance;

"(F) fully inform patients about the differences in the alternative and current tort litigation systems, including the availability of prompt and fair resolution of disputes;

"(G) provide patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

"(H) would not conflict with State law at the time of the application in a way that would prevent the adoption of an alternative to current tort litigation; and

"(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access to an appropriate legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

"(3) Sources of Compensation.—Each State desiring a grant under subsection (a) shall identify the sources from which compensation will be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall be designed to provide financial incentives for activities that improve patient safety.

"(4) Scope.—

"(A) In General.—Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

"(B) Notification of Patients.—A State shall demonstrate how patients would be notified if they are receiving health care services that fall within such scope, and the process for allowing patients to voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating shall be in any way.

"(C) Preference in Awarding Demonstration Grants.—In awarding grants under subsection (a), the Secretary shall give preference to States—

"(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing health care providers, medical malpractice insurers, and patient safety experts;

"(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

"(C) that make proposals that are likely to improve access to liability insurance.

"(5) Application.—

"(1) In General.—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

"(2) Review Panel.—

"(A) In applying the provisions under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

"(B) Composition.—

"(i) Nomination.—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

"(ii) Appointment.—The Comptroller General shall appoint, at least 9 but not more than 13, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

"(I) Patient advocates;

"(II) Health care providers and health care organizations;

"(III) Attorneys with expertise in representing health care providers;

"(IV) Medical malpractice insurers;

"(V) State officials;

"(VI) Patient safety experts;

"(C) Chairperson.—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

"(D) Availability of Information.—The Comptroller General shall make available to each State receiving a grant under subsection (a) personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

"(E) Reports.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

"(6) Conditions for Demonstration Grants.—

"(1) By State.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

"(2) By Secretary.—The Secretary shall submit to Congress each year a report analyzing the results of the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences that result in terms of the quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of medical liability insurance.

"(7) Technical Assistance.—

"(1) In General.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

"(2) Requirements.—Technical assistance under paragraph (1) shall include—

"(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

"(3) Use of Common Definitions, Formats, and Data Collection Infrastructure.—The Secretary receiving grants under subsection (a) may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

"(8) Evaluation.—

"(1) In General.—The Secretary, in consultation with the review panel established under subsection (b)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

"(2) Contents.—The evaluation under paragraph (1) shall include—

"(A) an analysis of the effects of the grants awarded under subsection (a) with regard to the measures described in paragraph (3);

"(B) for each State, an analysis of the extent to which the alternative developed under subsection (a) meet the elements described in subsection (c)(2);
‘(C) a comparison among the States receiving grants under subsection (a) of the effectiveness of the various alternatives developed by such States under subsection (c)(1); ‘(D) a comparison, considering the measures described in paragraph (3), of States receiving grants approved under subsection (a) and similar States not receiving such grants; and ‘(E) a comparison, with regard to the measures described in paragraph (3), of— ‘(i) States receiving grants under subsection (a); ‘(ii) States that enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, any cap on non-economic damages; and ‘(iii) States that have enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, a requirement that the complainant obtain an opinion regarding the merit of the claim, although the substance of such opinion may have no bearing on whether the complainant may proceed with a case. ‘(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of— ‘(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations; ‘(B) the number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a); ‘(C) the disposition of disputes and claims, including the length of time and estimated costs to all parties; ‘(D) the medical liability environment; ‘(E) health care quality; ‘(F) patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events; ‘(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment; and ‘(H) impact on utilization of medical services, appropriately adjusted for risk. ‘(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (k) to carry out this subsection. (b) MedPAC and MACPAC REPORTS.— (1) MEDPAC.—The Medicare Payment Advisory Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grant under subsection (a) to determine the impact of such alternatives on the Medicare program under title XVIII of the Social Security Act, and its beneficiaries. ‘(2) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grant under subsection (a) to determine the impact of such alternatives on the Medicaid or CHIP programs under titles XIX and XXI of the Social Security Act, and its beneficiaries. ‘(3) REPORTS.—Not later than December 31, 2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on independent reviews conducted pursuant to paragraphs (1) and (2), including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs. ‘(1) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as limiting the authority of the Secretary to receive grants approved under this subsection to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States that have enacted section 18001 of the Affordable Care Act at the time the application was submitted, in which the Secretary would not estimate that the application would not prohibit the adoption of an alternative to current tort litigation. ‘(2) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan. ‘(3) HEALTH CARE PROVIDER.—The term ‘health care provider’ means any individual or entity— ‘(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or ‘(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation. ‘(4) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan. ‘(m) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit any prior existing order of any State to establish any alternative to tort litigation. ‘(n) RULING OF CONSTRUCTION.—Nothing in this section shall be construed as limiting States’ authority over or responsibility for their state justice systems.’. SEC. 10608. EXTENSION OF MEDICAL MALPRACTICE COVERAGE TO FREE CLINICS. ‘(a) In General.—Section 224(o)(1) of the Public Health Service Act (42 U.S.C. 298(o)(1)) is amended by inserting ‘‘and’’ after ‘‘and individual’’ the following: ‘‘; or an officer, governing board member, employee, or contractor of a free clinic’’ and in subsection (c), by striking paragraphs (2) and (3) and inserting the following: ‘‘(2) the sponsor of the application under section (c) otherwise has met the requirements for approval under this subsection’’ and the provisions described in subsection (b). ‘(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on the date of enactment of this Act and apply to any act of omission which occurs on or after that date. SEC. 10609. LABELING CHANGES. Section 355(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended by adding at the end the following: ‘‘(10)(A) If the proposed labeling of a drug that is the subject of an application under this subsection indicates that the drug is a covered drug, due to a labeling revision described under clause (i), the drug that is the subject of such application shall, notwithstanding any other provision of this Act, be eligible for approval and shall not be considered misbranded under section 502(f) if— ‘‘(i) the application is otherwise eligible for approval under this Act, ‘‘(ii) the application is otherwise eligible for approval under this Act for expiration of patent, an exclusivity period, or of a delay in approval described in paragraph (5)(A)(iii), and a revision to the labeling of the listed drug has been approved by the Secretary within 60 days of such expiration; ‘‘(iii) the labeling revision described under clause (i) does not include a change to the ‘‘Warnings’’ section of the labeling; ‘‘(iv) the sponsor of the application under this subsection agrees to submit revised la-
added by section 9005 of this Act, is amended to read as follows:

“(1) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

“(i) in general.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

“(2) ADJUSTMENT FOR INFLATION.—In the case of any taxable year beginning after December 31, 2011, the dollar amount described in paragraph (1) shall be increased by an amount equal to—

(A) such amount, multiplied by

(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting ‘calendar year 2010’ for ‘calendar year 1992’ in subparagraph (B) thereof.

If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.’’.

**With respect to a covered entity’s net premiums written during the calendar year that are:**

<table>
<thead>
<tr>
<th>Category</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>

**‘(c) EXEMPTION FROM ANNUAL FEE ON HEALTH INSURANCE FOR CERTAIN NONPROFIT ENTITIES.—Section 9010(c)(2) of this Act is amended by striking ‘or’ at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting a comma, and by adding at the end the following new subparagraph:**

“(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Internal Revenue Code of 1986).”

**‘(D) any entity—**

“(i) which is incorporated as a nonprofit corporation under a State law, or

“(ii) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code),

“(iii) the premium rate increases which are regulated by a State authority.

“(iv) to which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 2718(b)(1)(A) of the Public Health Service Act) with respect to the individual insurance market for such entity for the calendar year is not less than 100 percent.

“(e) APPLICABLE AMOUNT.—The term ‘health insurance’ shall not include—

“(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986.

“(B) any insurance for long-term care, or

“(C) any Medicare supplemental health insurance (as defined in section 1852(c)(1) of the Social Security Act).”

**‘(f) ANTI-ELICITATION GUIDANCE.—Subsection (i) of section 9010 of this Act is amended by inserting ‘or shall prescribe such regulations as may be necessary to prevent avoidance of the purposes of this section, including inappropriate actions taken**
to qualify as an exempt entity under subsection (c)(2)" after "section".

CONFORMING AMENDMENTS.—

(1) Section 901b(a)(1) of this Act is amended by striking "beginning after December 31, 2002" and inserting "beginning after December 31, 2008).

(2) Section 901c(c)(2)(B) of this Act is amended by striking "(except)" and all that follows through "1323)".

(3) In which subparagraphs of this Act is amended by adding at the end the following resent ence: "If any entity described in subparagraph (C)(i)(1), (D)(i)(1), or (E)(i) of paragraph (2) is, in its report to the Secretary of the Treasury, a covered entity by reason of paragraph (2), remuneration received after the date of enactment of section 9010 shall be treated as a covered entity by reason of paragraph (2) for purposes of this section."

(4) Section 901b(g)(1) of this Act is amended by striking "third party administration fees" and inserting "third party administration agreement fees".

(5) Section 901(b)(3) of this Act is amended—

(A) by striking "2008" and inserting "2009", and

(B) by striking "and" and any third party administration agreement fees received after such date.)

(6) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9010.

SEC. 10906. MODIFICATIONS TO ADDITIONAL HOSPITAL INSURANCE TAX ON HIGH-INCOME TAXPAYERS.

(a) FICA.—Section 3101(b)(2) of the Internal Revenue Code of 1986, as added by section 901(a)(1) of this Act, is amended by striking "0.5 percent" and inserting "0.9 percent".

(b) SECA.—Section 1401(b)(2)(A) of the Internal Revenue Code of 1986, as added by section 901(b)(1) of this Act, is amended by striking "0.5 percent" and inserting "0.9 percent".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 9010.

SEC. 10907. EXCISE TAX ON INDOOR TANNING SERVICES IN LIEU OF ELECTIVE COSMETIC MEDICAL PROCEDURES.

(a) IN GENERAL.—The provisions of, and amendments made by, section 9017 of this Act are hereby deemed null, void, and of no effect.

(b) EXCISE TAX ON INDOOR TANNING SERVICES.—Subtitle D of the Internal Revenue Code of 1986, as added by this Act, is amended by adding at the end the following new chapter:

"CHAPTER 49—COSMETIC SERVICES"

"Sec. 5000A. Imposition of tax on indoor tanning services.

"Sec. 5000B. Imposition of tax on indoor tanning services.

"Sec. 5000C. Imposition of tax on indoor tanning services.

"(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 1 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

"(b) INDOOR TANNING SERVICE.—For purposes of this section—

"(1) IN GENERAL.—The term 'indoor tanning service' does not include any phototherapy service performed by a licensed medical professional.

"(c) PAYMENT OF TAX.—Such tax imposed by this section shall be paid by the individual on whom the service is performed.

"(2) COLLECTION.—Every person receiving a payment for services on which a tax is imposed under subsection (a) shall collect the amount of the tax from the individual on whom the service is performed and remit such tax quarterly to the Secretary at such time and in such manner as provided by the Secretary.

"(3) SECONDARY LIABILITY.—Where any tax imposed by subsection (a) is not paid at the time payments for indoor tanning services are made, then to the extent that such tax is not collected by the person who performs the service,"

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services performed on or after July 1, 2010.
SA 3279. Mr. Reid proposed an amendment to amendment SA 3278 proposed by Mr. Reid to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

In the amendment, strike "4" and insert "3".

SA 3280. Mr. Reid proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after enactment.

SA 3281. Mr. Reid proposed an amendment to amendment SA 3280 proposed by Mr. Reid to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after enactment.

SA 3282. Mr. Reid proposed an amendment to amendment SA 3281 proposed by Mr. Reid to the amendment SA 3280 proposed by Mr. Reid to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after enactment.

SA 3283. Mr. Coburn submitted an amendment intended to be proposed to amendment SA 3280 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the amendment SA 2786 proposed by Mr. Reid (for himself, Mr. Baucus, Mr. Dodd, and Mr. Harkin) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of the amendment, add the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3278. Mr. Reid proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of the amendment proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

SA 3279. Mr. Reid proposed an amendment to amendment SA 3278 proposed by Mr. Reid to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

This section shall become effective 4 days after enactment.

SA 3280. Mr. Reid proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

In the amendment, strike "4" and insert "3".
Sec. 712. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and to allow employees to health care professionals.

Sec. 713. Rules of construction regarding use of consortia.

Title VIII—Health Care Services Commission

Subtitle A—Establishment and General Duties

Sec. 801. Establishment.

Sec. 802. General authorities and duties.

Sec. 803. Dissemination.

Subtitle B—Forum for Quality and Effectiveness in Health Care

Sec. 811. Establishment of office.

Sec. 812. Membership.

Sec. 813. Duties.

Sec. 814. Adoption and enforcement of guidelines and standards.

Sec. 815. Additional requirements.

Subtitle C—General Provisions

Sec. 821. Certain administrative authorities.

Sec. 822. Funding.

Sec. 823. Definitions.

Subtitle D—Terminations and Transition

Sec. 831. Termination of Agency for Healthcare Research and Quality.

Sec. 832. Transition.

Subtitle E—Independent Health Record Trust

Sec. 841. Short title.

Sec. 842. Purpose.

Sec. 843. Definitions.

Sec. 844. Establishment, certification, and management of Independent Health Record Trust.

Sec. 845. Duties of IHRT to IHRT participants.

Sec. 846. Availability and use of information from records in IHRT consistent with privacy protections and agreements.

Sec. 847. Voluntary nature of trust participation and information sharing.

Sec. 848. Financing of activities.

Sec. 849. Regulatory oversight.

Title IX—Miscellaneous

Sec. 901. Health care choice for veterans.

Sec. 902. Health care choice for Indians.

Sec. 903. Transfer of functions of the National Advisory Committee for Comparative Effectiveness Research.

Sec. 904. HHS and GAO joint study and report required on potential of the 5 medical conditions that have the greatest impact.

Sec. 905. Conscience protection.

Sec. 906. Nondiscrimination on abortion and respect for rights of conscience.

Sec. 907. Prohibition on government entities using comparative effectiveness research for certain purposes.

Sec. 908. Solvency of Medicare program.

Sec. 909. To ensure patients receive doctor recommended treatments for preventive health services, including mammograms and cervical cancer screening, without interference from government or insurance company bureaucrats.

Sec. 910. Ensuring that government health care rationing does not harm, injure, or deny medically necessary care.


Sec. 912. Using health care professionals to reduce fraud.

Title I—Investing in Prevention

Sec. 101. Strategic Approach to Outcome-Based Prevention.

(a) Interagency Coordinating Committee.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the “Secretary”) shall convene an interagency coordinating committee to develop a strategic plan to reduce unnecessary care and grading of evidence for disease prevention and health promotion initiatives, programs, and agencies. Such reviews shall be evaluated based on effectiveness in evidence summary charts, database, and electronic dissemination of resource reports posted on such agencies’ public Internet websites.

(b) Federal Messaging on Health Promotion and Disease Prevention.—

(1) MEDIA CAMPAIGNS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national, science-based health promotion campaign on health promotion and disease prevention.

(B) REQUIREMENTS OF CAMPAIGN.—The campaign implemented under subparagraph (A) shall be designed to address proper nutrition, regular exercise, smoking cessation, obesity reduction, the 5 leading disease killers in the United States, and secondary prevention through disease screening and treatment.

(i) shall be carried out through competitively bid contracts with private-sector companies providing for the professional production and design of such campaign;

(ii) may include the use of television, radio, Internet, and other commercial marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(iii) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(iv) may include the use of humor and nationally recognized positive role models.

(C) EVALUATION.—The Secretary shall ensure that the campaign implemented under subparagraph (A) is subject to an independent evaluation every 2 years and shall report every 2 years to Congress on the effectiveness of such campaigns towards meeting science-based metrics.

(2) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain or enter into a contract to maintain an Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and specific chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(3) DISSEMINATION OF INFORMATION THROUGH PRESCRIPTION DRUGS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plan under subsection (a)(3)(A), to health care providers who participate in Federal programs, including programs administered by the Indian Health Service, the Department of Veterans Affairs, the Department of Defense, and the Health Resources and Services Administration, and the Medicare and Medicaid Programs.

(4) PERSONALIZED PREVENTION PLANS.—

(A) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a directed Internet website personalized prevention plan tool.

(B) USE.—The website developed under paragraph (A) shall be designed to be used as a source of the most up-to-date scientific evidence relating to disease prevention for...
use by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other factors) related to the leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(5) INCENTIVES.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(6) FUNDING.—Funding for the activities authorized under this section shall be from amounts appropriated under subsection (d).
health insurance plan to participate in, and offer health insurance coverage through, the State Exchange, so long as the health insurance issuers involved are duly licensed under State law to offer or sell health insurance to all beneficiaries in the State and otherwise comply with the requirements of this title.

(4) PREMIUMS.—
(A) In general.—The State Exchange shall not determine premium or cost sharing amounts for health insurance coverage offered through the State Exchange.

(B) FAIR TAX TREATMENT FOR ALL AMERICANS TO AFFORD HEALTH CARE SEC. 301. REFUNDABLE AND ADVANCABLE CREDIT FOR CERTAIN HEALTH INSURANCE COVERAGE.

(a) ADVANCABLE CREDIT.—Subpart A of part IV of subchapter A of chapter 1 (relating to nonrefundable personal credits) is amended by adding at the end the following new section:

SEC. 35E. QUALIFIED HEALTH INSURANCE CREDIT.

"(a) ALLOWANCE OF CREDIT.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer’s spouse and dependents for each month for which such individual is an eligible individual.

"(B) LIMITATION ON AGGREGATE AMOUNT.—Nothing in this section shall be construed to limit the aggregate monthly limitations for the taxpayer and the taxpayer’s spouse and dependents for any month not exceeded by the applicable amount for such month under this section and subparagraph (A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment."

(b) LIMITATION ON AGGREGATE AMOUNT.—The applicable aggregate amount for each month during the taxable year for an eligible individual is $1,000.

(c) LIMITATION ON AGGREGATE AMOUNT.—The applicable aggregate amount for each month during the taxable year for an eligible individual is $1,000.

(d) LIMITATION ON AGGREGATE AMOUNT.—The applicable aggregate amount for each month during the taxable year for an eligible individual is $1,000.

(e) LIMITATION ON AGGREGATE AMOUNT.—The applicable aggregate amount for each month during the taxable year for an eligible individual is $1,000.

(f) LIMITATION ON AGGREGATE AMOUNT.—The applicable aggregate amount for each month during the taxable year for an eligible individual is $1,000.
‘‘(1) PRISONERS.—The term ‘eligible individual’ shall not include any individual for a month if, as of the first day of such month, such individual is imprisoned under Federal, State, or local law.

‘‘(2) ALIENS.—The term ‘eligible individual’ shall not include any alien individual who is not a lawful permanent resident of the United States for all of the calendar year in which the taxable year begins by substituting ‘2010’ for ‘1996’ in subclause (II) thereof.

‘‘(iii) Rounding.—Any increase determined under clause (i) shall be rounded to the nearest multiple of $50.

‘‘(C) REVENUE NEUTRALITY ADJUSTMENTS.—

‘‘(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2010, the amount contained in subparagraph (B), shall be further adjusted (if necessary) such that the aggregate of such dollar amounts allowed as credits under this section for such taxable year equals but does not exceed the total increase in revenues in the Treasury resulting from the amendments made by sections 301 and 401 of the Patients’ Choice Act for such taxable year as estimated by the Secretary.

‘‘(ii) DATE OF ADJUSTMENT.—The Secretary shall make the adjustments for any taxable year under this subparagraph not later than the preceding October 1.

‘‘(c) LIMITATION BASED ON AMOUNT OF TAX.—

‘‘(i) IN GENERAL.—In the case of a taxable year to which section 26(a)(2) does not apply, the credit allowed under subsection (a) for the taxable year shall not exceed the excess of—

‘‘(1) the sum of the regular tax liability (as defined in section 26(b)) plus the tax imposed under subsection (a) for the taxable year, over

‘‘(2) the sum of the credits allowed under this paragraph (other than this paragraph) and section 27 for the taxable year.

‘‘(d) EXCESS CREDIT REFUNDABLE TO CERTAIN TAX-FAVORED ACCOUNTS.—In—

‘‘(1) the case of a taxable year to which section 26(b)(2) does not apply, the excess under subsection (a) if only qualified refund eligible health insurance were taken into account under this section, exceeds

‘‘(2) the limitation imposed by section 26 or subsection (c) for the taxable year, such excess shall be paid by the Secretary into the designated account of the taxpayer.

‘‘(e) ELIGIBLE INDIVIDUAL.—For purposes of this section—

‘‘(1) IN GENERAL.—The term ‘eligible individual’ means, with respect to any month, an individual who—

‘‘(A) is the taxpayer, the taxpayer’s spouse, or the taxpayer’s dependent, and

‘‘(B) is covered under qualified health insurance for such month.

‘‘(2) MEDICARE COVERAGE, MEDICAID DISABILITY COVERAGE, AND MILITARY COVERAGE.—The term ‘eligible individual’ shall not include any individual who—

‘‘(A) entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, and the individual (or dependent thereof) is a beneficiary in a group health plan or large group health plan that is a primary plan (as defined in section 1862(b)(2)(A) of such Act),

‘‘(B) enrolled by reason of disability in the program under title XIX of such Act, or

‘‘(C) entitled to benefits under chapter 55 of title 10, United States Code, including under the FECA program (as defined in section 1072(7) of such title).

‘‘(3) IDENTIFICATION REQUIREMENTS.—The term ‘eligible individual’ shall not include any individual who is in a covered group health plan for that month unless the policy number associated with the qualified health insurance and the TIN of each eligible individual covered under such health insurance are included on the return of tax for the taxable year in which such month occurs.

‘‘(4) TAXABLE YEAR.—The term ‘taxable year’ means the period beginning on January 1 of such year and ending on December 31 of such year, or the period beginning on such later date as the Secretary may prescribe.

‘‘(5) ALIENS.—The term ‘taxable year’ means the period beginning on the date such alien first becomes a lawful permanent resident of the United States for all of the calendar year. For purposes of this section, such date shall be treated as January 1 of such taxable year.

‘‘(6) MARRIED COUPLES MUST FILE JOINT RETURNS.—With respect to any taxable year, the amount which would (but for this section) be allowed as a credit to the taxpayer and qualifying family members shall be reduced by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

‘‘(C) COORDINATION WITH MEDICAL DEDUCTION.—Any amount paid by a taxpayer for insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under subsection (a) shall not be taken into account in computing the amount allowable to the taxpayer as a deduction under section 213(a) or 162(l).

‘‘(A) LIMITATION ON DEDUCTION.—No credit shall be allowed under subsection (a) for such taxable year to any taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year.

‘‘(C) LIMITATION ON DEDUCTION.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual’s taxable year begins.

‘‘(4) MARRIED COUPLES MUST FILE JOINT RETURNS.—With respect to such taxable year, the amount which would (but for this section) be allowed as a credit to the taxpayer and qualifying family members shall be reduced by the aggregate amount paid on behalf of such taxpayer under section 7527A for months beginning in such taxable year.

‘‘(5) VERIFICATION OF COVERAGE, ETC.—No credit shall be allowed under this section with respect to any individual unless such individual’s coverage (and such related information as the Secretary may require) is verified in such manner as the Secretary may prescribe.

‘‘(6) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—In the case of a taxable year beginning in a calendar year after 2002, the amount which would (but for this section) be allowed as a credit to the taxpayer and qualifying family members with respect to whom a credit under section 151 is allowed for such taxable year shall be increased by the sum of—

‘‘(A) such excess, plus

‘‘(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the underpayment under section 7527A to the date such excess is paid.

‘‘(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.

‘‘(2) SPECIFIED ACCOUNT.—For purposes of this paragraph, the term ‘specified account’ means—

‘‘(A) any health savings account under section 223 or Archer MSA under section 220, or

‘‘(B) any health insurance reserve account.

‘‘(3) HEALTH INSURANCE RESERVE ACCOUNT.—For purposes of this subsection, the term ‘health insurance reserve account’ means a trust created or organized in the United States as a health insurance reserve account exclusively for the purpose of paying the qualified medical expenses (within the meaning of section 223(d)(2)(A) of the Internal Revenue Code) to the extent that payments are permitted under such account. The term ‘health insurance reserve account’ includes only if the written governing instrument creating the trust meets the requirements set forth in subparagraph (B), (C), (D), and (E) of section 223(d)(1) of the Internal Revenue Code.

‘‘(4) TREATMENT OF PAYMENT.—Any payment under subsection (d) to a designated account shall not be taken into account with respect to any dollar limitation which applies with respect to contributions to such account (or to tax benefits with respect to such contributions).

‘‘(5) INSURANCE WHICH COVERS OTHER INDIVIDUALS.—In the case of a taxable year beginning in a calendar year after 2008, the amount which would (but for this section) be allowed as a credit to the taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year shall be increased by the sum of—

‘‘(A) such excess, plus

‘‘(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the underpayment under section 7527A to the date such excess is paid.

‘‘(C) TREATMENT OF EXCESS ADVANCE PAYMENTS.—If the aggregate amount paid on behalf of the taxpayer under section 7527A for months beginning in the taxable year exceeds the sum of the monthly limitations determined under subsection (b) for the taxpayer and the taxpayer’s spouse and dependents for such months, then the tax imposed by section 151 on such taxable year shall be increased by the sum of—

‘‘(A) such excess, plus

‘‘(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the underpayment under section 7527A to the date such excess is paid.

‘‘(C) which, under such terms, provides for the payment of expenses by the taxpayer or on behalf of such taxpayer by the trustee or custodian of such account, including payment to such provider.
any amount imposed by reason of subpara-
graph (B) if such excess was not the result of the
actions of the taxpayer:".

(2) ASSESSABLE PENALTIES.—
(A) Subparagraph (B) of section 6724A(d)(1)
(relating to definitions) is amended by striking
"or" and by inserting "and" before "or".

(b) ADVANCE PAYMENT OF CREDIT.—Chapter
77 (relating to tax on employer-provided
coverage) is amended by inserting after section
7527 the following new section:

"SEC. 7527A. ADVANCE PAYMENT OF CREDIT FOR
QUALIFIED REFUND ELIGIBLE HEALTH
INSURANCE.

"(a) In General.—The Secretary shall es-
tablish a program for making payments on
behalf of individuals to providers of qualified
refund eligible health insurance (as defined
under section 7527) to such individuals.

"(b) LIMITATION.—The Secretary may
make payments under subsection (a) only to
the extent that the Secretary determines
that the Secretary's payments made on behalf
of any taxpayer for any month does not
exceed the sum of the monthly limita-
tions determined under section 25E(b) for the
taxpayer's spouse and dependents
for such month.

(c) INFORMATION REPORTING.—
(1) In General.—Subpart B of part III of
chapter 61 (relating to information
concerning transactions with other persons)
is amended by inserting after section
6050X the following new section:

"SEC. 6050X. RETURNS RELATING TO CREDIT
FOR QUALIFIED REFUND ELIGIBLE
HEALTH INSURANCE.

"(a) Requirements for Reporting.—Every
person who is entitled to receive payments
for any month of any calendar year under
section 7527A (relating to advance payment of
credit for qualified refund eligible health
insurance) with respect to any individual
shall, at such time as the Secretary may
prescribe, make the return described in sub-
section (b) with respect to each such indi-
vidual.

"(b) FORM AND MANNER OF RETURNS.—A re-
turn described in this subsection if such return—

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of each
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage pro-
vided by such payment with respect to such in-
dividual and the policy number associated
with such coverage,

"(E) the name, address, and TIN of the
spouse and each dependent covered under
such coverage, and

"(F) such other information as the Sec-
retary may prescribe.

"(c) STATEMENTS TO BE FURNISHED TO IN-
DIVIDUALS WITH RESPECT TO WHOM INFORMA-
TION CONCERNING TRANSACTIONS WITH
OTHER PERSONS IS REQUIRED.—Every person
required to make a return under section (a) shall furn-
ish to each individual whose name is re-
quired to be set forth in such return a writ-
ten statement showing—

"(1) in such form as the Secretary may
prescribe, and

"(2) the information required to be shown
on the return with respect to such indi-
vidual.

The written statement required under the
preceding sentence shall be furnished on or
before January 31 of the year following the
calendar year for which the return under
subsection (a) is required to be made.

(C) RETURNS WHICH WOULD BE REQUIRED TO BE
FURNISHED TO NONEMPLOYEES PERSONS.—Except
to the extent provided in regulations pres-
scribed by the Secretary, in the case of any
amount received by any person on behalf of
another person, only the person receiving
such amount shall be required to make the
return under subsection (a).

(1) IN GENERAL.—Section 106 (relating to
contributions by employer to accident and
health plans) is amended by adding at the end
the following new subsection:

"(hh) NON EXCLUSION FOR INDIVIDUALS ELIGI-
BLE FOR QUALIFIED HEALTH INSURANCE CRED-
IT.—Subsection (a) shall not apply with re-
spect to any employer-provided coverage
under an accident or health plan for any indi-
vidual for any month unless such individual
is described in paragraph (2) or (5) of section
25E(e) for such month.

(2) CONFORMING AMENDMENTS.—
(A) Section 106(b)(1)(C) is amended—
(i) by inserting "gross income does not in-
clude" before "amounts contributed", and
(ii) by striking "shall be treated as em-
ployer-provided coverage for medical ex-
penes under an accident or health plan".

(B) Section 106(d)(1) is amended—
(i) by inserting "gross income does not in-
clude" before "amounts contributed", and
(ii) by striking "shall be treated as em-
ployer-provided coverage for medical ex-
penes under an accident or health plan".

(3) AMOUNTS RECEIVED UNDER ACCIDENT
AND HEALTH PLANS.—Section 105 (relating
to amounts received under accident and
health plans) is amended by adding at the end
the following new subsection:

"(hh) the following new subparagraph:

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage pro-
vided by such payment with respect to such in-
dividual and the policy number associated
with such coverage,

"(E) the name, address, and TIN of the
spouse and each dependent covered under
such coverage, and

"(F) such other information as the Sec-
retary may prescribe.

"(c) SPECIAL RULES FOR HEALTH INSUR-
ANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

Subsection (a) of section 106(c) is amended
by inserting after paragraph (10) the follow-
ing new paragraph:

"(11) for any month unless such individual
is described in paragraph (10) or (11) of section
25E(e) for such month.

(1) NO EXCLUSION FOR INDIVIDUALS ELIGI-
BLE FOR QUALIFIED HEALTH INSURANCE CRED-
IT.—Subsection (a) shall not apply with re-
spect to any employer-provided coverage
under an accident or health plan for any indi-
vidual for any month unless such individual
is described in paragraph (11) or (12) of section
25E(e) for such month.

(2) SPECIAL RULES FOR HEALTH INSUR-
ANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

Subsection (a) of section 106(c) is amended
by inserting after paragraph (10) the follow-
ing new paragraph:

"(10) the following new subparagraph:

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage pro-
vided by such payment with respect to such in-
dividual and the policy number associated
with such coverage,

"(E) the name, address, and TIN of the
spouse and each dependent covered under
such coverage, and

"(F) such other information as the Sec-
retary may prescribe.

"(c) SPECIAL RULES FOR HEALTH INSUR-
ANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

Subsection (a) of section 106(c) is amended
by inserting after paragraph (10) the follow-
ing new paragraph:

"(10) the following new subparagraph:

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage pro-
vided by such payment with respect to such in-
dividual and the policy number associated
with such coverage,

"(E) the name, address, and TIN of the
spouse and each dependent covered under
such coverage, and

"(F) such other information as the Sec-
retary may prescribe.

"(c) SPECIAL RULES FOR HEALTH INSUR-
ANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

Subsection (a) of section 106(c) is amended
by inserting after paragraph (10) the follow-

"(10) the following new subparagraph:

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage pro-
vided by such payment with respect to such in-
dividual and the policy number associated
with such coverage,

"(E) the name, address, and TIN of the
spouse and each dependent covered under
such coverage, and

"(F) such other information as the Sec-
retary may prescribe.

"(c) SPECIAL RULES FOR HEALTH INSUR-
ANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

Subsection (a) of section 106(c) is amended
by inserting after paragraph (10) the follow-

"(10) the following new subparagraph:

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,

"(C) the amount of each such payment,

"(D) the type of insurance coverage pro-
vided by such payment with respect to such in-
dividual and the policy number associated
with such coverage,

"(E) the name, address, and TIN of the
spouse and each dependent covered under
such coverage, and

"(F) such other information as the Sec-
retary may prescribe.

"(c) SPECIAL RULES FOR HEALTH INSUR-
ANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.

Subsection (a) of section 106(c) is amended
by inserting after paragraph (10) the follow-

"(10) the following new subparagraph:

"(1) in such form as the Secretary may
prescribe, and

"(2) contains, with respect to each indi-
vidual referred to in subsection (a)—

"(A) the name, address, and TIN of
such individual,

"(B) the months for which amounts pay-
ments under section 7527A were received,
month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

(i) NO INTENT TO ENCOURAGE STATE TAXATION OF HEALTH BENEFITS.—No intent to encourage State taxation of health benefits is hereby expressed or implied by the amendments made by this title.

SEC. 304. DETERMINATION OF ELIGIBILITY.

APPLICATION OF INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS) AND THE SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE) PROGRAMS.—In order to obtain coverage through an Exchange, an individual must have had his or her eligibility determined and approved under the Income and Eligibility Verification System (IEVS) and the Systematic Alien Verification for Entitlements (SAVE) programs under section 1137 of the Social Security Act. The benefit determination and approval under this subsection shall be the responsibility of the Exchange-participating health plans involved.

(b) CREDITS.—In addition to satisfying the eligibility requirements specified in subsection (a), to be considered a credit eligible individual under the amendments made by this title, an individual must have had his or her eligibility determined and approved under the Income and Eligibility Verification System (IEVS) and the Systematic Alien Verification for Entitlements (SAVE) programs under section 1137 of the Social Security Act. The benefit determination and approval under this subsection shall be the responsibility of the Exchange-participating health plans in which the individual enrolls and attempts to utilize the credit.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 305. ADJUSTMENTS.

Notwithstanding any other provision of law, the Secretary of the Treasury shall adjust the growth of tax credits provided for under this amendment made by this title at such levels as are necessary for fiscal year 2011 and each fiscal year thereafter.

TITLE IV—FAIRNESS FOR EVERY AMERICAN PATIENT

Subtitle A—Medicaid Modernization

SEC. 101. MEDICAID MODERNIZATION.

(a) IN GENERAL.—In effect on January 1, 2011, title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended to read as follows:

"Sec. 1901. PURPOSE; APPROPRIATION.

"Sec. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

"Sec. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND ACUTE CARE MEDICAL ASSISTANCE.

"Sec. 1904. State plan requirements for acute care medical assistance.

"Sec. 1905. Definitions.

"(a) PURPOSE.—It is the purpose of this part to provide the Secretary of the Treasury with the policies embodied in this title as effect on and after January 1, 2011.

"(b) CONTINUITY FOR COMMONWEALTHS AND TERRITORIES.—In the case of Puerto Rico, the United States Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, this title as in effect on and after January 1, 2011, shall apply to such commonwealths and territories, and old title XIX shall apply to a Medicaid program operated by such commonwealths or territories on and after that date.

"PART A—GRANTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

(a) PURPOSE.—For the purpose of making payments to States under this part, there is appropriated out of any money in the Treasury not otherwise appropriated, such sums as are necessary for fiscal year 2011 and each fiscal year thereafter.

"Sec. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

"(a) IN GENERAL.—In this title, the amounts appropriated under section 1901 for a fiscal year, the Secretary shall pay to each State upon approval of a plan under this part, for each quarter, beginning with the quarter commencing January 1, 2011, an amount equal to the Federal medical assistance percentage (as defined in section 1905(b)) of the total amount expended during such quarter as acute care medical assistance under the State plan under this part.

"(b) ADMINISTRATIVE EXPENSES.—Each State with a plan approved under this part shall receive a payment determined in accordance with part E for administrative expenses incurred in carrying out the plan under this part and part B (if the State has a plan approved under that part).

"Sec. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND ACUTE CARE MEDICAL ASSISTANCE.

in this title, the term 'eligible individuals' means an individual—

(1) a blind or disabled individual, or

(2) an individual described in paragraph (2); and

(b) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(c) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individual' means an individual—

(1) who is—

(i) a blind or disabled individual, or

(ii) an individual described in paragraph (2); and

(2) who the State determines satisfies—

(iii) the income and resources eligibility requirements established by the State under the State plan under this part; and

(iv) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(b) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individuals' means an individual—

(1) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(d) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individuals' means an individual—

(1) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(e) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individuals' means an individual—

(1) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(f) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individuals' means an individual—

(1) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(g) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individuals' means an individual—

(1) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

"(h) ELIGIBLE INDIVIDUALS.—In this title, the term 'eligible individuals' means an individual—

(1) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements for assistance as are imposed under this title, including documentation of a familial relationship as a qualified alien under title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.
age or services in an institution for mental diseases).

(2) OPTIONAL BENEFITS.—Any care or services listed in a paragraph of old section 1905(a), other than paragraph (16).

(3) EXCEPTIONS.—

(A) Certain services limited to part B.—Services described in paragraphs (15), (22), (24), and (26) of old section 1905(a) shall only be provided under the State plan under part B.

(B) Limit on provision of long-term care services and supports.—(A) In general.—A care or service that the Secretary determines is a long-term care service and support (including nursing facility services described in old section 1905(b)(22)) shall not be provided to an individual under the State plan under this part for more than 30 days within any 12-month period.

(C) Exclusions.—Such term shall not include any payments with respect to care or services for any individual who is an inmate of a public institution or a patient in an institution for mental diseases (regardless of age).

SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE MEDICAL ASSISTANCE.

(a) In general.—In order to receive payments under this part, a State shall have an approved State plan for acute care medical assistance plan(s) pursuant to part B.

(b) Federal medicaid assistance plan(s) as provided for in the State plan(s). Such assistance includes payments for preventive care, primary care, diagnosis and treatment of acute and chronic health conditions, emergency care, diagnosis and treatment of mental illnesses and related conditions, and rehabilitation and other services to help eligible individuals attain or retain capability for independent living. A State medical assistance plan shall include a description, consistent with the requirements of this part of—

(1) eligibility standards, including income and asset standards;

(2) benefits, including the amount, duration, and scope of covered items and services;

(3) strategies for improving access and quality of care; and

(4) methods of service delivery.

(c) Public availability of State plan.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

(d) Amount, duration, and scope.—The State plan shall provide that the acute care medical assistance made available to any eligible individual shall not be less than the same amount, duration, or scope than the acute care medical assistance made available to any other eligible individual.

(e) Application of certain pre-modernized medicaid requirements.—

(1) Old state plan requirements.—The following provisions of old section 1902 shall apply to the State plans under this part:

(A) Old section 1902(a)(10)(C) (relating to eligibility and other requirements).

(B) Old section 1902(a)(10)(D) (relating to home health services).

(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income benefit eligibility criteria).

(D) The subclauses in the flush matter following old section 1902(a)(10)(G) (relating to the provision of certain services other than subparagraphs (V), (VI), (VIII), and (IX)).

(E) Old section 1902(a)(17) (relating to reasonable standards for determining eligibility).

(F) Old section 1902(a)(19) (relating to eligibility safeguards).

(G) Old section 1902(a)(34) (relating to eligibility beginning with the third month prior to application).

(H) Subparagraphs (A), (B), and (C) of old section 1902(a)(43) (relating to early and peri-

odic screening, diagnostic, and treatment services).

(I) Old section 1902(a)(46)(A) (relating to compliance with section 1137 requirements).

(2) Other old title xix requirements.—

(A) Old section 1905(a) (relating to eligibility for certain individuals).

(B) Old section 1905(e) (relating to optional respiratory care services).

(C) Old section 1905(f) (relating to eligibility of certain blind disabled individuals).

(D) Old section 1905(m) (relating to eligibility of certain aged or disabled individuals, other than paragraph (4).

(E) Old section 1905(o) (relating to disregard of certain supplemental security income benefits).

(F) Old section 1905(v) (relating to eligibility determinations of blind or disabled individuals).

(G) Other old provisions.—

(A) Old section 1903(m) (relating to the definition of a medically managed care organization).

SEC. 1905. DEFINITIONS.

(a) In general.—The definitions specified in this section shall apply for purposes of this part and, to the extent applicable and consistent with the policy embodied in such part, parts B, C, D, E, and F.

(b) Federal Medical Assistance Percentage.—The term 'Federal Medical Assistance Percentage' for any State shall be 100 percent less the State percentage; and the Federal Medical Assistance Percentage shall in no case be less than 50 percent or more than 83 percent. The Federal Medical Assistance Percentage for any State shall be determined and promulgated in accordance with the provisions of section 1110(a)(8)(B).

(c) Application of certain pre-modernized medicaid requirements.—

(1) Old section 1905 provisions.—The following provisions of old section 1905 shall apply under this part:

(A) Old section 1905(a) (relating to the definition of an intermediate care facility for the mentally retarded).

(B) Old section 1905(b) (relating to the definition of preventive services).

(C) Old section 1905(c) (relating to the definition of nursing facility services).

(D) Old section 1905(d) (relating to the provision of chiropractors' services).

(E) Old section 1905(e) (relating to State supplementary payments).

(F) Old section 1905(k) (relating to supplemental medical income benefits payable pursuant to section 211 of Public Law 93–66).

(G) Old section 1905(l)(1) (relating to rural health clinic services).

(H) Old section 1905(o) (relating to hospice care).

(I) Old section 1905(q) (relating to the definition of a qualified severely impaired individual).

(J) Old section 1905(r) (relating to the definition of early and periodic screening, diagnostic, and treatment services).

(K) Old section 1905(t) (relating to the definition of a qualified disabled and working individual).

SEC. 1906. ENROLLMENT OF INDIVIDUALS UNDER GROUP HEALTH PLANS AND OTHER ARRANGEMENTS.

The following old provisions shall apply under this part:

(1) Old section 1906 (relating to enrollment of individuals under group health plans).

(2) Old section 1902(a)(70) (relating to State option to establish a non-emergency medical transportation brokerage program).

(3) Paragraphs (2) and (11) of old section 1902(e) (relating to eligibility for individuals enrolled with a group health plan or under a managed care arrangement during a minimum enrollment period).

SEC. 1907. DRUG REBATES.

Old sections 1902(a)(54) and 1927 (relating to payment for covered drugs and rebates) shall apply under this part.

SEC. 1908. MANAGED CARE.

The following old provisions shall apply under this part:

(1) Old section 1932 (relating to managed care), other than subsection (a)(2) of such section.

(2) Old section 1903(k) (relating to technical and actuarial assistance for States).

SEC. 1909. ANNUAL REPORTS.

(a) In general.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

(b) Application of old EPSDT reporting requirements.—Each annual report shall include the information required to be reported under old section 1902(a)(8)(D)(iv).

SEC. 1910. GRANT TO STATES FOR LONG-TERM CARE SERVICES AND SUPPORTS.

SEC. 1111. PURPOSE.

(a) In general.—The purpose of this part is to increase the flexibility of States in operating a system of long-term care services and supports designed to—

(1) provide assistance to needy families so that individuals with disabilities and low-income senior citizens may be served and supported in their own homes and communities;

(2) emphasize the independence and dignity of the person served by public programs;

(3) end the institutional bias that existed under the Medicaid program prior to January 1, 1981.

(b) Provide stable and predictable funding for States as they rebalance their long-term care systems from institutions to communities;

(c) provide flexibility to States to adopt new and innovative service delivery methods; and

(d) promote independence and support activities that will enable individuals to return to maintain ties to the community, including through employment.

(b) No individual entitlement.—No individual determined eligible for long-term care services and supports under this part shall be entitled to a specific service or type of delivery of service.

SEC. 1912. STATE PLAN.

(a) In general.—In order to receive payments under this part, a State must have an
approved State plan for long-term care services and supports. A State long term care services and supports plan shall include a description, consistent with the requirements of this part, of—

(1) income and assets eligibility standards and spousal impoverishment protections consistent with subsection (b);
(2) standardized assessments tools used to determine eligibility for specific long-term care services and supports;
(3) the person-centered plans used to provide services and supports;
(4) the proposed uses of funding, if applicable, to provide targeted methods to meet individual level of support needs including tiering (preventive, emergency, low, medium, high); and
(5) the long-term care services and supports to be available under the plan based on individual assessment of need in accordance with sections 1916 and 1917.

(b) Minimum Eligibility Standards.—
(1) Populations Covered.—The State plan shall specify the disabled and elderly populations who are eligible for long-term care services and supports.
(2) Needs-Based Criteria.—The plan shall include a description of the needs-based criteria the State will use to assess an individual’s need for specific services and supports available under the State plan.
(3) Other Eligibility Requirements.—
(A) Income and Assets.—A State may use different income and asset standards and methodologies for determining eligibility than those used for determining eligibility for acute care medical assistance under part A. A State may not make eligibility standards related to income, asset, and spousal impoverishment protection more restrictive than the Federal minimum requirements of December 31, 2008.
(B) Prevention of Spousal Impoverishment Protections.—The State plan shall provide that the State shall comply with the requirements of section 1912 (relating to spousal impoverishment protections).
(C) StateWidens.—The State plan shall provide that, except with respect to methods used for determining homestead exemptions, the income and asset standards and methodologies shall be in effect in all political subdivisions of the State.
(D) Transition Assistance.—The State plan shall specify how the State will provide transition assistance for individuals who, on December 31, 2010, are enrolled under the State plan under old title XIX (or under a waiver program) receiving long-term care services or supports on that date. The State shall provide such assistance to individuals who are and are not likely to be determined eligible for long-term care services and supports under the State plan under this part, as in effect on January 1, 2011 (or the first day on which the State plan is in effect under this part).
(E) Payment Methodologies to Providers.—
(1) In General.—The State plan shall describe the methodologies used to determine payments to providers. Such methodologies—
(A) may be varied to assist in transitioning from facilities-based to community-based care; and
(B) shall not be subject to Secretarial approval.
(2) Transparency.—The State plan shall provide that the State shall make publicly available—
(A) the payment methodologies applicable under the plan; and
(B) the name of any provider that receives $1,000,000 or more in any 12-month period and the amount paid to the provider during that period.
(3) Coordination of Effort With Other Related Public and Private Programs.—The plan shall include a description of the State’s efforts to coordinate the delivery of services and supports under the plan with other related public and private programs that serve individuals with disabilities or aged populations that need or may be at risk of needing long term care.
(4) Public Availability of State Plan.—The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.
(5) Application of Old Title XIX Requirements.—The following old title XIX provisions shall apply to a State plan under this part:—
(A) Subsections (a)(50) and (q) of old section 1902 (relating to a monthly personal needs allowance for certain institutionalized individuals and couples).
(B) Old section 1902(a)(67) (relating to payments for certain services furnished to a PACE program eligible individual).
(C) Paragraph (2) of old section 1902(c) (relating to the post-eligibility treatment of income for certain individuals) and paragraph (2) of such section (relating to methodologies for determining income and resource eligibility for individuals, but only with respect to individuals who are eligible under this part on or after January 1, 2011).
(D) Old section 1905(c) (relating to the definition of an institution for mental diseases).
(E) Other Requirements of Other Parts.—The State plan under this part shall—
(1) comply with the requirements of the other parts of this title; and
(2) provide that the State will make the contributions specified under section 1904(e) of the Public Health Service Act.

SEC. 1913. STATE ALLOTMENTS.

(a) Appropriation.—For the purpose of providing allotments to States under this section, there is appropriated out of any money in the Treasury not otherwise appropriated—
(1) for fiscal year 2011, $65,274,560,000; 
(2) for fiscal year 2012, $67,885,540,000; 
(3) for fiscal year 2013, $70,600,964,100; 
(4) for fiscal year 2014, $73,425,090,000; 
(5) for fiscal year 2015, $76,362,000,000; 
(6) for fiscal year 2016, $79,415,480,000; 
(7) for fiscal year 2017, $82,583,140,000; 
(8) for fiscal year 2018, $85,696,970,000; and 
(9) for fiscal year 2019, $89,332,743,000.

(b) Allocations to 50 States and the District of Columbia.—
(1) Fiscal Year 2011 Allocations.—Subject to subsection (e), the Secretary shall allot to each State with a long term care plan approved under this title an amount in fiscal year 2011 equal to the Federal expenditures made by the State for long-term care as defined in section 1916 in fiscal year 2008, increased by 8 percent.
(2) Subsequent Fiscal Year Allocations.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment for a State under this section is equal to the allotment for the State determined for the preceding fiscal year, increased by 4 percent.

(c) Limitation.—
(1) In General.—Except as provided in paragraph (2), no other Federal funds are available under this title for expenditures incurred for long-term care services and supports after December 31, 2010, except as provided under a State plan approved under this part.
(2) Exception.—
(A) In General.—If a State does not have an approved State plan by October 1, 2010, the Secretary may make payments equal to 85 percent of the State’s estimated quarterly allotment until June 30, 2011.
(B) Full Funding.—A State shall receive 100 percent of its allotment for fiscal year 2011 if the State has a plan approved under this part by June 30, 2011.

D. Full Funding.—A State shall receive 100 percent of its allotment for fiscal year 2011 if the State has a plan approved under this part by June 30, 2011.

H. Maintenance of Effort.—In order to qualify for the grant payable under this section, the State must demonstrate in each fiscal year that it made long-term care services and supports expenditures (including funding from local government sources) equal to the amount of not less than 95 percent of the nonfederal share amount spent in fiscal year 2009 under the State plan under old title XIX on long term care services and supports (as defined in section 1915). Expenditures not made under this part shall not be recognized by the Secretary for purposes of this requirement.

(e) Grants Reduced If Insufficient Appropriations.—
(1) In General.—If the amount appropriated for fiscal year 2011 under subsection (a) is less than the amount necessary to fund each State’s allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2).
(2) Applicable Percentage.—For purposes of paragraph (1), the applicable percentage determined with respect to a State is as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>$0</td>
</tr>
<tr>
<td>1%</td>
<td>$5,624,740</td>
</tr>
<tr>
<td>2%</td>
<td>$11,249,480</td>
</tr>
<tr>
<td>3%</td>
<td>$16,874,220</td>
</tr>
<tr>
<td>4%</td>
<td>$22,498,960</td>
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<tr>
<td>5%</td>
<td>$28,123,700</td>
</tr>
<tr>
<td>6%</td>
<td>$33,748,440</td>
</tr>
<tr>
<td>7%</td>
<td>$39,373,180</td>
</tr>
<tr>
<td>8%</td>
<td>$44,997,920</td>
</tr>
<tr>
<td>9%</td>
<td>$50,622,660</td>
</tr>
<tr>
<td>10%</td>
<td>$56,247,400</td>
</tr>
</tbody>
</table>

If the ratio of the State’s non-institutional spending to total long-term care spending for fiscal year 2009 is: 

- 50 percent or greater ........................................................................................................... 100
- at least 46, but less than 50 ................................................................................................ 99
- at least 40, but less than 46 .............................................................................................. 98
- at least 36, but less than 40 .............................................................................................. 97
- at least 32, but less than 36 .............................................................................................. 96
- at least 30, but less than 32 .............................................................................................. 95
- less than 30 percent .......................................................................................................... 94

(1) Administrative Expenses.—
(2) Allowable Costs.
**SEC. 1914. USE OF GRANTS.**

(a) IN GENERAL.—A State shall use funds for long-term care services and supports as defined in section 1916.

(b) The individual shall determine eligibility and the self-directed long-term care services and supports.

**SEC. 1915. ADMINISTRATIVE PROVISIONS.**

(a) FUNDING FROM A QUARTERLY BASIS.—The Secretary shall make payments to States in equal amounts of a State’s annual allotment on a quarterly basis. Each quarterly payment shall remain available for use by the State for twelve succeeding fiscal year quarters.

(b) PUBLICATION.—The Secretary shall publish the allotment—

(1) for fiscal year 2011 not later than December 15, 2009; and

(2) for each subsequent fiscal year, not later than December 15 of the calendar year preceding the calendar year in which the fiscal year begins.

**SEC. 1916. DEFINITION OF LONG-TERM CARE SERVICES AND SUPPORTS.**

(a) DEFINITION.—

(1) IN GENERAL.—Subject to subsection (e), in this part, the term ‘long-term care services and supports’ means any of the services or supports specified in paragraphs (2) and (3) that may be provided in a nursing facility, an institution, a home, or other setting.

(2) SERVICES AND SUPPORTS.—For purposes of paragraph (1), the services and supports described in this paragraph include assistive technology, adaptive equipment, remote monitoring equipment, case management for the aged, case management for individuals with disabilities, nursing home services, long-term rehabilitative services necessary to restore functional abilities, services provided in intermediate care facilities for people with disabilities, habilitation services (including adult day care programs), community programs for individuals with mental illness, home health services, services provided in an institution for mental disease, a Program of All-Inclusive Care for the Elderly (PACE), personal care (including personal assistance services), recovery support including peer counseling, supportive employment, training skills necessary for independent or supports specified in paragraphs (2) or (3) for individuals with disabilities, foster care (with the exception of training of foster parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.

(3) INCLUSION OF CERTAIN BENEFITS UNDER PACE.—For purposes of rehabilitation due to acute care medical needs, a State may claim rehabilitative services provided in an institutional setting, including partial hospitalization, health expenditures as acute care benefits under the State plan under part A rather than under the State plan under this part for a cumulative period of 30 days within a 12-month period if such care is directly related to the onset of an acute care need. A State shall demonstrate the services were provided as a direct result of an acute care need.

(b) Managed Care.—If a State provides long-term care services and supports through managed care, the State shall submit a method that the level of expenditures attributed to long term care for approval by the Secretary.

(c) APPLICATION OF PART A DEFINITIONS.—A definition specified in section 1905 shall apply to the same term used in this part, unless the Secretary otherwise specifies.

**SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM CARE SERVICES AND SUPPORTS, INCLUDING OPTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.**

(a) REQUIREMENTS FOR THE PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—

(1) IN GENERAL.—Subject to the success criteria in subparagraph (B), a State may provide through a State plan amendment for the provision of long-term care services and supports for individuals eligible under the State plan under this part, subject to the following requirements:

(A) NEEDS-BASED CRITERIA FOR ELIGIBILITY FOR, AND RECEIPT OF, LONG-TERM CARE SERVICES IN A MANNER THAT IS CONSISTENT WITH THE NEEDS-BASED CRITERIA ESTABLISHED FOR DETERMINING ELIGIBILITY FOR, AND RECEIPT OF, SERVICES AND SUPPORTS PROVIDED IN A FACILITY OR INSTITUTION THAT ARE MORE STRINGENT THAN THE CRITERIA ESTABLISHED FOR DETERMINING ELIGIBILITY FOR, AND RECEIPT OF, SERVICES AND SUPPORTS PROVIDED IN A FACILITY OR NON-INSTITUTIONALIZED SETTING.

(B) CRITERIA FOR INSTITUTIONALIZED VERSUS NON-INSTITUTIONALIZED SERVICES.—In establishing needs-based criteria, the State shall establish criteria that are more stringent that the criteria established for determining eligibility for, and receipt of, services and supports provided in a facility or institution that are more stringent that the criteria established for determining eligibility for, and receipt of, services and supports provided in a facility or non-institutionalized setting.

(C) AUTHORITY TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS.—A State may limit the number of individuals who are eligible for such services and supports and may establish waiting lists for the receipt of such services and supports.

(D) CRITERIA BASED ON INDIVIDUAL ASSESSMENT.—

(II) The State determines that the criteria developed by the State are appropriate.

(III) A State may limit the number of individuals eligible for services and supports for the individual in accordance with subparagraph (E).

(F) ASSESSMENT.—The State plan provides for the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for long-term care services and supports.

(G) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(H) An examination of the individual’s eligibility to perform or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(I) A face-to-face evaluation of the individual’s ability to perform or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(J) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(K) An examination of the individual’s ability to perform or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(L) A face-to-face evaluation of the individual’s ability to perform or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.

(M) Consultation with appropriate treating and consulting health and support professionals caring for the individual.

(N) An examination of the individual’s ability to perform or more activities of daily living (as defined in section 7702B(c)(2)(B) of the Internal Revenue Code of 1986) or the need for significant assistance to perform such activities.
ties and the requirements of subclauses (II) and (III) of section 1915(b)(2) of such title, the terms of which are consistent with the individual's abilities and supports in a manner which gives them the opportunity to elect to receive self-directed long-term care services and supports, and are planned and purchased under the direction of the individual or the individual's authorized representative, including the amount, duration, scope, provider, and control of such individual or the individual's authorized representative; and

(2) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative; and

(3) is reviewed at least annually and as needed, when there is a significant change in the individual's circumstances.

(2) SELF-DIRECTED.—The term ‘self-directed’ means, with respect to the long-term care services and supports offered under the State plan amendment, such services and supports for the individual which are planned and purchased under the direction and control of such individual or the individual's authorized representative, including the amount, duration, scope, provider, and location of such services and supports, under the State plan consistent with the following requirements:

(a) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services and supports;

(b) SELF-DIRECTED.—Based on such assessment, there is developed jointly with such individual or the individual’s authorized representative a plan for such services and supports for the individual that is approved by the State and that satisfies the requirements of subclause (III).

(3) PLAN REQUIREMENTS.—For purposes of subclause (II)(bb), the requirements of this subclause are that the plan—

(aa) specifies those services and supports which the individual or the individual's authorized representative would be responsible for directing;

(bb) identifies the methods by which the individual or the individual’s authorized representative will select, manage, and dismiss the individuals on whose behalf and in whose interest the individual or the individual’s authorized representative builds upon the individual’s capacity to engage in activities that promote community life and that respects the individual’s preferences, choices, and abilities, and involves families, friends, and professionals as appropriate in the individual or the individual’s authorized representative;

(cc) includes appropriate risk management tools that recognize the roles and sharing of responsibilities in obtaining services and supports in a self-directed manner and assure the appropriateness of such plan based upon the capabilities of the individual or the individual’s authorized representative; and

(dd) is developed through a person-centered process as required under subparagraph (E) to determine an individual’s eligibility for self-directed long-term care services and supports. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (B) to determine an individual’s eligibility for self-directed long-term care services. Such presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (B) to determine an individual’s eligibility for self-directed long-term care services and supports that the individual will receive.

The State establishes standards for the conduct of the independent evaluation and the independent assessment to safeguard against conflicts of interest.

(1) REDETERMINATIONS AND APPEALS.—The State allows for a period of presumptive eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(J) PRESumptive ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for long-term care services. Any presumptive eligibility shall be limited to medical assistance for carrying out the independent evaluation and assessment under subparagraph (B) to determine an individual’s eligibility for self-directed long-term care services and supports that the individual will receive.

(2) Definition of Individual’s Representative.—In this section, the term ‘individual’s representative’ means, with respect to an individual, a parent, a family member, or guardian of the individual, an advocate for the individual, or any other individual who is authorized to represent the individual.

(3) Self-Directed Personal Assistance Services.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of paragraph (1) for individuals who elect to self-direct the receipt of such care or services.

SEC. 1918. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

Old section 1942 (relating to treatment of income and resources for certain institutionalized spouses) is amended by--

(1) for fiscal year 2011, $100,000,000; and

(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

(3) AUTHORIZATION OF APPROPRIATIONS.

For the purpose of carrying out our Federal activities and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

(1) for fiscal year 2011, $10,000,000; and

(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

SEC. 1922. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

(1) Old section 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

(2) Old section 1902(a)(33)(B) (relating to licensing health institutions).

(3) Old section 1902(d) (relating to medical or utilization review functions).

(4) Old section 1911 (relating to inter-and intra-state medical care facilities for the mentally retarded).

(5) Old section 1912 (relating to psychiatric hospitals).

(6) Old sections 1903(a)(1) and (6) of old section 1903(g) (relating to the Secretary's requirement to conduct sample on-site surveys of private and public institutions and recertifications for the need for certain services).

(7) Old section 1916 (relating to the definition of a board and care facility).

(8) Old section 1919 (relating to certification and approval of rural health clinics and intermediate care facilities for the mentally retarded).

(9) Old section 1921 (relating to Indian Health Service facilities).

(10) Old section 1923 (relating to hospital providers of nursing facility services).

(11) Old section 1929 (relating to requirements for nursing facility services).

(12) Old section 1931 (relating to requirements for nursing facility services).

PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

(1) In General.—For the purpose of carrying out Federal activities under this part and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

(1) for fiscal year 2011, $100,000,000; and

(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year, increased by 5 percent.

(b) Availability; Authority for Use of Funds.—
Congressional Record — Senate

December 19, 2009

‘‘(1) AVAILABILITY.—Amounts appropriated pursuant to subsection (a) shall remain available until expended.

‘‘(2) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION AND TRAVEL. — Except for transportation and travel expenses, the authority of subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies of the United States Government under section 57 of title 5, United States Code, while away from their homes or regular places of business, shall be extended to beneficiaries, described in subsection (b)(4) who attend education, training, or consultation activities, conducted under the authority of that subsection.

‘‘(b) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

‘‘(1) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

‘‘(2) the effectiveness of the use of such funds.

‘‘SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

‘‘The following old provisions shall apply under this title with respect to the area in which such provisions apply:

‘‘(1) Old subsections (a)(25) (other than subparagraph (E)); and

‘‘(2) Old sections 1902(a)(2)(B), 1902(a)(4)(B), 1912(a), and 1917 (relating to hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases admission screening and review requirements).

‘‘(3) Old section 1902(a)(32) (relating to certain payment requirements).

‘‘(4) Old section 1902(a)(35) (relating to disclosure of Federal or State identifiers for physicians).

‘‘(5) Old section 1902(a)(37) and the fifth sentence (relating to claims payment procedures).

‘‘(6) Old section 1902(a)(44) (relating to payment for inpatient hospital services, services in an intermediate care facility for the mentally retarded, or inpatient mental hospital services).

‘‘(7) Old sections 1902(a)(45) and 1912 (relating to assignment of rights of payment).

‘‘(8) Old sections 1902(a)(49) and 1921 (relating to information and access to information concerning sanctions taken by State licensing authorities against health care practitioners and providers).

‘‘(9) Old section 1902(a)(61) and 1903(q) (relating to requirements for a medicaid fraud and abuse control unit).

‘‘(10) Old section 1902(a)(64) (relating to reports from beneficiaries and others and data compilation requirements concerning alleged instances of waste, fraud, and abuse).

‘‘(11) Old section 1902(a)(65) (relating to provisions that a surety bond requirement be provided for suppliers of durable medical equipment).

‘‘(12) Old section 1902(a)(68) (relating to requirements concerning prepayment).

‘‘(13) Old sections 1902(a)(69) and 1936 (relating to the Medicaid Integrity Program) other than paragraphs (1), (2)(A), and (3) of old section 1902(a)(69).

‘‘(14) Old section 1902(a)(70)(B)(iv) (relating to provisions on referrals and conflict of interest for certain brokers of non-emergency medical transportation).

‘‘(15) Old sections 1902(a)(71) and 1940 (relating to a required asset verification program).

‘‘(16) Old section 1903(w) (relating to exclusion of certain individuals or entities).

‘‘(17) Old section 1902(x) (relating to unique identifiers for physicians).

‘‘(18) Old section 1902(f) (relating to interstate collection of rights of support).

‘‘(19) Old section 1903(r)(2) (relating to requirements for mechanismized claims processing and payment retrieval systems).

‘‘(20) Old section 1903(u) (relating to erroneous excess payments), other than clause (v) of paragraph (1).

‘‘(21) Old section 1903(v) and the seventh sentence of old section 1902(a) (relating to limitations on payments for services furnished to aliens), other than subparagraphs (A) and (B) of paragraph (4).

‘‘(22) Old section 1903(x) (relating to citizenship documentation).

‘‘(23) Old section 1909 (relating to State false claims act requirements for increased State share of recoveries).

‘‘(24) Old section 1914 (relating to withholding of Federal share of payments for certain Medicare providers).

‘‘(25) Old section 1917 (relating to liens, adjustments and recoveries, and transfers of assets).

‘‘(26) Old section 1922 (relating to correction and reduction plans for intermediate care facilities for the mentally retarded).

‘‘PART E—GRANTS TO STATES FOR ADMINISTRATION

‘‘SEC. 1951. AUTHORIZATION OF APPROPRIATIONS; PAYMENTS TO STATES.

‘‘(a) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for the fiscal year, the Secretary shall pay to each State an amount equal to the product of—

‘‘(1) for fiscal year 2011, $7,000,000,000; and

‘‘(2) for each succeeding fiscal year, the amount authorized under this subsection for the preceding fiscal year, increased by 3 percent.

‘‘(b) PAYMENTS TO STATES.—

‘‘(1) IN GENERAL.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay to each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount authorized for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a) for fiscal year 2011 to the total amount of payments made to all States for such fiscal year.

‘‘(2) PRO RATA ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year, so as not to exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

‘‘SEC. 1952. COST-SHARING PROTECTIONS

‘‘(a) IN GENERAL.—A State may impose cost-sharing for individuals provided acute medical care assistance under a State plan under part A or long-term care services and supports under a State plan under part B consistent with the following:

‘‘(1) The State may impose cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.

‘‘(2) Cost-sharing became past due. The State may waive payment of any such premium or cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.

‘‘(b) APPLICATION TO INSTITUTIONALIZED INDIVIDUALS.—A State may impose cost-sharing consistent with subsection (a) to individuals who are patients in, or residents of, a medical institution or nursing facility except that for a resident of a post-eligibility treatment of income (including a minimum monthly personal needs allowance) applicable to institutionalized individuals under title XIX, cost-sharing shall be in the same manner to individuals eligible for long-term care services and supports under a State plan under part B.

‘‘(c) POVERTY LINE DEFINED.—In this section, the term ‘poverty line’ has the meaning given such term in section 673(c) of the Comprehensive Health Care Act (42 U.S.C. 9902(c)), including any revision required by such section.

‘‘SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

The following old provisions shall apply to the State plans under title XVIII:

‘‘(1) OLD STATE PLAN REQUIREMENTS.—

‘‘(A) Old section 1902(a)(1) (relating to the requirement for plans to be in effect in all political subdivisions of the State).

‘‘(B) Old section 1902(a)(2) (relating to State financial participation).

‘‘(C) Old section 1902(a)(3) (relating to opportunity for a fair hearing).

‘‘(D) Old section 1902(a)(4) (relating to administrative appeals).

‘‘(E) Old section 1902(a)(5) (relating to designation of a single State agency).

‘‘(F) Old section 1902(a)(6) (relating to reporting requirements).

‘‘(G) Old section 1902(a)(7) (relating to restrictions on the use or disclosure of information).

‘‘(H) Old section 1902(a)(8) (relating to applications for assistance).

‘‘(I) Old section 1902(a)(11) (relating to cooperative agreements with other State agencies).

‘‘(J) Old section 1902(a)(12) (relating to determinations of blindness).

‘‘(K) Old section 1902(a)(13) (relating to determination of rates of payment for certain services), other than clause (iv) of subparagraph (A).

‘‘(L) Old section 1902(a)(15) and (bb) of old section 1902(a) (relating to payment for services provided by rural health clinics and federally qualified health centers).

‘‘(M) Old section 1902(a)(16) (relating to furnishing services to individuals when absent from the State).

‘‘(N) Old section 1902(a)(22) (relating to certain administrative provisions).

‘‘(O) Paragraphs (23) and (25)(D) of old section 1902(a) (relating to any willing provider requirements).

‘‘(P) Old section 1902(a)(24) (relating to consultation services by other agencies).

‘‘(Q) Old section 1902(a)(28) (relating to revenue needs for inpatient hospital services and written plan of care requirements).

‘‘(R) Old section 1902(a)(29) (relating to cost-sharing for health care services provided to individuals enrolled in State plans under this title and eligible for services under title XVIII).
(B) Old section 1902(a)(27) (relating to provider record keeping requirements).

(S) Old section 1902(a)(30)(A) (relating to utilization review).

(T) Old section 1902(a)(31) (relating to written plan of care for services and review for intermediate care facility for the mentally retarded services).

(U) Old section 1902(a)(33)(A) (relating to quality review requirements).

(V) Old section 1902(a)(36) (relating to public availability of facility surveys).

(W) Old section 1902(a)(38) (relating to the provision of information described in section 1125(b)(9) by certain entities).

(X) Old section 1902(a)(39) (relating to the exclusion of claims).

(Y) Old section 1902(a)(40) (relating to requirement for uniform reporting systems).

(Z) Old section 1902(a)(41) (relating to notice to State medical licensing boards).

(aa) Old section 1902(a)(42) (relating to certain audit requirements).

(bb) Old section 1902(a)(46) (relating to eligibility cards).

(cc) Old section 1902(a)(55) (relating to the receipt and initial processing of applications, but only to the extent such section is consistently and specifically codified in the State plans under parts A and B).

(dd) Subsections (a)(56) and (e) of old section 1962 (relating to adjusted payments for certain institutional services).

(ee) Old section 1902(a)(59) (relating to maintenance of list of participating physicians).

(ff) The second sentence of old section 1902 (relating to designation of certain State agencies).

(gg) Old section 1902(b) (relating to limitations on approval of plans).

(hh) Old section 1902(j) (relating to application of requirements to American Samoa and the Northern Mariana Islands).

(ii) Old section 1902(k) (relating to public availability of information contained in records of plan).

(jj) Old section 1902(l) (relating to limitations on payments).

(kk) Old section 1902(m) (relating to costs with respect to certain hospital services).

(ll) Old section 1903(a)(1) (relating to limitations on payments).

(mm) Old section 1903(r) (relating to requirements for mechanized claims processing and information retrieval systems).

(nn) Subsections (b)(15) and (w) of old section 1903 (relating to limitations on payments related to provider taxes).

(oo) Old section 1904 (relating to operation of State plans).

(pp) Old sections 1902(a)(60) and 1908A (relating to medical child support).

(qq) Paragraphs (32)(D) and (62) of old section 1902(a) and section 1928 (relating to program for distribution of pediatric vaccines).

PART F—OTHER PROVISIONS

SEC. 161. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

The following old provisions shall apply under this Act:

(1) The third sentence of old section 1902 (relating to nonapplicability of certain old provisions to a religious nonmedical health care facility).

(2) Old section 1918 (relating to application of provisions of title II relating to subpoenas).

(3) Old section 1939 (relating to references to laws directly affecting the Medicaid program).
family during the calendar year 2011 shall be determined as follows:

“(A) Each family whose annual income does not exceed 100 percent of the poverty level, or a family eligible to a family of the size involved, shall receive $5,000.

“(B) Each family whose annual income exceeds 100 percent but does not exceed 200 percent of the poverty level, if applicable, or a family of the size involved, shall receive an amount as follows:

(i) For families whose annual income exceeds 100 percent but does not exceed 120 percent of the poverty level, $4,000.

(ii) For families whose annual income exceeds 120 percent but does not exceed 140 percent of the poverty level, $3,500.

(iii) For families whose annual income exceeds 140 percent but does not exceed 160 percent of the poverty level, $3,000.

(iv) For families whose annual income exceeds 160 percent but does not exceed 180 percent of the poverty level, $2,500.

(v) For families whose annual income exceeds 180 percent but does not exceed 200 percent of the poverty level, $2,000.

“(2) ADDITIONAL AMOUNTS.—In addition to the amounts under paragraph (1), subject to paragraph (3), an additional amount of $500 shall be added to the supplemental debit cards of qualifying families:

(A) For each pregnancy during which a pregnancy-related condition is eligible for assistance under this section, an additional amount of $1,000 shall be added to the family’s supplemental debit card, except that no family shall receive such additional $1,000 for any pregnancy for which the family received such amount in the previous 12-month period.

(B) For each member of an eligible family who is less than 1 year old on any day within the calendar year in which the family is eligible for assistance, an additional amount of $500 shall be added to the family’s supplemental debit card.

“(3) COST OF LIVING ADJUSTMENTS.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (c)(2) of section 25E of the Internal Revenue Code for the taxable year involved.

“(4) STATE OPTION TO INCREASE AMOUNTS.—At the option of each State, amounts in excess of the annual dollar amounts under paragraph (2) may be provided through the supplemental debit card to eligible families in that State, but no Federal funds shall be paid to any State for any amount provided in excess of such annual dollar amount.

“(5) RISK ADJUSTMENT.—The Secretary may adjust the amount of financial assistance available to an eligible family for a calendar year under this section based on age, health indicators, and other factors that represent the variation in costs of health care services utilization and costs.

“(e) CONTRIBUTIONS OF STATES.—

“(1) IN GENERAL.—As a condition for receiving Federal funds under Part A or Part B of Medicaid, each State shall contribute 50 percent of the total amount expended under the supplemental debit card program by the participating families that reside within the State during the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household.

“(2) PAYMENTS FROM STATES.—

(A) BILLING NOTIFICATION.—
under such plans, the Secretary shall establish and implement a competitive bidding mechanism under this part.

(2) MECHANISM TO BEGIN IN 2011.—The mechanism under paragraph (1) shall apply to all MA organizations and plans beginning in 2011.

(3) NO EFFECT ON PART D BENEFITS.—The mechanism established under paragraph (1) shall not affect the provisions of this part relating to benefits under part D, including the bidding mechanism used for benefits under such part.

(b) RULES FOR COMPETITIVE BIDDING MECHANISM.—Notwithstanding any other provision of this title, the following rules shall apply under the competitive bidding mechanism established under subsection (a).

(1) BENCHMARK.—Benchmark amounts for an area for a year shall be established solely through the competitive bids of MA plans. The benchmark amount for each area for a year shall be the average bid of the plans in that area for that year. In establishing the benchmark for an area for a year under the preceding sentence, the Secretary shall exclude the highest and lowest bid for that area and year, the benchmark amount for an area for a year may not exceed the benchmark amount for that area and year that would have applied if this section had not been enacted.

(2) BIDS.—The MA plan bid shall reflect the per capita payments that the MA plan will accept for providing a benefit package that is reasonably equivalent to 100 percent of the value of the original Medicare fee-for-service program option. MA plan bid submissions shall include data on plan average provider network encounter rates compared to the rates under the original Medicare fee-for-service program option for the top 5 most common claim submissions per provider type.

(3) RISK ADJUSTMENT.—The benchmark under paragraph (1) and the MA plan bid shall be risk adjusted using the risk adjustment requirements under this part.

(4) BENEFICIARY PREMIUMS.—The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is at or below the benchmark shall be zero and the beneficiary shall receive the full difference (if any) between the bid and the benchmark amount for an area for a year. The benchmark amount for an area for a year may not exceed the benchmark amount for that area and year that would have applied if this section had not been enacted.

(5) BENCHMARK AMOUNTS FOR RURAL COUNTRIES.—The Secretary may adjust the benchmark amount established under paragraph (1) for any rural county (as identified by the Secretary after consultation with the Secretary of Commerce) to encourage plan participation in such county.

(6) EXISTING REQUIREMENTS.—Requirements relating to licensure, quality, and benefits that would otherwise be applied under this part shall apply under the competitive bidding mechanism established under subsection (a).

(c) WAIVER.—In order to implement the competitive bidding mechanism under established subsection (a), the Secretary may waive or modify requirements under this part.

SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAMS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to promote innovative care coordination and delivery that is cost-effective, the Secretary of Human Services (in this section referred to as the "Secretary") shall conduct a demonstration program under the Medicare program under which—

(A) groups of providers meeting certain criteria may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an Accountable Care Organization (in this section referred to as an "ACO"); and

(B) providers participating in the program are eligible for bonuses based on performance.

(2) MEDICARE FEE-FOR-SERVICE BENEFICIARY DEFINED.—In this section, the term "Medicare fee-for-service beneficiary" means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act and not enrolled in an MA plan under part C of such title.

(b) ELIGIBLE ACOs.—

(1) IN GENERAL.—Subject to paragraph (2), the following provider groups are eligible to participate as ACOs under the demonstration program under this section:

(A) Physicians in group practice arrangements.

(B) Networks of individual physician practices.

(C) Partnerships or joint venture arrangements between physicians.

(D) Partnerships or joint ventures, which may include pharmacists providing medication therapy management.

(E) Hospitals and physicians.

(F) Integrated delivery systems.

(G) Community-based coalitions of providers.

(2) REQUIREMENTS.—An ACO shall meet the following requirements:

(A) The ACO shall have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers.

(B) The ACO shall include the primary care providers of at least 5,000 Medicare fee-for-service beneficiaries.

(C) The ACO shall be willing to become accountable for the overall care of the Medicare fee-for-service beneficiaries.

(D) The ACO shall provide the Secretary with a list of primary care and specialist physicians participating in the ACO to support the beneficiary assignment, implementation of performance measures, and the determination of bonus payments under the demonstration program.

(E) The ACO shall have in place contracts with a core group of specialists and primary care physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(F) The ACO may include pharmacists providing medication therapy management, community-based coalitions of providers, or other organizations that are appropriate.

(G) The ACO shall have in place contracts with a core group of specialists and primary care physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(H) The ACO shall have in place contracts with a core group of specialists and primary care physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(i) REIMBURSEMENT.—Upon completion of the demonstration program under this section, the Secretary shall submit to Congress a report that includes recommendations as the Secretary determines appropriate.

SEC. 503. REDUCING GOVERNMENT HANDOUTS TO WEALTHIEST SENIORS.

(a) ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART B PREMIUM SUBSIDIES.

(1) IN GENERAL.—Paragraph (5) of section 1839(i) of the Social Security Act (42 U.S.C. 1395w–113(a)) is repealed.

(b) REDUCE EFFECTIVE DATE.—The repeal made by paragraph (1) shall apply to premiums for months beginning after December 2010.

(c) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.

(1) INCOME-RELATED REDUCTION IN PART D PREMIUM SUBSIDY.

(A) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–22(a)) is amended by adding at the end the following new paragraph:

(7) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.—

(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (5) of section 1839(i) (including application of paragraph (5) of such section for the calendar year), the monthly amount of the premium subsidy applicable to the Medicare fee-for-service program for a month after December 2010 shall be reduced (and the monthly premium subsidy shall

(B) spending for their Medicare fee-for-service beneficiaries meets the requirement under paragraph (3).

(2) QUALITY.—Under the demonstration programs under this section, providers meeting the requirement under paragraph (1)(A) if they generally follow consensus-based guidelines established by non-government professionals in the medical society, regulation, and risk-adjusted outcomes shall be determined through an independent entity with medical expertise.

(3) REQUIREMENTS RELATING TO SPENDING.—

(A) IN GENERAL.—An ACO shall only be eligible to receive a bonus payment if the average Medicare expenditures under the ACO for the two-year period is at least 2 percent below the average benchmark for the corresponding two-year period. The benchmark for each ACO shall be set using the most recent three years of total per-beneficiary spending for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be updated by the projected rate of growth in national per capita spending for the original Medicare fee-for-service program, as projected (using the most recent three years of data) by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(4) AMOUNT OF BONUS PAYMENTS.—The amount of the bonus payment to a participating ACO shall be one-half of the percentage point difference between the two-year average of their patients’ Medicare expenditures and 2 percent of the two-year average benchmark. The bonus amount, in dollars, shall be equal to the bonus share multiplied by the benchmark for the most recent year.

(5) LIMITATION.—Bonus payments may only be made to an ACO if the primary care provider to which the Medicare fee-for-service beneficiary has been assigned under subsection (c) (electronic claims) by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(6) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be appropriate for the purpose of carrying out the demonstration program under this section.
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 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(II) the base beneficiary premium (as computed under paragraph (2));

``(iii) the modified adjusted gross income (as determined under subsection (2)) of such individual for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(ii) the modified adjusted gross income (as determined under subsection (2));

``(iii) the applicable percentage determined under paragraph (3)(C) of section 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(i) the quotient obtained by dividing—

``(I) the modified adjusted gross income (as determined under subsection (2));

``(II) the applicable percentage determined under paragraph (3)(C) of section 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(iii) the monthly adjustment amount specified in subparagraph (B).

``(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 1393(i)(4) determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

``(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

``(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

``(i) Disclosure of Base Beneficiary Premium.—Before September 30 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as determined under paragraph (3)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

``(ii) Additional Disclosure.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

``(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1393(i) (including application of paragraphs (4)(A) and (4)(B));

``(II) The applicable percentage determined under paragraph (3)(C) of section 1393(i) (including application of paragraph (5) of such section); and

``(III) The monthly adjustment amount specified in subparagraph (B).

``(F) Rule of Construction.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining the adjustment amount under such subparagraph.

``(B) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1866D-13(c) of the Social Security Act (42 U.S.C. 1395w-113(c)) is amended—

``(i) in paragraph (1), by striking ‘‘(2) and (3)’’ and inserting ‘‘(2), (3), and (4)’’; and

``(ii) striking at the end the following new paragraph:

``(F) Collection of Monthly Adjustment Amount.—

``(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7) shall be paid through withholding from benefit payments in the manner provided under section 1840.

``(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual are insufficient to pay the amount described in subparagraph (A) of this paragraph, the Commissioner of Social Security shall enter into agreements with eligible entities of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in such subparagraph but not withheld under such subparagraph.

``(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 1393(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

``(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

``(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

``(i) Disclosure of Base Beneficiary Premium.—Before September 30 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as determined under paragraph (3)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

``(ii) Additional Disclosure.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

``(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1393(i) (including application of paragraphs (4)(A) and (4)(B));

``(II) The applicable percentage determined under paragraph (3)(C) of section 1393(i) (including application of paragraph (5) of such section); and

``(III) The monthly adjustment amount specified in subparagraph (B).

``(F) Rule of Construction.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining the adjustment amount under such subparagraph.

``(B) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1866D-13(c) of the Social Security Act (42 U.S.C. 1395w-113(c)) is amended—

``(i) in paragraph (1), by striking ‘‘(2) and (3)’’ and inserting ‘‘(2), (3), and (4)’’; and

``(ii) striking at the end the following new paragraph:

``(F) Collection of Monthly Adjustment Amount.—

``(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month (as determined under subsection (a)(7) shall be paid through withholding from benefit payments in the manner provided under section 1840.

``(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual are insufficient to pay the amount described in subparagraph (A) of this paragraph, the Commissioner of Social Security shall enter into agreements with eligible entities of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in such subparagraph but not withheld under such subparagraph.

``(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 1393(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

``(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

``(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

``(i) Disclosure of Base Beneficiary Premium.—Before September 30 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as determined under paragraph (3)) for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

``(ii) Additional Disclosure.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

``(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1393(i) (including application of paragraphs (4)(A) and (4)(B));

``(II) The applicable percentage determined under paragraph (3)(C) of section 1393(i) (including application of paragraph (5) of such section); and

``(III) The monthly adjustment amount specified in subparagraph (B).

``(IV) Any other information the Commissioner of Social Security determines necessary to carry out the income-related reduction in premium subsidy under this paragraph.

``(F) Rule of Construction.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining the adjustment amount under such subparagraph.

``(B) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1866D-13(c) of the Social Security Act (42 U.S.C. 1395w-113(c)) is amended—

``(i) in paragraph (1), by striking ‘‘(2) and (3)’’ and inserting ‘‘(2), (3), and (4)’’; and

``(ii) striking at the end the following new paragraph:

``(F) Collection of Monthly Adjustment Amount.—

``(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month 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 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(II) the modified adjusted gross income (as determined under subsection (2));

``(iii) the modified adjusted gross income (as determined under subsection (2)); and

``(I) the modified adjusted gross income threshold applicable under paragraph (2) of section 1393(i) (including application of paragraphs (4)(A) and (4)(B));

``(II) the applicable percentage determined under paragraph (3)(C) of section 1393(i) (including application of paragraph (5) of such section); and

``(III) The monthly adjustment amount specified in subparagraph (B).

``(F) Collection of Monthly Adjustment Amount.—

``(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related reduction in premium subsidy for an individual for a month 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 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(II) the modified adjusted gross income (as determined under subsection (2)); and

``(iii) the modified adjusted gross income (as determined under subsection (2)); and

``(I) the quotient obtained by dividing—

``(I) the applicable percentage determined under paragraph (3)(C) of section 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;

``(I) the quotient obtained by dividing—

``(I) the applicable percentage determined under paragraph (3)(C) of section 1393(i), determined for the calendar year applicable under subparagraphs (B) and (C) of such section;
for which data is made available under subsection (a) is equal to the reported outlays from the Federal government and the States under such titles during the preceding years.

Title VIII

SECT. 511. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED TO IDENTIFY MEDICARE BENEFICIARIES UNDER THE MEDICARE PROGRAM.

(a) Procedures. — (1) IN GENERAL. — Not later than 1 year after the date of enactment of this Act, in order to protect beneficiaries from identity theft, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual’s social security account number is not used. Such procedures shall provide that the new Medicare beneficiary identifier includes biometric identification protection.

(2) LIMITING EXISTING EIN STRUCTURE. — In order to minimize the impact of the change under paragraph (1) on systems that communicate with Medicare beneficiary eligible individuals, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) PROTECTION AGAINST FRAUD. — The procedures under paragraph (1) shall provide for a process for changing the Medicare beneficiary identifier linked to an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(b) EDUCATION AND OUTREACH. — The Secretary shall establish a program of education and outreach for individuals entitled to benefits under such titles during the preceding years.

(c) DATA MATCHING. — (1) A CCESS TO CERTAIN INFORMATION. — The Secretary shall enter into an agreement with the Commissioner of Social Security (42 U.S.C. 1301 et seq.) to establish procedures to match data in the system of records of the Commissioner for the purpose of matching data in the Secretary’s records.

(2) LIMIT. — The phase-in period under subparagraph (A) shall not exceed 10 years.

(3) NEWLY ENTITLED AND ENROLLED INDIVIDUALS. — The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(4) LIMIT. — The phase-in period under subparagraph (A) shall not exceed 10 years.

(5) BY-PRODUCT. — The Secretary shall refer the investigation to the Inspector General of the Department of Health and Human Services to determine the effectiveness of such implementation.

(6) USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW. — (A) IN GENERAL. — The Secretary shall establish procedures for the use of technology (including front-end, pre-payment, and social security technology databases) to provide real-time data analysis of claims for payment under this title and to implement procedures under this title that could fraud or abuse.

(B) REQUIREMENT FOR PARTICIPATION. — In no case shall a provider of services or supplier who does not meet the requirements under subparagraph (A) participate in the program under this title.

(7) EXPANDED IMPLEMENTATION. — Not later than 24 months after the date of enactment of this subsection, the Secretary shall establish procedures for the implementation of such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services...
and suppliers, including those not in high risk areas designated under paragraph (1).

“(3) COMPETITIVE BIDDING.—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

“(4) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.”

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate to offset the administrative cost of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, to-gether with recommendations for such legislation and administrative action as the Secretary determines appropriate.”

SEC. 514. EDITING ON S-855S MEDICARE ENROLLMENT APPLICATION AND EXEMPTION OF PHARMACISTS FROM SUR- ETY BOND REQUIREMENT.

(a) EDITS ON S-855S MEDICARE ENROLLMENT APPLICATION.—Section 1395(a) of the Social Security Act (42 U.S.C. 1395a(a)) is amended by adding at the end the following new para- graphs:

“(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

“(A) IN GENERAL.—Not later than 1 year after enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

(i) that the National Provider Identifier of the supplier or beneficiary is valid and active;

(ii) that the Medicare identification number of the supplier is valid and active; and

(iii) that the item or service for which the claim for payment was submitted is properly certified, licensed, or accredited.

(b) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, suppliers, or other entities to view information on specialties and the types of items and services each supplier has indicated on the CMS-855S Medicare enrollment application.

“(C) NOTIFICATION OF CLAIM DENIAL AND RE-SUBMISSION.—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

(i) the National Supplier Clearinghouse shall—

(I) provide the provider written notification of the denial, including such information as appropriate certification, licensing, or accredi- tion; and

(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accredi-

and suppliers, including those not in high risk areas designated under paragraph (1).

“(3) COMPETITIVE BIDDING.—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

“(4) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, to-gether with recommendations for such legislation and administrative action as the Secretary determines appropriate.”

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate to offset the administrative cost of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, to-gether with recommendations for such legislation and administrative action as the Secretary determines appropriate.”

SEC. 514. EDITING ON S-855S MEDICARE ENROLLMENT APPLICATION AND EXEMPTION OF PHARMACISTS FROM SUR- ETY BOND REQUIREMENT.

(a) EDITS ON S-855S MEDICARE ENROLLMENT APPLICATION.—Section 1395(a) of the Social Security Act (42 U.S.C. 1395a(a)) is amended by adding at the end the following new para- graphs:

“(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

“(A) IN GENERAL.—Not later than 1 year after enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

(i) that the National Provider Identifier of the supplier or beneficiary is valid and active;

(ii) that the Medicare identification number of the supplier is valid and active; and

(iii) that the item or service for which the claim for payment was submitted is properly certified, licensed, or accredited.

(b) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, suppliers, or other entities to view information on specialties and the types of items and services each supplier has indicated on the CMS-855S Medicare enrollment application.

“(C) NOTIFICATION OF CLAIM DENIAL AND RE-SUBMISSION.—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

(i) the National Supplier Clearinghouse shall—

(I) provide the provider written notification of the denial, including such information as appropriate certification, licensing, or accredi- tion; and

(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with ap-
section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

(B) Establishment of Panel.—Under the system established under paragraph (A), the State shall establish an expert panel to review any disputes concerning injuries allegedly caused by health care providers or health care organizations described in the guidelines described in this paragraph.

(C) COMPOSITION.—

(1) In GENERAL.—An expert panel under this paragraph is composed of 3 medical experts (either physicians or health care professionals) and 3 attorneys to be appointed by the head of the State agency responsible for health.

(2) LICENSURE AND EXPERIENCE.—Each physician or health care professional appointed to an expert panel under clause (1) shall—

(i) be appropriately credentialed or licensed in the State in which the dispute takes place to deliver health care services; and

(ii) typically treat the condition, make the diagnosis, or provide the type of treatment that is under review.

(3) INDEPENDENCE.—

(i) In GENERAL.—Subject to subparagraph (II), each medical expert appointed to an expert panel under this paragraph shall—

(aa) not have a material familial, financial, or professional relationship with a party involved in the dispute reviewed by the panel; and

(bb) not otherwise have a conflict of interest with any such party.

(ii) EXCEPTION.—Nothing in subclause (I) shall be construed to prohibit an individual who has staff privileges at an institution where the treatment involved in the dispute was provided from serving as a member of an expert panel merely on the basis of such affiliation, if the affiliation is disclosed to the parties and the panel.

(iv) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

(i) In GENERAL.—In a dispute before an expert panel that involves treatment, or the provision of items or services—

(aa) a physician, the medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the physician who typically treats the condition, makes the diagnosis, or provides the type of treatment under review; and

(bb) by a health care professional other than a physician, at least two medical experts on the expert panel shall be practicing physicians (allopathic or osteopathic) of the same or similar specialty as the health care professional who typically treats the condition, makes the diagnosis, or provides the type of treatment under review, and, if determined appropriate by the State agency, the third medical expert shall be a practicing health care professional (other than such physician) of such a same or similar specialty.

(ii) PRACTICING DEFINED.—In this paragraph, the term ‘practicing’ means, with respect to a physician who is practicing medicine or other health care professional, that the individual provides health care services to individual patients on average at least 2 days a week.

(v) PEDIATRIC EXPERTISE.—In the case of dispute relating to a child, at least 1 medical expert on the expert panel shall have expertise described in the guidelines described in this paragraph.

(D) DETERMINATION.—After a review, an expert panel shall make a determination as to the liability of the parties involved and the amount of compensation that is paid based on a schedule of compensation developed by the tribunal. Such a schedule shall be in conformity with any determination made under subparagraph (C).

(E) ACCEPTANCE.—If the parties agree to forgo any further action against the health care providers or health care organizations involved.

(2) Failure to accept.—If any party objects to the determination of the expert panel, the dispute shall then be referred to an administrative health care tribunal established by the State involved.

(3) ADMINISTRATIVE HEALTH CARE TRIBUNAL.—

(A) In GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

(ii) ESTABLISHMENT OF EXPERT PANEL.—

(i) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an administrative health care tribunal system under which the provision of items or services described in paragraph (A) is admissible into evidence in any State court proceeding under this subparagraph.

(ii) REQUIREMENTS.—In establishing an administrative health care tribunal under this paragraph, the State shall—

(i) ensure that such tribunals are presided over by special judges with health care expertise; and

(ii) provide for an appeals process toState courts.

(iii) Provision of items or services.—Prior to submitting any dispute described in clause (I) to an administrative health care tribunal under this paragraph, the State shall—

(i) RIGHT TO FILE.—If the State elects not to permit the expert panel under this paragraph to conduct its own reviews of determinations, or if the State elects to permit such reviews but a party is not satisfied with the final decision of the panel after such a review, the party shall have the right to file an action in a State court of competent jurisdiction.

(ii) FORFEIT OF AWARDS.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

(B) ADMINISTRATIVE HEALTH CARE TRIBUNAL.—

(i) In GENERAL.—In a dispute concerning injuries allegedly caused by health care providers or health care organizations that are under review of decisions by State courts.

(ii) FAILURE TO ACCEPT DETERMINATION OF EXPERT PANEL.—

(i) IN GENERAL.—If the state elects to establish an administrative health care tribunal under this subparagraph, the State shall—

(ii) FORFEIT OF AWARD.—Any party filing an action in a State court under clause (i) shall forfeit any compensation award made under subparagraph (C).

(C) COMPOSITION.—

(i) In GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

(ii) LICENSURE AND EXPERIENCE.—Each physician or health care professional appointed to an expert panel under this paragraph shall—

(iii) ADMISSIBILITY.—The determinations of the expert panel pursuant to a review under subparagraph (C) shall be admissible into evidence in any State court proceeding under this subparagraph.

(iii) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the liability of the parties involved and the amount of compensation that is paid based on a schedule of compensation developed by the tribunal. Such a schedule shall be in conformity with any determination made under subparagraph (C).

(i) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

(ii) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party filing an action under subparagraph (D) refuses to accept the panel’s determination, the dispute shall be referred to an administrative health care tribunal under paragraph (D).
“(I) IN GENERAL.—Upon the failure of any party to accept the determination of an expert panel under subparagraph (C), the parties shall request a hearing concerning the liability or compensation involved by an administrative health care tribunal established by the State involved under this subparagraph.

“(ii) REQUIREMENTS.—The provisions of paragraph (3) shall apply with respect to the establishment and operation of an administrative health care tribunal under this subparagraph.

“(iii) FORFEIT OF AWARDS.—Any party proceeding to the second step administrative health care tribunal under this model shall forfeit any compensation awarded by the 
expert panel.

“(iv) ADMISSIBILITY.—The determinations of the expert panel under subparagraph (C) shall be admissible in evidence in any administrative health care tribunal proceeding under this subparagraph.

“(E) RIGHT TO FILE.—Nothing in this paragraph shall be construed to prohibit any individual who is not satisfied with the determination of the tribunal (after having proceeded through both the expert panel under subparagraph (C) and the tribunal under subparagraph (D)) from filing a claim for the injury involved in a State court of competent jurisdiction.

“(F) ADMISSIBILITY.—The determinations of both the expert panel and the tribunal under this paragraph shall be admissible in evidence in an action in State court proceeding under this paragraph.

“(G) FORFEIT OF AWARDS.—Any party filing an action in State court under subparagraph (E) shall forfeit any compensation award made by both the expert panel and the administrative health care tribunal under this paragraph.

“(e) DEFINITIONS.—In this section:

“(1) CURRENT TORT LITIGATION.—The term ‘current tort litigation’ means the tort litigation system existing in the State on the date on which the State submits an application under subsection (b)(1), for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

“(2) HEALTH CARE ORGANIZATION.—The term ‘health care organization’ means any individual or entity that is obligated to provide, pay for, or administer health benefits under any health plan.

“(3) NET ECONOMIC LOSS.—The term ‘net economic loss’ means—

“(A) reasonable expenses incurred for products, services and accommodations needed for health care, training and other remedial treatment and care of an injured individual;

“(B) reasonable and appropriate expenses for rehabilitation treatment and occupational training;

“(C) 100 percent of the loss of income from work that an injured individual would have performed if not injured, reduced by any income from substitute work actually performed; and

“(D) reasonable expenses incurred in obtaining ordinary and necessary services to replace services an injured individual would have performed for the benefit of the individual or the family of such individual if the individual had not been injured.

“(4) DAMAGES.—The term ‘non-economic damages’ means losses for physical and emotional pain, suffering, in-convenience, physical impairment, mental anguish, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), injury to reputation, and all other non-economic losses, whether to a person or to property, to the extent permitted under State law.

“(E) FUNDING.—(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for fiscal year 2013 under section 1902(a) of the Social Security Act (as amended by section 401) for fiscal year 2011 (in addition to the any increase applicable for that fiscal year under section 1903) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396(a) for purposes of carrying out a grant awarded under this Act) but determined without regard to any such increase) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2011 under section 1903(a) of the Social Security Act (42 U.S.C. 1396(a)) for purposes of carrying out a grant awarded under this Act, but determined without regard to any increase attributable for that fiscal year under section 1903.

“(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).

TITLE VII—ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 701. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure for the secure and efficient exchange and use of healthcare information.

SEC. 702. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of this Act, the Secretary of Health and Human Services shall promulgate regulations to provide for the certification and auditing of the banking of electronic medical records.

(b) GENERAL RIGHTS.—An individual who has a health record contained in a health record bank shall maintain ownership over the health record and shall have the right to review the contents of the record.

TITLE VIII—APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS

SEC. 801. IN GENERAL.

Current Federal security and confidentiality standards and State security and confidentiality laws shall apply to this subtitle until such time as Congress acts to amend such standards.

(b) CRIMINAL PENALTIES AND CRIMINAL FORFEITURE.

(1) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for that fiscal year under title XVIII of the Social Security Act (as amended by section 401) for fiscal year 2011 (in addition to any increase applicable for that fiscal year under section 1903) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396(a) for purposes of carrying out a grant awarded under this Act) but determined without regard to any such increase) shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2011 under section 1903(a) of the Social Security Act (42 U.S.C. 1396(a)) for purposes of carrying out a grant awarded under this Act, but determined without regard to any increase attributable for that fiscal year under section 1903.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).

TITLE VII—ELECTRONIC HEALTH INFORMATION TECHNOLOGY

Subtitle B—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL FORFEITURE.

(a) Definitions.—The term ‘‘State security and confidentiality laws’’ means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(b) State Security and Confidentiality Law.—The term ‘‘State security and confidentiality laws’’ means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(c) State.—The term ‘‘State’’ has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

Subtitle C—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL FORFEITURE.

(a) Definitions.—The term ‘‘State security and confidentiality laws’’ means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(b) State.—The term ‘‘State’’ has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL FORFEITURE.

(a) Definitions.—The term ‘‘State security and confidentiality laws’’ means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(b) State.—The term ‘‘State’’ has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).
Secretary, considering the goals and objectives of this section, as well as the goals to better coordinate the delivery of health care and to promote the adoption and use of health information technology.

(c) EFFECTIVE DATE AND EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1320a–7a(b)(4)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in subsections (a) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(d) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBORS ON HEALTH SYSTEM.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system and is accessible to consumers.

(2) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(3) The extent to which the financial or other business relationships between providers under each safe harbor have been changed as a result of the safe harbor in a way that adversely affects or benefits the health care system and is accessible to consumers.

(e) THE IMPACT OF THE ADOPTION OF HEALTH INFORMATION TECHNOLOGY ON THE DELIVERY OF HEALTH CARE SERVICES.

(f) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(1) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 120 days after the date of the enactment of this Act.

(2) PREEMPTION OF STATE LAWS.—No State (as defined in section 1320a–7a(b)(4)) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for a transaction described in subsections (a) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(f) SAFE HARBORS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are:

(A) The safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a); and

(B) the safe harbor under section 1128B(b)(3)(J), as added by subsection (b).

SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN PROFESSIONALS (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1177(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end of the section the following new subparagraph:

"(g) INFORMATION TECHNOLOGY AND TRAINING SERVICES.—

(A) Any nonmonetary remuneration (in the form of health information technology or related installation, maintenance, support or training services) made by a specified entity to a specified individual, if—

(i) the provision of such remuneration is not without an agreement between the parties or legal condition that—

(1) provides the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity.

(2) The impact of the adoption of health information technology on health care quality, cost, and access under the exception.

(3) The extent to which the financial or other business relationships between providers under the exception have been changed as a result of the adoption of health information technology on health care quality, cost, and access under the exception.

SEC. 713. RULES OF CONSTRUCTION REGARDING THE USE OF CONSULTA

(a) APPLICABILITY TO SAFE HARBORS FROM CRIMINAL PENALTIES.—Section 1123b(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended by adding after and below paragraph (3) the following:

"(i) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made under each safe harbor (and, in the case of such remuneration made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and"

(II) limits or restricts the use of the information technology products in order to take into account the varying needs of such providers receiving such products.

(B) APPLICATION TO STARK EXCEPTION.—Paragraph (i) of section 1123b(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is further amended by adding at the end the following new subparagraph:

"(J) Nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from forming a consortium composed of health care providers, payers, employers, and other interested entities to collectively purchase and donate health information technology, or from offering health care providers a choice of health information technology products in order to take into account the varying needs of such providers receiving such products.

TITLE VIII—HEALTH CARE SERVICES
support research, demonstration projects, evaluations, training, guideline development, and the dissemination of information, on health care services and on systems for the delivery of health care services, including activities with respect to—

(1) the effectiveness, efficiency, and quality of health care services;

(2) the outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

SEC. 803. DISSEMINATION.

(a) In General.—The Commissioners shall—

(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the guidelines, standards, and review criteria developed under this title;

(2) promptly make available to the public data developed in such research, demonstration projects, and evaluations; and

(3) as appropriate, provide technical assistance to States and local government and health agencies and conduct liaison activities to such agencies for foster dissemination.

(b) Prohibition Against Restrictions.—Except as provided in subsection (c), the Commissioners may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

(c) Limitation on Use of Certain Information.—No information, if an establishment or person supplying the information or descriptive material, obtained by the course of activities undertaken or supported under this title may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose. Such information may not be published or released in other form if the person who supplied the information or who is described in it is identifiable unless such person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

(d) Certain Interagency Agreement.—The Commissioners and the Director of the National Library of Medicine shall enter into an agreement providing for the implementation of subsection (a)(1).

Subtitle B—Forums for Quality and Effectiveness in Health Care

SEC. 811. ESTABLISHMENT OF OFFICE.

There is established within the Commission an office to be known as the Office of the Forum for Quality and Effectiveness in Health Care. The office shall be headed by a director (referred to in this title as the “Director”) who shall be appointed by the Commissioners.

SEC. 812. MEMBERSHIP.

(a) In General.—The Office of the Forum for Quality and Effectiveness in Health Care shall be composed of 15 individuals nominated by private sector health care organizations and appointed by the Commission and shall include representation from at least the following:

(1) Health insurance industry.

(2) Health care provider groups.

(3) Non-profit organizations.

(4) Patient and family organizations.

(b) Terms.—(1) In General.—Except as provided in paragraph (2), members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve for a term of 5 years.

(2) Staggered Rotation.—Of the members first appointed to the Office of the Forum for Quality and Effectiveness in Health Care, the Commissioners shall appoint 5 members to serve for a term of 2 years, 5 members to serve for a term of 3 years, and 5 members to serve for a term of 4 years.

SEC. 813. DUTIES.

(a) Establishment of Forum Program.—The Commissioner, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care. For the purpose of promoting the development of guidelines, standards, performance measures, and review criteria and to give patients access to such information, the Commissioner shall conduct or support evaluations, training, guideline development and periodic review and updating of standards, performance measures, and medical review criteria through which health care providers and other appropriate entities can review the provision of health care and assure the quality of such care.

(b) Certain Requirements.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) Public Disclosure of Recommendations.—For each fiscal year beginning with 2010, the Director shall make publicly available the following:

(1) Quarterly reports for public comment that include proposed recommendations for guidelines, standards, performance measures, and review criteria under subsection (a) and any updates, guidelines, standards, performance measures, and review criteria.

(2) After consideration of such comments, a final recommendation for guidelines, standards, performance measures, and review criteria that is the final recommendation for such guidelines, standards, performance measures, and review criteria.

(d) Date Certain for Initial Guidelines and Standards.—The Commissioners, by not later than January 1, 2012, shall assure the development of an initial set of guidelines, standards, performance measures, and review criteria under subsection (a).

SEC. 814. ADOPTION AND ENFORCEMENT OF GUIDELINES AND STANDARDS.

(a) Adoption of Recommendations of Forum for Quality and Effectiveness in Health Care.—For each fiscal year, the Commissioners shall adopt the recommendations made for such year in the final report under subsection (d)(2) of section 813 for guidelines, standards, performance measures, and review criteria described in subsection (a) of such section.

(b) Enforcement Authority.—The Commissioners, in consultation with the Secretary of Health and Human Services, have the authority to make recommendations to the Secretary to enforce compliance of health care providers with the guidelines, standards, performance measures, and review criteria adopted under subsection (a). Such recommendations may include the following, with respect to a health care provider who is not in compliance with such guidelines, standards, performance measures, and review criteria:

(1) Exclusion from Federal participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)));

(2) Impose a civil money penalty on such provider.

SEC. 815. ADDITIONAL REQUIREMENTS.

(a) Program Agenda.—The Commissioners shall provide for an agenda for the development of the guidelines, standards, performance measures, and review criteria described in section 813(a), including with respect to the standards, performance measures, and review criteria, identifying specific aspects of health care for which the standards, performance measures, and review criteria are to be developed and the criteria to be given priority in the development of the standards, performance measures, and review criteria.

Subtitle C—General Provisions

SEC. 821. CERTAIN ADMINISTRATIVE AUTHORITIES.

The Commissioners, in carrying out this title, may accept voluntary and uncompensated services.

SEC. 822. FUNDING.

For purposes of carrying out this title, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 823. DEFINITIONS.

For purposes of this title:

(1) the term “Commissioners” means the Commissioners of the Health Care Services Commission.

(2) the term “Commission” means the Health Care Services Commission.

(3) the term “Director” means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.

(4) the term “Secretary” means the Secretary of Health and Human Services.

Subtitle D—Terminations and Transition

SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

As of the date of the enactment of this Act, the Agency for Healthcare Research and Quality is terminated, and title IX of the Public Health Service Act is repealed.

SEC. 832. TRANSITION.

(1) Exclusions from contracts, grants, and agreements. —Exclusions from contracts, grants, and agreements of the Agency for Healthcare Research and Quality that are effective as of the date before the date of the enactment of this Act, shall be transferred to the Secretary and shall continue in effect according to their terms unless otherwise changed pursuant to law.

Subtitle E—Independent Health Record Trust Act

SEC. 841. SHORT TITLE.

This subtitle may be cited as the “Independent Health Record Trust Act of 2009.”

SEC. 842. PURPOSE.

The purpose of this subtitle is to provide for the establishment of a nationwide health information technology network that—
(1) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services; (2) improves Disease Prevention Services, and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of the individual; (3) ensures that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location the medical service involved is provided; (4) produces greater value for health care expenditures by reducing health care costs that result from inefficient, medical errors, inappropriate care, and incomplete information; (5) promotes a more effective marketplace, greater competition, greater systems analysts, increased choice, enhanced quality, and improved outcomes in health care services; and (6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health information; and (7) supports health information privacy, security, and confidentiality of individually identifiable health information is protected.

SEC. 844. DEFINITIONS

In this subtitle:

(1) ACCESS.—The term "access" means, with respect to an electronic health record, entering information into such account as well as retrieving information from such account.

(2) ACCOUNT.—The term "account" means an electronic health record of an individual contained in an independent health record trust.

(3) AFFIRMATIVE CONSENT.—The term "affirmative consent" means, with respect to an individual, the selection of the form of affirmative consent (as described in section 1171(6) of the Social Security Act (42 U.S.C. 1320d(6))).

(4) AUTHORIZED EHR DATA USER.—The term "authorized EHR data user" means, with respect to an individual, an authorized user of the electronic health records of an individual, including a physician, health care provider, IHRT participant, individual, or any other individual authorized by the individual to access such records.

(5) BE HELD IN TRUST BY IHRT.—With respect to information that is entered by an authorized EHR data user pursuant to standards prescribed by the Federal Trade Commission for the protection of such information, the term "be held in trust by IHRT" means, with respect to an electronic health record of an IHRT participant, the obligation of those who receive such information to respect the health information privacy and security of such individual.

(6) CERTIFICATION.—The term "certification" means a determination, made by an entity, that a vendor, electronic health record, or other part of the electronic health record structure satisfies the certification requirements of this section.

(7) ELECTRONIC HEALTH RECORD.—The term "electronic health record" means a longitudinal, digital collection of information concerning an individual during the course of health care provided by physicians and personal health information, that is stored electronically.

(8) ELECTRONIC HEALTH RECORD TRUSTS.—The terms "independent health record trust" and "IHRT" mean a legal arrangement that is responsible for the administration and operation of the IHRT in accordance with this subtitle.

(9) ELECTRONIC HEALTH RECORD TRUST/by any authorized EHR data user (or specified parts of such electronic health record) for purposes of amending such information.

(10) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" means, with respect to an individual, health information; and (11) IHRT OPERATOR.—The term "IHRT operator" means, with respect to an IHRT, the organization that is responsible for the administration and operation of the IHRT.

(12) IHRT.—The term "IHRT" means an independent health record trust by any authorized EHR data user (or specified parts of such electronic health record) for purposes of amending such information.

(13) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term "individually identifiable health information" means, with respect to an electronic health record of an IHRT participant, any information that is individually identifiable health information of an individual, the obligation of those who receive such information to respect the health information privacy and security of such individual.

(14) SECURITY.—The term "security" means, with respect to an individual, the protection of the health information of the individual, the obligation of those who receive such information to respect the health information privacy and security of such individual.

(15) STANDARDS.—The term "standards" means, with respect to an individual, the standards promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

(16) THIRD PARTY.—The term "third party" means any entity (other than the participant or an IHRT) that is responsible for the administration and operation of an IHRT or IHRT participant.

(17) VENDOR.—The term "vendor" means a vendor of an electronic health record system as defined in section 842a of this title.
(iii) **Identification of Information Entered by Participant.**—Any additions or amendments made by the participant to the health record shall be identified and disclosed within such record as being made by such participant.

(b) **Access by Entities Other Than IHRT Participants.**—(1) **Authorized Access Only.**—Except as provided under subparagraph (C) and paragraph (4), access to the electronic health record (or any portion of the record) shall be permitted by authorized EHR data users and only to such portions of the record as specified by the participant; and

(2) **Limited by the Participant for Purposes of Entering Information into Such Record,** retrieving information from such record, or both.

(i) **Identification of Entity That Enters Information.**—Any information that is added by an authorized EHR data user to the health record shall be identified and disclosed within such record as being made by such user.

(ii) **Satisfaction of HIPAA Privacy Regulations.**—In the case of a record of a covered entity, any additions or amendments to such record shall be made in accordance with the HIPAA privacy regulations, with respect to an individual, if such individual is an IHRT participant with an independent health record and trust agreement with an authorized EHR data user, the requirements under the HIPAA privacy regulations for such entity to provide the record to the participant shall be deemed satisfied if provided by such entity without charge to the IHRT or the participant—

(I) forwards to the trust an appropriately formatted electronic copy of the record (and updates to such records) for inclusion in the electronic health record of the participant maintained by the trust;

(II) enters such record into the electronic health record of the participant so maintained; or

(III) otherwise makes such record available for electronic access by the IHRT or the individual in a manner that permits such record to be included in the account of the individual contained in the IHRT.

(iv) **Notification of Sensitive Information.**—Any information, with respect to the participant, that is sensitive information, as specified by the Federal Trade Commission, shall be made only by authorized EHR data users and only to such portions of the record as specified by the participant; and

(v) **Limited by the Participant.**—Any additions or amendments to such record that includes the use of unique provider identifiers;

(vi) **Payment Information.**—(A) the transfer is authorized by the participant pursuant to an agreement between the participant and the IHRT and is in accordance with the privacy protection agreement described in subsection (a); (B) the transfer is made only by authorized EHR data users and only to such portions of the record as specified by the participant; and

(b) **Privacy Protection Agreement; Treatment of State Privacy and Security Laws.**—(1) **Privacy Protection Agreement.**—Nothing in this paragraph shall be construed as prohibiting or limiting the use of health care information of an individual, including an individual who is an IHRT participant, for public health reporting (or other research) purposes prior to the inclusion of such information in an electronic health record maintained by an IHRT.

(2) **Law Enforcement Clarification.**—Nothing in this paragraph shall prevent an IHRT from disclosing information contained in an electronic health record maintained by the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.

(5) **Rule of Construction.**—Nothing in this section shall be construed to require a health care provider that does not utilize electronic health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a requirement for participation or compliance under this subtitle.

(6) **Privacy Protection Agreement; Treatment of State Privacy and Security Laws.**—(1) **Privacy Protection Agreement.**—A privacy protection agreement described in subsection (b) of this section is an agreement, with respect to an electronic health record of an IHRT participant to be maintained by an independent health record trust, between the participant and the trust—

(A) that is consistent with the standards described in subsection (a)(2); and

(B) under which the participant specifies the circumstances under which portions of the record may be accessed, under what circumstances such portions may be accessed, any authorization for indicated authorized EHR data users to access information contained in the record, and the purposes for which the information (or portions of the information) in the record may be used;

(2) **Provision for the Authorization of the Transfer of Information Contained in the Record to a Third Party.**—In the case of a record of a covered entity, the participant may limit the purposes for which an authorized EHR data user and such third party, including for the purpose of research, by an authorized EHR data user and such third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant.

(3) **Provisions for the Authorization of the Participation of the Trust and IHRT in an Electronic Health Record.**—In the case of an electronic health record of an IHRT participant, the IHRT may provide such record to the trust as permitted under paragraph (2) if the trust and IHRT enter into the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.

(7) **Privacy Protection Agreement; Treatment of State Privacy and Security Laws.**—(1) **Privacy Protection Agreement.**—Nothing in this section shall be construed to require a health care provider that does not utilize electronic health information technology on the date of the enactment of this Act to adopt such electronic methods or technology as a requirement for participation or compliance under this subtitle.

(2) **Provision for the Authorization of the Transfer of Information Contained in the Record to a Third Party.**—In the case of a record of a covered entity, the participant may limit the purposes for which a third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant.

(3) **Provisions for the Authorization of the Participation of the Trust and IHRT in an Electronic Health Record.**—In the case of an electronic health record of an IHRT participant, the IHRT may provide such record to the trust as permitted under paragraph (2) if the trust and IHRT enter into the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.

(4) **Provision for the Authorization of the Transfer of Information Contained in the Record to a Third Party.**—In the case of a record of a covered entity, the participant may limit the purposes for which a third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant.

(5) **Provision for the Authorization of the Participation of the Trust and IHRT in an Electronic Health Record.**—In the case of an electronic health record of an IHRT participant, the IHRT may provide such record to the trust as permitted under paragraph (2) if the trust and IHRT enter into the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.

(6) **Provision for the Authorization of the Transfer of Information Contained in the Record to a Third Party.**—In the case of a record of a covered entity, the participant may limit the purposes for which a third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant.

(7) **Provision for the Authorization of the Participation of the Trust and IHRT in an Electronic Health Record.**—In the case of an electronic health record of an IHRT participant, the IHRT may provide such record to the trust as permitted under paragraph (2) if the trust and IHRT enter into the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.

(8) **Provision for the Authorization of the Transfer of Information Contained in the Record to a Third Party.**—In the case of a record of a covered entity, the participant may limit the purposes for which a third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant.

(9) **Provision for the Authorization of the Participation of the Trust and IHRT in an Electronic Health Record.**—In the case of an electronic health record of an IHRT participant, the IHRT may provide such record to the trust as permitted under paragraph (2) if the trust and IHRT enter into the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.

(10) **Provision for the Authorization of the Transfer of Information Contained in the Record to a Third Party.**—In the case of a record of a covered entity, the participant may limit the purposes for which a third party, including a provision requiring that such transfer and reuse is not in violation of any privacy or transfer restrictions placed by the participant on the independent health record of such participant.

(11) **Provision for the Authorization of the Participation of the Trust and IHRT in an Electronic Health Record.**—In the case of an electronic health record of an IHRT participant, the IHRT may provide such record to the trust as permitted under paragraph (2) if the trust and IHRT enter into the IHRT when required for purposes of a lawful investigation proceeding inquiring into a violation of, or failure to comply with, any criminal or civil statute or regulation, rule, or order issued pursuant to such a statute.
(b) Prohibition Against Access Fees for Health Care Providers.—For purposes of providing incentives to health care providers to access information maintained in an IHRT, as authorized by the IHRT participants involved, the IHRT may not charge a fee for services specified by the IHRT. Such services shall include the transmission of information related to the health care of patients, or other specified information by which the standardized collection and transmission of individual health records (or portions of such records) to authorized EHR data users through a common interface and for the portability of such records among independent health record trusts; and

(c) Required Disclosures.—The sources and amounts of revenue derived under subsection (a) for the operations of an IHRT shall be available to such IHRT participants of such IHRT and to the public.

(d) Treatment of Income.—For purposes of the Internal Revenue Code of 1986, any revenue described in subsection (a) shall not be included in gross income of any IHRT, IHRT participant, or authorized EHR data user.

SEC. 409. REGULATORY OVERSIGHT

(a) In General.—In carrying out this subtitle, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

(b) Establishment of Interagency Steering Committee.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

(2) CHAIRPERSON.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.

(3) MEMBERSHIP.—The members of the Interagency Steering Committee shall consist of the Attorney General, the Chairperson of the Federal Trade Commission, the Chairperson for the National Committee for Vital and Health Statistics, a representative of the Federal Reserve, and other Federal officials determined appropriate by the Secretary of Health and Human Services.

(4) DUTIES.—The Interagency Steering Committee shall coordinate the implementation of this title, including the implementation of policies described in subsection (b) based upon the recommendations provided under such subsection, and regulations promulgated under this subtitle.

(c) Federal Advisory Committee.—

(1) IN GENERAL.—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 80 percent of such membership shall consist of representatives of non-government entities, at least one of whom shall be a representative from an organization representing health care consumers.

(2) DUTIES.—The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs.

(d) Policies Promulgated by Federal Trade Commission.—The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics, shall promulgate policies to:

(1) Provide assistance to encourage the growth of independent health record trusts;

(2) Track economic progress as it pertains to the establishment of health record trusts and individuals receiving nontaxable income with respect to accounts;

(3) Conduct public education activities regarding the creation and usage of the independent health record trusts;

(4) Establish standards for the interoperability of technology or to ensure that information contained in such record may be shared between the trust involved, the participant, and authorized EHR data users through a common interface and for the portability of such records among independent health record trusts; and

(5) carry out any other activities determined appropriate by the Federal Trade Commission.

(e) Regulations Promulgated by Federal Trade Commission.—The Federal Trade Commission shall promulgate regulations based on, at a minimum, the following factors:

(1) Requiring that an IHRT participant, who has an electronic health record that is maintained by an IHRT, be notified of a security breach with respect to such record, and any corrective action taken on behalf of the participant.

(2) Requiring that information sent to, or received from, an IHRT that has been determined as highly authenticated through the use of methods such as the periodic changing of passwords, the use of biometrics, the use of tokens or other technology as determined appropriate by the Council.

(3) Requiring a delay in releasing sensitive health care test results and other similar information in order to give physicians time to contact the patient.

(4) Recommendations for entities operating IHRTs, including requiring analysis of the potential risk of health transaction security breaches based on set criteria.

(5) The conduct of audits of IHRTs to ensure that they are in compliance with the requirements and standards established under this subtitle.

(6) Disclosure to IHRT participants of the means by which such trusts are financed, including revenue from the sale of patient data.

(7) Prevention of certification of an entity seeking certification of a health record trust certification on—

(A) the potential for conflicts between the interests of such entity and the security of the health information maintained by such entity;

(B) the involvement of the entity in any activity that is contrary to the best interests of a patient.

(8) Prevention of the use of revenue sources that are contrary to a patient’s interests.

(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

(10) Requiring notification to a participating entity that the information contained in such record may not be representative of the complete and accurate electronic health record of such account holder.

(11) COMPLIANCE REPORT.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commission shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Education, Labor, and Pensions of the House of Representatives, a report on compliance by and progress of independent health record trusts with this subtitle. Such report shall describe the following:

(A) The number of complaints submitted about each IHRT participant, which shall be divided by complaints related to security breaches, and complaints not related to security breaches, and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(B) The number of enforcement actions undertaken by the Commission against independent health record trusts in response to complaints under paragraph (1), which shall include security breaches and enforcement actions not related to security breaches and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(2) The economic progress of the individual organizations, institutions, or other entities authorized by this Act through independent health record trust usage and existing barriers to such usage.

(4) The progress in security auditing as provided for by the Interagency Steering Committee and under subsection (b).

(5) The other core responsibilities of the Commission as described in subsection (a).

(f) Interagency Memorandum of Understanding.—The Interagency Steering Committee shall ensure, through the execution of an interagency memorandum of understanding—

(1) regulations, rulings, and interpretations issued by Federal officials relating to matters over which such officials have responsibility under this subtitle are administered so as to have the same effect at all times; and

(2) provides for the coordination of policies related to enforcing the same requirements through such officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE IX—MISCELLANEOUS

SEC. 901. HEALTH CARE FOR VETERANS.

Beginning not later than 2 years after the date of the enactment of this Act, the Secretary of Veterans Affairs may—

(1) permit veterans, and survivors and dependents of veterans, who are eligible for health care and services under the laws administered by the Secretary to receive such care and services through such non-Department of Veterans Affairs providers and facilities as the Secretary may approve for purposes of this section; and

(2) pursuant to such procedures as the Secretary of Veterans Affairs shall prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to veterans, and such survivors and dependents, at such rates as the Secretary may specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

SEC. 902. HEALTH CARE CHOICE FOR INDIGENS.

(a) In General.—Beginning not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services shall—

(1) permit Indians who are eligible for health care and services under a health care program operated or financed by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (and any such other individuals who are so eligible as the Secretary may specify), to receive such care and services through such non-Department of Veterans Affairs, Indian Tribal Organization, Tribal Organization, or Urban Indian Organization providers and facilities as the Secretary shall approve for purposes of this section, in the same manner as veterans and dependents of veterans under section 901 of this Act.

(b) Pursuant to such procedures as the Secretary of Health and Human Services shall—
prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to Indians and individuals described in paragraph (1), and the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

SEC. 903. TERMINATION OF FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

The Federal Coordinating Council for Comparative Effectiveness Research is hereby terminated and section 804 of the American Recovery and Reinvestment Act of 2009 establishing and funding such Council is hereby repealed.

SEC. 904. HIS AND GAO JOINT STUDY AND REPORT ON COSTS OF THE 5 MEDICAL CONDITIONS THAT HAVE THE GREATEST IMPACT.

(a) STUDY.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) and the Comptroller General of the United States (in this section referred to as the “Comptroller General”) shall jointly conduct a study on the costs of the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost. Such study shall include—

(1) current estimates as well as a “generational score” to capture the cost and health toll of certain medical conditions will inflict on the baby boomer generation and on other individuals; and

(2) a careful review of certain medical conditions, including heart disease, obesity, diabetes, stroke, cancer, Alzheimers, and other medical conditions the Secretary and Comptroller General determine appropriate.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Comptroller General shall jointly submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative actions as the Secretary and the Comptroller General determine appropriate.

SEC. 905. CONSCIENCE PROTECTION.

(a) IN GENERAL.—None of the funds made available in this Act (or an amendment made by this Act) may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) HEALTH CARE ENTITY.—In this section, the term “health care entity” shall include an institutional or individual health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsored by a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or plan.

SEC. 906. NONDISCRIMINATION ON ABDUCTION AND TREATMENT FOR RIGHTS OF CONSCIENCE.

(a) NONDISCRIMINATION.—A Federal agency or program, and any State or local government, or institutional or individual health care entity that receives Federal financial assistance under this Act (or an amendment made by this Act), shall not—

(1) subject an individual or institutional health care entity to discrimination; or

(2) require any health care entity that is established or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination; or

(b) DEFINITION.—In this section, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsored by a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or plan.

SEC. 907. PROHIBITION ON GOVERNMENT ENTITIES USING COMPARATIVE EFFECTIVENESS RESEARCH FOR CERTAIN PURPOSES.

Comparative effectiveness research and clinical guidelines established and recommendations for such legislation and administrative actions as the Secretary and the Comptroller General determine appropriate.

(c) TARGETING OF PREVENTION AND TREATMENT RECOMMENDATIONS FOR PREVENTIVE HEALTH SERVICES, INCLUDING MAMMOGRAMS AND CERVICAL CANCER SCREENING.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary of Health and Human Services under this Act (or an amendment made by this Act) shall be reinvested into the Federal Hospital Insurance Trust Fund, and the Medicare trust fund under section 1817 of the Social Security Act (42 U.S.C. 1395f), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395c).

SEC. 908. SOLENOLOGY OF MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary of Health and Human Services under this Act (or an amendment made by this Act) shall be reinvested into the Federal Hospital Insurance Trust Fund, and the Medicare trust fund under section 1817 of the Social Security Act (42 U.S.C. 1395f), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395c).

SEC. 909. TO ENSURE PATIENTS RECEIVE DOC willing or permitted to care for patients insured by each program; (2) any restrictions, denials, or rationing relating to the provision of services, including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies; (3) average wait times to see a primary care doctor; (4) average wait times for medically necessary surgeries and medical procedures; and (5) the estimated waste, fraud, and abuse (including improper payments) in each program.

(b) PROGRAMS.—The programs referred to in subsection (a) are—

(1) Medicare; (2) Medicaid; (3) the Federal Employees Health Service; (4) the Department of Veterans Affairs; and (5) the Federal Employee Health Benefits Program.

SEC. 912. USING HEALTH CARE PROFESSIONALS TO REDUCE FRAUD.

(a) IN GENERAL.—The Secretary of Health and Human Services referred to in this section as the “Secretary” shall establish a demonstration project that uses practicing health care professionals to conduct underwriting and investigations of other health care professionals.

(b) DEMONSTRATION PROJECT.—(1) IN GENERAL.—The Secretary, in coordination with the Office of the Inspector General of the Department of Health and Human Services referred to in this section as the “Inspector General”), shall establish a demonstration project in which the Secretary enters into contracts with practicing health care professionals to conduct investigations of health care providers that may be directed to reduce fraud.

(2) SCOPE.—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud;
(B) any level of Medicaid fraud.

(c) Eligibility.—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) Activities.—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) Follow-up by the Inspector General.—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) Limitation.—The Secretary shall not contract with a health care professional if, due to physical proximity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) Funding.—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, $500,000 for each of fiscal years 2010 through 2014.

ADJOURNMENT UNTIL 1 P.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 1 p.m. tomorrow.

There upon the Senate, at 5:34 p.m., adjourned until Sunday, December 20, 2009, at 1 p.m.