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

ADDITIONAL COSPONSORS S. 565

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

AMENDMENT NO. 3065

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

AMENDMENT NO. 3076

At the request of Mr. DURBIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a 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.

AMENDMENT NO. 3077

At the request of Mr. DURBIN, the name of the Senator from Illinois (Mr. BAUCUS) as a co-sponsor of amendment No. 3077 intended to be proposed to H.R. 3590, a bill to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes.

AMENDMENTS SUBMITTED AND PROPOSED

SA 3286. Mr. REID proposed an amendment to the bill H.R. 3590, supra.

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

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

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

SA 3276. Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) proposed an amendment to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

(1) EFFECTIVE DATE.—The amendments made by subsection (h) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

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

SUBTITLE A—Provisions Relating to Title I

SEC. 1001. AMENDMENTS TO SUBTITLE A.

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

"SEC. 2711. NO LIFETIME OR ANNUAL LIMITS.

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

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

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

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

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

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

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

"SEC. 2715A. PROVISION OF ADDITIONAL INFORMATION.

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

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

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

“(a) In General.—A group health plan (other than a self-insured plan) shall satisfy the requirements of section 105(b)(2) of the Internal Revenue Code relating to prohibition on discrimination in favor of highly compensated individuals.

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

‘(1) CERTAIN RULES TO APPLY.—Rules similar to the rules contained in paragraphs (3), (4), and (5) of section 105(h) of such Code shall apply.

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

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

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

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

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

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

‘(A) the presence or storage of a lawfully possessed firearm or ammunition in the residence on the premises of an individual; or

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

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

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

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

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

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

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

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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 on, any information provided to enrollees under this section available to the public on

(5) LIMITATION ON DATA COLLECTION REQUIREMENTS FOR INDIVIDUALS.—No individual shall be required to disclose any information under this section about an explanation of the nature of such

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

``SEC. 2718. BRINGING DOWN THE COST OF HEALTH CARE COVERAGE.
``(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, submit to the Secretary a report concerning the ratio of the incurred loss (or incurred claims) plus the loss adjustment expense (or change in contract reserves) to earned premiums. Such report shall include the percentage of total premium revenue, after accounting for collections or receipts for risk adjustment and risk corridors and payments of reinsurance, that such coverage expenditures—

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

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

``(3) on all other non-claims costs, including all 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 PAYOUTS.—
``(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—
``(A) REQUIREMENT.—Beginning not later than 1 year before the beginning of the plan year, a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan) shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage 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 (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 70256, and 1393 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 Health and Human Services for such issuers.

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

``(1) shall comply with the applicable State external review process for such plans and procedures set forth in such applicable law (as in existence on the date of enactment of this section), and shall update such process in accordance with any standards established by the National Association of Insurance Commissioners and is binding on such plans; or

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

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

``(B) if the plan is a self-insured plan that is subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)),

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

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

``SEC. 2719A. PATIENT PROTECTIONS.
``(a) CHOICE OF HEALTH CARE PROVIDER.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, requires or prohibits designation by a participant, beneficiary, or enrollee of a participating primary care provider who is available to accept such individual.

``(b) COVERAGE OF EMERGENCY SERVICES.—Under a group health plan, or a health insurance issuer offering group or individual health insurance issuer, provides

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(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) 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 or providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

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

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

(B) ‘‘emergency services’’ means—

(i) services provided to a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage that—

(1) requires, described in this paragraph is a group health plan, or health insurance issuer described in paragraph (2) shall—

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

(B) requires the designation by a participating primary care provider.

(2) 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 or providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

C. DELAYED EFFECT.

SEC. 10103. AMENDMENTS TO SUBTITLE C.

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

(1) in the matter preceding clause (i), by striking ‘‘group health benefits plan and in

in ‘‘group benefits plan providing health benefits’’; and

(2) in clause (i)(I), by inserting ‘‘or any agency or instrumentality of any of the fore

before the closing semicolon.

(b) Section 1103(a)(1) of this Act is amended—

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

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

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

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

(i) a single disease or condition; or

(ii) an unreasonably limited set of diseas

es or conditions (as determined by the Secretary).

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

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

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

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

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 49 of the Internal Revenue Code of 1986 (as added by section 1221), and other information specifically for small busin

esses regarding affordable health care options.

SEC. 10102. AMENDMENTS TO SUBTITLE B.

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

(1) in the matter preceding clause (i), by striking ‘‘group health benefits plan and in

in ‘‘group benefits plan providing health benefits’’; and

(2) in clause (i)(I), by inserting ‘‘or any agency or instrumentality of any of the fore

before the closing semicolon.

(b) Section 1103(a)(1) of this Act is amended—

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

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

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

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

(i) a single disease or condition; or

(ii) an unreasonably limited set of diseas

es or conditions (as determined by the Secretary).

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

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

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

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

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 49 of the Internal Revenue Code of 1986 (as added by section 1221), and other information specifically for small busin

esses regarding affordable health care options.
this Act, is amended by inserting “other than self-insured group health plans offered in such market” after “such market”.

(b) Section 2708 of the Public Health Service Act, as added by section 2708 of the Public Health Service Act, is amended by redesigning section 2708, as added by section 4(d), as follows:

2709. COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIAL

“(a) COVERAGE.—

(1) IN GENERAL.—If a group health plan or a health insurance issuer offering group or individual health insurance coverage provides medical and scientific information established by the Secretary, in coordination with the Secretary, in conducting the study under subsection (a), the individual participating in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

(2) ROUTINE PATIENT COSTS.—

(A) Inclusion.—For purposes of paragraph (1), the term ‘qualified individual’ includes medical and scientific information established by the Secretary, in coordination with the Secretary, in conducting the study under subsection (a), the individual participating in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

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

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

(3) USE OF IN-NETWORK PROVIDERS.—If one or more participating providers is participating in an approved clinical trial according to paragraph (1) shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial in such a participating provider if the provider network unless out-of-network benefits are otherwise provided under the plan or coverage.

(4) 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:

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

(i) The National Institutes of Health.

(ii) The Centers for Disease Control and Prevention.

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

(iv) The Centers for Medicare & Medicaid Services.

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

(C) A qualified non-governmental research entity identified in the guidelines issued by the Agency for Healthcare Research and Quality.

(2) Conditions for Departmen.

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

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

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

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

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

(3) Life-Threatening condition defined.—In this section, the term ‘life-threatening condition’ means a condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

(4) Construction.—Nothing in this section shall be construed to limit a plan’s or issuer’s coverage with respect to clinical trials.

(5) Application to FEHBP.—Notwithstanding any provision of section 89 of title 5, United States Code, this section shall apply to health benefits under the program under such chapter.

(6) Preemption.—Notwithstanding any other provision of this Act, nothing in this Act shall be construed to require a clinical trials policy for State regulated health insurance plans that is in addition to the policy required under this section.

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

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

(2) by adding at the end the following:

(3) Application of certain provisions.—The provisions of section 1262 of the Public Health Service Act (as added by subtitle A) shall apply to grandfathered health plans for plans years beginning on or after the date of enactment of this Act.

(e) Section 1253 of this Act is amended—

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

(i) by redesigning section 1253 as section 1252; and

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

1254. STUdy of large group market.

“(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study of the extent that self-funded and self-insured group health plans of large market employers—

(i) compare the characteristics of employers (including industry, size, and other characteristics) to non-self-funded employers (including information on assets, liabilities, contributions, investments, and expenses).

(ii) collect information on the extent that employers reduce health benefits during economic downturns; and

(iii) evaluate the extent that plans scale back health benefits during economic downturns (to evaluate the extent that plans scale back health benefits during economic downturns, and the impact of the limited coverage on costs for enrollees and employers).

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

(1) the extent to which self-funded group health plans can offer less costly coverage;

(2) the extent to which self-funded 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;

(3) the extent to which self-funded 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;

(4) the extent to which self-funded 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;

(5) the extent to which self-funded 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; and

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

SEC. 10104. AMENDMENTS TO SUBTITLE D

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

``(2) INCLUSION OF CO-OP PLANS AND MULTI-STATE QUALIFIED HEALTH PLANS.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under section 1322, and a multi-State plan under section 1341, unless specifically provided for otherwise.

(b) Section 1322 of this Act is amended—

(1) by striking paragraphs (5)(B)(ii), (6)(B)(ii), and (7)(B)(ii); and

(2) by striking subsections (b), (c), and (d).

(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, including a multi-State plan, offered through the CO-OP program, under section 1322, and a multi-State plan under section 1341, unless specifically provided for otherwise.

``(2) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

``(A) IN GENERAL.—A State may elect to prohibit abortion coverage in qualified health plans, including a multi-State plan, under section 1322, and a multi-State plan under section 1341, unless specifically provided for otherwise.

``(B) SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.—

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

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

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

``(B) ABORTION SERVICES.

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

``(ii) ABORTION COVERAGE IS ALLOWED.—The services described in this clause are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

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

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

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

``(ii) Any cost-sharing reduction under section 1442 of the Patient Protection and Affordable Care Act.

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

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

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

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

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

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

``(D) SPECIAL RULES.—

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

``(2) ALLOCATION ACCOUNTS.—The issuer of a plan to which subparagraph (A) applies shall—

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

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

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

``(i) IN GENERAL.—Subject to clause (ii), State health insurance commissioners shall ensure that health plans comply with the segregation requirements in this subsection through the segregation of plan funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Government Accountability Office.

``(ii) REPORTING.—State health insurance commissioners shall report to the Secretary of the Treasury the amounts in the separate accounts established under paragraph (A), and the amount (if any) of the advance payment of the credit under section 36B of the Patient Protection and Affordable Care Act.
appropriately by the Secretary.

(e) Section 1311(d) of this Act is amended—
(1) in paragraph (3)(B), by striking clause (i) and inserting the following:

(ii) and inserting the following:

(iii) other information as determined appropriate by the Secretary.

(f) Subsection (a) of section 1324(a) of this Act is amended—
(1) in paragraph (2), by redesignating paragraph (4) as paragraph (5); and

(2) by adding at the end the following:

(5) COST SHARING TRANSPARENCY.—The Exchange shall require health plans seeking certification as qualified health plans to disclose to the Secretary, the Exchange, the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, solvency regulations, and other similar State laws that may apply. In promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, taking into consideration any appropriate State reserve requirements, solvency regulations, and requirements of any applicable Federal law. Such loans and grants must be repaid in a State to provide for such repayment prior to awarding such loans and grants.

(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) ADMINISTRATION.—The Director shall

(5) REPAYMENT OF LOANS AND GRANTS.—Not later than July 1, 2013, and prior to awarding loans and grants under the CO-OP program, the Secretary shall promulgate regulations with respect to the repayment of such loans and grants in a manner that is consistent with State solvency regulations and other similar State laws that may apply.
meet the terms and conditions defined by the Director with respect to the elements described in subparagraphs (A) through (D) of paragraph (4).''

(4) AFFIRMATIVE ACONTRUCTION 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 under such plan that does not provide coverage of services described in section 1323(b)(1)(B)(i).

(5) APPROVAL OF CONTRACT.—Approval of a contract under subsection (b) shall include consideration of whether the contract is consistent with this section, including the terms and conditions of the program described in this section. A significant percentage of the members of such board shall be comprised of enrollees in a multi-State qualified health plan, or representatives of such enrollees.

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

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

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

(b) Section 1341 of this Act is amended—

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

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

(3) in subsection (c)(1)(A), by striking “and small group markets” and inserting “market”;

SEC. 10165. AMENDMENTS TO SUBTITLE B OF TITLE XXVII OF THE PUBLIC HEALTH SERVICE ACT

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

(b) Section 36B(c)(1)(A) of the Internal Revenue Code of 1986, as added by section 1401(a) of this Act, is amended by inserting “equals or 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 striking “subparagraph (b)(3A)(ii)” and inserting “subsection (b)(3A)(i)’’.

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

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**S.13497**

**DECEMBER 19, 2009**

**CONGRESSIONAL RECORD — SENATE**

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

> **SEC. 1416. STUDY OF GEOGRAPHIC VARIATION IN COST OF COVERAGE.**

> (1) IN GENERAL.—The Secretary shall conduct a study to examine the feasibility and impact of adjusting the application of the Federal Premium Assistance Program (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 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and shall include such recommendations as the Secretary determines appropriate.

> (b) INCLUSION OF TERRITORIES.—

> (1) IN GENERAL.—The Secretary shall ensure that the study under subsection (a) covers the territories of the United States and that special attention is paid to the disparity that exists among poverty levels and the cost of living in such territories and to the impact of such disparity on efforts to expand health coverage and ensure health care for all who choose to self-insure, which increases financial risks to households and medical providers.

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

> (A) The requirement regulates activity that is commercial and economic in nature: the decisions and actions of individuals to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the provisions of this Act, will improve financial security for families.

> (B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to be $4,700,000,000,000 in 2019. Private health insurance, which was $90,000,000,000 in 2008. To pay for this cost, health care providers, employers, and individuals will pass on the cost to private insurers, who are insured.

> (C) The requirement, together with the other provisions of this Act, will significantly reduce the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce the number of the uninsured, the requirement, together with the other provisions of this Act, will significantly reduce the number of the uninsured.

> (D) Administrative costs for private health insurance, which were $90,000,000,000 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, such economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce the administrative costs and lower health insurance premiums. The requirement will be expected to significantly increase the health insurance markets that do not require underwriting and eliminate its associated administrative costs.

> (e) Section 5000A(c)(3) of the Internal Revenue Code of 1986, as added by section 1501(b)(1) of this Act, is amended by striking "$350" and inserting "$495.

> (f) Part I of subtitle E of title I of this Act which certifies that such individual is—

> (G) 62 percent of all personal bank-ruptcies 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.
Section 1503. SMALL BUSINESS PROCUREMENT

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

SEC. 10018. FREE CHOICE VOUCHERS.

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

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

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

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

(3) 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 employee—

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

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

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

(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 by such employer;

(2) INDEXING.—In the case of any calendar year beginning after 2014, the Secretary shall adjust the $240,000 level of subparagraph (A) by section 1412(b)(1)(B) (as added by section 1412(c)(1)(D)) for the calendar year to reflect the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

(d) FREE CHOICE VOUCHER.—(1) AMOUNT.—

(A) IN GENERAL.—The amount of any free choice voucher provided under subsection (a) shall be equal to the monthly portion of the cost of the eligible employer-sponsored plan which would have been paid by the employer if the employee covered under the plan with respect to which the employer pays the largest portion of the cost of the plan. Such amount shall be equal to the amount the employer would pay for family 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 rules similar to the rules of section 2204 of the Public Health Service Act, except that such amount shall be adjusted for age and category of enrollment in accordance with regulations established by the Comptroller General.

(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.

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

(ii) Other Definitions.—Any term used in this section which is also used in section 5000A of the Code of 1986 shall have the meaning given such term under such 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 36B of such Act) by the taxpayer.’’

(2) Clerical Amendment.—The table of sections for part III of chapter 1 of this Act, as added by section 139C, is amended by inserting at the end 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.

SEC. 139E. DEDUCTION ALLOWED TO EMPLOYER.

(A) IN GENERAL.—Section 139B of the Internal Revenue Code of 1986 is amended by adding at the end the following new item:

“Free choice vouchers’’

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

SEC. 139F. ACCOUNT IN DETERMINING PREMIUM CREDIT.

(A) IN GENERAL.—Subsection (c)(2) of section 36B of the Internal Revenue Code of 1986, as added by section 1412, is amended by adding at the end the following new paragraph:

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

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

SEC. 139G. COORDINATION WITH EMPLOYER RESPONSIBILITIES.

(A) Shared Responsibility Penalty.—

(1) Shared responsibility penalty.—

(A) IN GENERAL.—Subsection (c) of section 4980H(c) of the Internal Revenue Code of 1986, as added by section 1513, is amended by adding at the end the following new paragraph:
“(3) SPECIAL RULES FOR EMPLOYERS PROVIDING FREE CHOICE VOUCHERS.—No assessable payment shall be imposed under paragraph (1) for any month with respect to any employer, or the employer provides a free choice voucher under section 10108 of the Patient Protection and Affordable Care Act for such month.

(B) NOTIFICATION REQUIREMENT.—Section 12818 of the Fair Labor Standards Act of 1938, as added by section 1512, is amended—

(A) by inserting “and the employer does not provide a free choice voucher” after “Employer’s

(B) by striking “will lose” and inserting “may lose”.

(1) EMPLOYER REPORTING.—

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

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

“(1) DEFINITIONS.—For purposes of this section—

“(1) OFFERING EMPLOYER.—

“(A) IN GENERAL.—The term ‘offering employer’ means—

(v) in the case of an applicable large employer, ‘before the length’ in clause (i);

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

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

(iv) by inserting “and” at the end of clause (ii);

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

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

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

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

(C) Section 6056(d)(2) of such Code is amended by striking “applicable large employer” after “applicable employer.”

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

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

(G) The table of sections for part D of title II of the Patient Protection and Affordable Care Act, as added by section 1514, is amended by striking “Large employers” in the item relating to section 6056 and inserting “Certain employers.”.

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

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

(a) ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—

(1) DEVELOPMENT OF ADDITIONAL TRANSACTION STANDARDS AND OPERATING RULES.—

Section 6056 of the Social Security Act (42 U.S.C. 1320d-2(h)), as added by section 1104(b)(2), is amended by—

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

and

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

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

“(A) IN GENERAL.—For purposes of carrying out paragraph (1)(B), the Secretary shall so order, and not later than January 1, 2014, shall, after consultation with the appropriate stakeholders, as determined appropriate by the Secretary, task the ICD-9-CM Coordination and Maintenance Committee to convene a meeting of such committee at which the Secretary shall receive recommendations about appropriate revisions to such crosswalk.

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

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

(b) Section 1902(k)(2) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IX)), as added by section 2001(a)(4), is amended to read as follows:

“(IX) who—

“(aa) are under 26 years of age;

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

“(cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 1171(5)(b)(1)(ii); and

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

(2) Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G), by striking “and (XV)” and inserting “(XV)”;

(3) Section 1902(d) of this Act is amended by striking “2019” and inserting “2014”.

(4) Section 1902(c)(2) of the Social Security Act (42 U.S.C. 1396d(k)(2)), as added by section 2001(a)(4)(A), is amended by striking...
“(A) The increase in the Federal medical assistance percentage for a State under paragraphs (1), (2), or (3) shall apply only for purposes of this title and shall not apply with respect to amounts expended for non-Federal share of expenditures under the State plan under this title or to the non-Federal share of payments under the waiver and such payments pursuant to the allotments provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year pursuant to the allotment provided in the budget neutrality provision of the QUEST Demonstration Project;”;
and
(B) in paragraph (7)—

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

(ii) in subparagraph (B)—

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

“(I) if the State is a low DSH State described in paragraph (6)(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 (6)(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 (6)(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."; and

(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 (6)(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 27.5 percent;

(II) if the State is a low DSH State described in paragraph (6)(B) and has spent more than 99.90 percent of the DSH allotments for the State on average for the period of fiscal years 2004 through 2008, as of September 30, 2009, the applicable percentage is equal to the product of the percentage reduction in uncovered individuals for the fiscal year from the preceding fiscal year and 20 percent;

(III) if the State is not a low DSH State described in paragraph (6)(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 17.5 percent; and

(IV) if the State is not a low DSH State described in paragraph (6)(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 12.5 percent; and

(V) if the State is not a low DSH State described in paragraph (6)(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 7.5 percent; and

(VI) if the State is not a low DSH State described in paragraph (6)(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 5 percent; and

(III) certain hospital payments.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST'® demonstration project unless the Secretary determines that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), ii, with respect to such payments made under the waiver and such payments pursuant to the allotments provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year pursuant to the allotment provided in the budget neutrality provision of the QUEST Demonstration Project.";
(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 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 of the preceeding fiscal year and 40 percent.

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

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

(g) Section 2105(d)(3)(B) of the Social Security Act (42 U.S.C. 1397ee(d)(3)(B)), as added by section 2301(b)(1), is amended by adding at the end the following: “For purposes of eligibility and priority for premium assistance for the purchase of a qualified health plan under section 133B of the Internal Revenue Code of 1986 and reduction of the Medicaid guarantee under section 1902(g)(1) of the Patient Protection and Affordable Care Act, children described in the preceding sentence is to be ineligible for coverage under the State child health plan.”

(h) Clause (i) of subparagraph (C) of section 5312(b)(2) of the Social Security Act, as added by section 2906 of this Act, is amended to read as follows:

(1) Healthy relationships, including marriage and domestic relationships;

(2) A process for notice and comment on any experiment, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXXI in a State that will have an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State program under title XIX or XXXI (in this subsection referred to as a ‘‘demonstration project’’) shall be considered by the Secretary in accordance with the regulations required to be promulgated under paragraph (2).

(2) Not later than 180 days after the date of enactment of this subsection, the Secretary shall require—

(A) a proposed budget that details the demonstration project;

(B) requirements relating to—

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

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

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with the standards for XIX or XXXI in effect for such purposes on December 31, 2010;

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

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

(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 (adult health quality measures).

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

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

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

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

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

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

(H) Section 3013 (quality measure development).

(I) Section 3014 (quality measurement).

(J) Section 3021 (Establishment of Center for Medicare Care Disparities Research).

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

(L) Section 3501 (health care delivery system research and development).

(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. 10292. 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. 1396n(b)) and section 1906(b)(2) of the Social Security Act (42 U.S.C. 1396n(b)(2)), the Secretary shall make available to States the State Balancing Incentive Payments (as defined in section 1906(b)(2)), that meets the conditions described in subsection (c).

(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).

(1) IN GENERAL.—The Comptroller General of the United States shall require—

(A) a proposed budget that details the demonstration project;

(B) requirements relating to—

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

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

(iii) the specific plans of the State to ensure that the demonstration project will be in compliance with the standards for XIX or XXXI in effect for such purposes on December 31, 2010.

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

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

(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: “No wrong door - single entry point system”, optional presumptive eligibility, case management services, and the use of core standardized 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.

(1) 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 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 PERCENTAGES.—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 2008 were 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.

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

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

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

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

(B) CONFLICT-FREE CASH MANAGEMENT SERVICES.—The management services to develop a service plan, arrange for services and supports, benefit 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 and achieved intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Core standardized assessment instruments for determining eligibility for non-institutionalized long-term services and supports described in subsection (c)(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 development of an individual service plan to address such needs.

(D) DATA COLLECTION.—The State agrees to collect from providers of services and supports in the State that are linked to or provided under the State plan under section 1115 of such Act and under any waiver approved with respect to such State plan.

SEC. 10203. EXTENSION OF FUNDING FOR CHIP THROUGH FISCAL YEARS 2013 AND 2014 AND OTHER CHIP-RELATED PROVISIONS.

(a) Section 1311(c)(1) of this Act is amended by striking “and” at the end of subparagraph (A), by striking the period at the end of subparagraph (B) and inserting “; and”, and by adding at the end the following:

“(i) report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1315 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. 1396(e)(2)) is amended by striking “and” and all that follows through the period and inserting “the meaning given that term in section 2105(c)(3)(A).”.

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

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

(c) Section 2105(c)(10) of the Social Security Act (42 U.S.C. 1396cc(c)(10)) is amended—

(1) in the matter preceding clause (i), by striking “and” and inserting “; and;”;

(2) in clause (i), by striking the period and inserting a semicolon.

(3) Section 1906 of the Social Security Act (42 U.S.C. 1397eee), as amended by section 2101, is amended—

(A) in the matter preceding clause (i), by striking “or” and inserting “or—”;

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

(4) Section 2105(c)(3)(A) of the Social Security Act (42 U.S.C. 1396a(c)(3)(A)) is amended—

(A) in the matter preceding clause (i), by striking “and” and inserting “and”;

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

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

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

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

(B) in subparagraph (B), by striking “pro-" and inserting “screened for eligibility for medical assistance under the State plan under title XIX or a waiver of that plan and, if found eligible, enrolled in such a plan or a waiver under title X,, ”; and

(C) by adding at the end the following:

“(C) CERTIFICATION OF COMPARABILITY OF PEDICIAN COVERAGE OFFERED BY QUALIFIED HEALTH PLANS.—Subject to such rules as the Secretary, not later than April 1, 2015, shall establish in the State Medicaid program, the Secretary shall not later than April 1, 2015, enroll the beneficiaries of all qualified health plans offered through an Exchange established by the Secretary under section 1311 of the Patient Protection and Affordable Care Act and enroll such plans for children who, as a result of such screening, are determined to not be eligible for medical assistance under the State plan or a waiver under title XIX, the State shall establish procedures to ensure that the children are enrolled in a qualified health plan that has been certified by the Secretary under subparagraph (C) and in the order; and

(C) by adding at the end the following:

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

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

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

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

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

(2) (A) Section 2104(m) of such Act (42 U.S.C. 1397dd(m)), as amended by section 2101(a)(1), is amended—

(1) in the subsection heading, by striking “2013” and inserting “2015;”;

(2) in paragraph (1), by striking the period and inserting “; and;

(i) by adding at the end the following:

“FISCAL YEARS 2013 AND 2014.—Subject to paragraphs (4) and (6), from the amount made available under paragraphs (4) and (17) of subsection (a) for fiscal years 2013 and
1397ee(g)(4)) is amended—

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

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

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

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

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

(B) MAINTENANCE OF EFFORT WITH RESPECT TO PERSON AGENCY CONTRIBUTION FOR FISCAL YEAR 2014.—If the public agency employs a person to which paragraph (18)(A) of section 426b of the Social Security Act (42 U.S.C. 1397ee(g)(4)) applies, the public agency satisfies such subparagraph if the amount of annual agency expenditures made on behalf of each employee enrolled in health coverage paid for by the agency that includes dependent coverage for the most recent State fiscal year is not less than the amount of such expenditures made by the agency for the 1997 State fiscal year, increased by the percentage increase for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (all items) (except for Metropolitan Average) for the most recent State fiscal year of 1.1 percent.

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

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

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

(ii) in subsection (b), by striking "2013" and inserting "2015"; and

(F) Section 108 of Public Law 111–3 is amended by striking "$11,706,000,000" and all that follows through the second sentence and inserting "$140,000,000 for the fiscal year 2015".

SEC. 10212. ESTABLISHMENT OF PREGNANCY ASSISTANCE FUND.

(a) IN GENERAL.—A State shall use amounts received under a grant under section 10211 for the purposes described in this section to assist pregnant and parenting teens and women.

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

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

SEC. 10213. PERMISSIBLE USES OF FUND.

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

(b) INSTITUTIONS OF HIGHER EDUCATION.—

(I).grant to the designated State agency (as appropriate), to reestablish or reestablish and maintain pregnancy assistance programs for institutions of higher education; and

(II) to States to assist pregnant and parenting students or students 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) ELIGIBLE 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 enhancepregnant and parenting student services and may use such funds 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 and programs; (ii) to set goals for possible improvements to such programs; and (iii) to develop resources for pregnant, parenting, and prospective parenting students; and

(B) Improving access to such resources.

(5) ANNUAL REPORT BY INSTITUTIONS.—(A) ANNUAL REPORT BY INSTITUTIONS.—(i) To the extent practicable, the report shall include information on the following:

(I) The number of pregnant and parenting students served by the institution;

(II) The number of preg

nation and nature of the pregnant woman’s injuries, and the establishment of mecha

nisms to ensure the privacy and confidentiality of those medical records; and

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

SEC. 10212. PREGNANT AND PARENTING TEENAGERS.

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

PART III—INDIAN HEALTH CARE IMPROVEMENT

SEC. 10211. INDIAN HEALTH CARE IMPROVEMENT.

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

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

(A) in subsection (d) (i) in paragraph (2), by striking “In establishing” and inserting “Subject to paragraphs (3) and (4), in establishing”; and

(ii) by adding at the end following:

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

(“A) IN GENERAL.—Subparagraph (B) of paragraph (2) shall not apply in the case of an election made by an Indian tribe or tribal organization located in a State (other than a State described in paragraph (2) of section 10212) in which the Indian Health Service has determined that health aide therapist services or midlevel dental health provider services is authorized under subsection (a) to supply such services in accordance with State law.

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

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

(B) by adding at the end the following:

“(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 amend

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

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

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

(4) The bill referred to in subsection (a) is amended by striking section 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) DEVELOPMENT 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) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following issues:

"(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395aaa) and section 1890A of such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in ambulatory surgical centers.

"(B) The reporting, collection, and validation of quality data.

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

"(D) Methods for the public disclosure of information on the performance of ambulatory surgical centers.

"(E) Any other issues determined appropriate by the Secretary.

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

"(A) consult with relevant affected parties; and

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

(4) DATES.—Not later than January 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(b) Notwithstanding section 3006(a)(2)(A) is amended by striking clauses (i) and (ii).

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

Section 399HH(a)(2)(B)(iii) of the Public Health Service Act, as added by section 3011, is amended by inserting "as defined in section 4 of the Indian Health Care Improvement Act;" before "the Secretary may elect to limit testing of a service delivery models under this section, the Secretary shall select measures on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.".

SEC. 10303. SELECTION OF EFFICIENCY MEASURES.

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

SEC. 10304. DATA COLLECTION, PUBLIC REPORTING.

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

"(a) IN GENERAL.—

"(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish, implement an overall strategic framework to carry out the public reporting of performance information, as described in section 399HH(a)(7)(B). Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

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

"(3) SCOPES.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (2) provide an increased availability to a broad range of patient populations, providers, and geographic areas over time.

SEC. 10305. IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.

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

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

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

(2) in subsection (b)(A) in subparagraph (A)—

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

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

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

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

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

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

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

"(4) in subsection (c)—

"(VIII) Whether the model demonstrates effective, cost-effective, limited to public sector or private sector payers.

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

"(E) MEASUREMENT.—Subject to the extent feasible, the Secretary shall select measures under this paragraph that reflect national priorities for quality improvement and payment that are relevant to the value-based purchasing program described in section 1890A of the Social Security Act (42 U.S.C. 1395l(i))."; and

"(4) in subsection (c)—

"(A) IN GENERAL.—

"(1) ESTABLISHMENT OF STRATEGIC FRAMEWORK.—The Secretary shall establish, implement an overall strategic framework to carry out the public reporting of performance information, as described in section 399HH(a)(7)(B). Such strategic framework may include methods and related timelines for implementing nationally consistent data collection, data aggregation, and analysis methods.

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

"(3) SCOPES.—The Secretary shall ensure that the data collection, data aggregation, and analysis systems described in paragraph (2) provide an increased availability to a broad range of patient populations, providers, and geographic areas over time.

SEC. 10306. IMPROVEMENTS UNDER THE CENTER FOR MEDICARE AND MEDICAID INNOVATION.
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 programs that are applicable to 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 MEDICARE PART D PRESCRIPTION DRUG SAVINGS PROGRAM

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

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

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

"(2) PAYMENT MODELS.—

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

"(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Payments to an ACO for items and services under this title for beneficiaries for a year under the partial capitation model shall be established in a manner that does not result in spending more for such ACO for such beneficiaries than would otherwise be spending for such beneficiaries for such year if the model were not implemented, as estimated by the Secretary.

"(3) OTHER PAYMENT MODELS.—

"(A) Subject to subparagraph (B), a model described in this paragraph is any payment model that the Secretary determines will improve the quality and efficiency of items and services furnished under this title.

"(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) in a similar manner as such subparagraph (B) applies to the payment model under paragraph (2).

"(1) IN GENERAL.—Subsection (d) of section 3101 of this Act, in so far as it relates to the Secretary under such subsection to 20. In this subsection, the term 'continuing care hospital' means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation facilities, including units (as defined in section 1886(d)(1)(B)(i)), long term care hospitals (as defined in section 1886(d)(2)(i)(V)(III)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1866(d)."

"(2) TECHNICAL AMENDMENTS.—

"(A) Section 3023 is amended by striking "1886C" and inserting "1866C".

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

SEC. 10309. REVISIONS TO HOSPITAL READMISSION REDUCTION PROGRAM

Section 1886 of the Social Security Act, as added by section 3025, in the manner preceding subparagraph (b), is amended by striking "the Secretary shall reduce the payment through the product of" and inserting "the Secretary shall make payments (in addition to the payments described in section 1886(a)(2)) for such a discharge to such hospital under subsection (d) (as so redesignated). The case of (2)(B)(ii), as the case may be) in an amount equal to the product of".

SEC. 10310. REPEAL OF PHYSICIAN PAYMENT UP-DATE

The provisions of, and the amendment made by, section 3010 are repealed.

SEC. 10311. REVISIONS TO EXTENSION OF AMBULANCE PAYMENT BUNDLING

(a) GROUND AMBULANCE.—Section 1834(m)(13)(A) of the Social Security Act (42 U.S.C. 1395m(13)(A), as amended by section 3105(a), is further amended—

"(i) in paragraph (a)(2)(B), in the matter preceding clause (i), by striking "8 conditions" and inserting "10 conditions";

"(ii) by striking subsection (c)(1)(B) and inserting the following:

"(B) EXPANSION.—The Secretary may, at any point after January 1, 2016, expand the duration and scope of the pilot program, to the extent determined appropriate by the Secretary, if—

"(i) the Secretary determines that such expansion is expected to—

"(I) reduce spending under title XVIII of the Social Security Act without reducing the quality of care; or

"(II) improve the quality of care and reduce spending;

"(ii) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under such title XVIII; and

"(iii) the Secretary determines that such expansion would not deny or limit the coverage or provision of benefits under this title for individuals.
"

In conducting the pilot program, the Secretary shall apply the provisions of the program so as to separately pilot the continuing care hospital model.

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

"(A) Such model shall be tested without the limitation to the conditions selected under subsection (a)(2)(B).

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

"(3) CONTINUING CARE HOSPITAL DEFINED.—In this subsection, the term ‘continuing care hospital’ means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management the medical and rehabilitation services provided in inpatient rehabilitation facilities, including units (as defined in section 1886(d)(1)(B)(i)), long term care hospitals (as defined in section 1886(d)(2)(i)(V)(III)), and skilled nursing facilities (as defined in section 1819(a)) that are located in a hospital described in section 1866(d).
"

"(b) TECHNICAL AMENDMENTS.—

"(1) Section 3023 is amended by striking "1886C" and inserting "1866C".

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

SEC. 10308. REVISIONS TO NATIONAL PILOT PROGRAMS TO INCREASE QUALITY AND REDUCE SPENDING

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

(a) CERTAIN PAYMENT RULES.—Section 114(e) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 402(a) of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) and section 3106(a) of this Act, is further amended by striking "December 31, 2010" and inserting "January 1, 2011".

(b) MORATORIUM.—Section 114(d) of such Act (42 U.S.C. 1395ww note), as added by section 3106(b) of this Act, in the matter preceding subparagraph (A), is amended by striking "4-year period" and inserting "5-year period".

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

(a) IN GENERAL.—Subsection (g) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is amended by adding after the last sentence of the preceding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 5-year period (in this section referred to as the ‘5-year extension period’) that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

"(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding section (a)(2), during the 5-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20.

In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States for inclusion for purposes of the initial 5-year period.

"(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding section (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 elects to continue participation in the demonstration 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; and

CONFORMING AMENDMENTS.—Subsection (a)(5) of section 419A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 230; as amended by section 10315 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 3131, is amended—

"(1) in subparagraph (C), 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) RE Julia.—Section 1885(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 (E), by striking “2016” and inserting “2017”.

(b) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REVISIONS IN ORDER TO ENSURE ACCESS TO CARE AND PAYMENT FOR SEVERITY OF ILLNESS.—

"(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’) shall conduct a study on home health agency costs involved with providing ongoing access to care to low-income communities 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 1885 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 beneficiaries or beneficiaries residing in medically underserved areas; and

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

"(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 (in this section referred to as the ‘Secretary’), the Medicare Commission, and vulnerable populations associated with implementing potential revisions;

"(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 legislation and administrative action as the Secretary determines appropriate.

"(4) STUDY.—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.

SEC. 10316. MEDICARE DSH.

Section 1886(b)(2) 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 after “2016” and inserting “2017”;

"(D) in subclause (III), by striking “2016” and inserting “2017”;

"(E) in subclause (IV), by striking “2016” and inserting “2017”;

"(2) in subparagraph (B), by striking “2012” and inserting “2013”;

"(3) in subparagraph (C), by striking “2012” and inserting “2013”;

"(4) in subparagraph (D), by striking “2012” and inserting “2013”;

"(5) in subparagraph (E), by striking “2012” and inserting “2013”;

"(6) in subparagraph (F), by striking “2012” and inserting “2013”;

"(7) in subparagraph (G), by striking “2012” and inserting “2013”;

"(8) in subparagraph (H), by striking “2012” and inserting “2013”;

"(9) in subparagraph (I), by striking “2012” and inserting “2013”;

"(10) in subparagraph (J), by striking “2012” and inserting “2013”;

"(11) in subparagraph (K), by striking “2012” and inserting “2013”;

"(12) in subparagraph (L), by striking “2012” and inserting “2013”;

"(13) in subparagraph (M), by striking “2012” and inserting “2013”;

"(14) in subparagraph (N), by striking “2012” and inserting “2013”;

"(15) in subparagraph (O), by striking “2012” and inserting “2013”;

"(16) in subparagraph (P), by striking “2012” and inserting “2013”;

"(17) in subparagraph (Q), by striking “2012” and inserting “2013”;

"(18) in subparagraph (R), by striking “2012” and inserting “2013”;

"(19) in subparagraph (S), by striking “2012” and inserting “2013”;

"(20) in subparagraph (T), by striking “2012” and inserting “2013”;

"(21) in subparagraph (U), by striking “2012” and inserting “2013”;

"(22) in subparagraph (V), by striking “2012” and inserting “2013”;

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

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

"(a) EXTENSION.—


"(2) TEMPORARY RULE PROVIDING FOR PATIENTS AND PROVIDERS ACT OF 2008.—

"(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, 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 wage index applicable for such hospital for the period beginning on October 1, 2009, and ending on March 31, 2010, was lower than 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 its wage index for such periods.

“(B) TIMEFRAME FOR PAYMENTS.—The Secretary shall make payments required under subparagraph by not later than December 31, 2010.

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

Section 1853(p)(3)(A) of the Social Security Act, as added by section 3201(h), is amended by inserting “in 2009” before the period at the end.

SEC. 10319. REVISIONS TO MARKET BASKET ADJUSTMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B)(i) of the Social Security Act, as added by section 3401(a), is amended—

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

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

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

“(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 1886(m)(4) of the Social Security Act, as added by section 3401(c), is amended—

(1) in subparagraph (A)—

(A) in clause (i)—

(i) by striking “each of rate years 2010 and 2011”; and

(ii) by striking “and” at the end;

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

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

“(ii) for rate years beginning in 2012 and 2013, 0.1 percentage point; and”; and

(D) in clause (v), as redesignated by subparagraph (B), by striking “2012” and inserting “2014”; and

(2) in subparagraph (B), by striking “(A)(ii)” and inserting “(A)(iv)”.

(c) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3)(D)(i) of the Social Security Act, as added by section 3401(d), is amended—

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

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

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

“(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 1850(b)(3)(B)(vii) of the Social Security Act, as added by section 3401(e), is amended—

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

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

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

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

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

(e) PSYCHIATRIC HOSPITALS.—Section 1886(m)(3)(A) of the Social Security Act, as added 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”.

(f) OUTPATIENT HOSPITALS.—Section 1833(c)(6)(B) of the Social Security Act, as added by section 3401(h), is amended—

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

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

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

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

(4) in clause (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 1890A of the Social Security Act, as added by section 3403, is amended—

(1) in subsection (c)—

(A) in paragraph (1)(B), by adding at the end the following new matter:

“(II) for each of rate years 2010 and 2011; and inserting “rate year 2010”;

(ii) by striking “and” at the end;

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

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

“(ii) for rate year 2011, 0.50 percentage point;

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

(D) in subsection (c)—

(1) in paragraph (1)(B), by adding at the end the following new matter:

“(II) for each of rate years 2010 and 2011; and inserting “rate year 2010”;

(ii) by striking “and” at the end;

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

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

“(ii) for rate years beginning in 2012 and 2013, 0.1 percentage point; and”; and

(D) in paragraph (3)—

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

(2) 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”;

(3) in subparagraph (A)(ii)—

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

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

(III) by inserting “; and” after “the Senate under”;

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

(B) in paragraph (3)—

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

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

(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 recommendation 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 (c)(6) exceeds the growth rate described in subsection (c)(6)(A)(i).

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

This subparagraph shall not apply if the recommendation contained in a proposal submitted by the Board or the President to Congress pursuant to this section in the proposal year preceding the proposal year was not required to be implemented by reason of this subparagraph.

(iii) NO AFFECT ON REQUIREMENT TO SUBMIT PROPOSALS FOR CONGRESSIONAL CONSIDERATION OF PROPOSALS.—Clause (i) and (ii) shall not affect—
Section 5249(a)(2)(A) is amended by inserting "or other primary care providers" after "physicians".

Section 10322. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

SEC. 10322. QUALITY REPORTING FOR PSYCHIATRIC HOSPITALS.

(a) In general.—Section 1886(e) of the Social Security Act, as added by section 3401(g), 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 or that submits inaccurate data 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.

(2) 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 payment rates for the preceding rate year.

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

(c) Submission of quality data.—For rate year 2014 and each subsequent rate year, each psychiatric hospital and psychiatric unit that does not submit data to the Secretary or that submits inaccurate data with respect to such a rate year, and after application of paragraph (2), shall be reduced by 2 percentage points.

(d) Quality measures.—

(1) In general.—Subject to clause (ii), any individual who is deemed eligible for purposes of this subpart to participate in the applicable pilot program under this subsection may—

(A) that the Secretary or other Federal agencies can implement administratively;

(B) that may require legislation to be enacted by Congress in order to be implemented;

(C) that may require legislation to be enacted by State or local governments in order to be implemented;

(D) that private sector entities can voluntarily implement; and

(E) with respect to other areas determined appropriate by the Board.

(2) Coordination.—In making recommendations under paragraph (1), the Board shall coordinate such recommendations with recommendations contained in proposals and advisory reports produced by the Board under subsection (c).

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

(b) Name change.—Any reference in the provisions of this title, or any rule of the Centers for Medicare & Medicaid Services, to "the Board" or "the Independent Medicare Advisory Board" as added by section 3403 oftitle 1886(g) shall be deemed to be a reference to the "Independent Payment Advisory Board".

(c) Rule of construction.—Nothing in the amendments made by this section shall preclude the use of data on the Internet website of the Centers for Medicare & Medicaid Services.

(d) Conforming amendment.—Section 1886(o)(7)(B)(i)(I) of the Social Security Act, as added by section 3401(h), is amended by inserting "1886(o)(7)(B)(i)(I)", after "1886(o)(7)(B)(i)(I)",.

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 1861 the following section:

"SEC. 1861A. 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 (b) to be an environmental exposure affected individual described in subsection (c) shall be deemed to meet the conditions specified in section 1826(a).

(2) Discretionary deeming.—For purposes of eligibility for benefits under this title, the Secretary may deem an individual determined under subsection (b) to be an environmental exposure affected individual described in subsection (c) to be eligible for the conditions specified in section 1826(a).

(3) Effective date of coverage.—An individual who is deemed eligible for benefits under this title under paragraph (1) or (2) shall be—

(A) entitled to benefits under the program part B 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 subsection (c). The Secretary may establish a separate pilot program, in accordance with this subsection, with respect to each geographic area subject to an emergency declaration (other than the declaration of June 17, 2009), in order to furnish such comprehensive, coordinated, and cost-effective care to individuals described in subsection (c) who reside in each such area.

(B) Individual described.—For purposes of paragraph (1), an individual described in paragraph (2)(A) of this subsection is an individual who—

(i) resides in or around the geographic area subject to an emergency declaration as of the effective date of the declaration; or

(ii) meets such other criteria or conditions as the Secretary determines.

(C) Application; cooperation.—The Secretary may enter into agreements with States to carry out this program.

(D) Pilot program payments.—For purposes of this section, the Secretary may make payments for services provided under this program.

(E) Pilot program program; reports.—The Secretary shall submit to Congress a report on the results of the demonstration project under this subsection not later than one year after the date of the enactment of this Act and not later than two years after the date of the beginning of the demonstration project.

(F) Interstate cooperatives.—The Secretary shall make payments under this section to an entity request the Secretary to make payments under this section.

(G) Authorization of appropriation.—There are authorized to be appropriated such sums as are necessary to carry out this program.

2. Conformity to title xviii—(a) In general.—This section is deemed to be an amendment to title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and shall be considered to be enacted as of the date of the enactment of this Act.

(b) Transactions considered.—For purposes of sections 1886, 1887, 1888, 1889, 1891, 1892, 1892A, 1893, 1894, 1895, 1896, 1897, 1898, 1899, 1901, 1902, 1902A, 1903, 1904, 1905, and 1906 of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), each reference to "the Board" or "the Independent Medicare Advisory Board" shall be deemed to be a reference to the "Independent Payment Advisory Board".
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 for purposes of the pilot program (as described in paragraph (1)).

(4) INNOVATIVE REIMBURSEMENT METHODOLOGIES.—For purposes of the pilot program under section (b), the Secretary—

(A) shall develop and implement appropriate methodologies to reimburse providers for furnishing benefits, items, or services for which payment is not otherwise covered or authorized under this title, if such benefits, items, or services are furnished pursuant to paragraph (3); and

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

(5) LIMITATION.—Consistent with section 1882(b), no payment shall be made under the pilot program under this subsection with respect to benefits, items, or services furnished to an environmental exposure affected individual (as defined in subsection (e)) to the extent that such individual is eligible to receive such benefits, items, or services through any other public or private benefit plan or local agreement.

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

(7) FUNDING.—For purposes of carrying out pilot programs under this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of such sums as the Secretary determines necessary, to the Health Care and Services Program Management Account.

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

(c) DETERMINATIONS.—

(1) BY THE COMMISSIONER OF SOCIAL SECURITY.—For purposes of this section, the Commissioner of Social Security, in consultation with affected individuals 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 19(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

(e) ENVIRONMENTAL EXPOSURE AFFECTED INDIVIDUAL DEFINED.—

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

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

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

(2) INDIVIDUAL DESCRIBED.—

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

(i) is diagnosed with 1 or more conditions described in subparagraph (B); 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—

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

(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 7; and

(III) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

(E) is determined under this section to meet the criteria in this subparagraph.

(B) CONDITIONS DESCRIBED.—For purposes of subparagraph (A), the following conditions are described in this subparagraph:

(i) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(ii) such other diagnostic standards as the Secretary specifies.

(B) a B reader diagnosis, or pleural plaques as established by—

(II) such other diagnostic standards as the Secretary specifies.

(III) such other diagnostic standards as the Secretary specifies;

(2) BY THE SECRETARY.—The Secretary, in consultation with the Commissioner of Social Security, determines is an asbestos-related medical condition, as established by—

(i) Any other diagnosis which the Secretary determines appropriate considering the type of environmental health condition at issue; and

(ii) meets such other criteria as the Secretary determines appropriate considering the type of environmental health condition at issue; and

(2) EMERGENCY DECLARATION.—The term ‘emergency declaration’ means a declaration of a public health emergency under section 19(a) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980.

(3) ENVIRONMENTAL HEALTH CONDITION.—The term ‘environmental health condition’ means—

(A) asbestosis, pleural thickening, or pleural plaques, as established by—

(i) interpretation by a ‘B Reader’ qualified physician of a plain chest x-ray or interpretation of a computed tomographic radiograph of the chest by a qualified physician, as determined by the Secretary; or

(ii) such other diagnostic standards as the Secretary specifies.

(B) mesothelioma, or malignancies of the lung, colon, rectum, larynx, stomach, esophagus, pharynx, or ovary, as established by—

(i) pathologic examination of biopsy tissue; or

(ii) cytology from pleural effusion.

(3) DEVELOPING AND DISSEMINATING PUBLIC INFORMATION AND EDUCATION.—

(1) IN GENERAL.—For purposes of this section, 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 paragraph (2), during a period ending—

(I) not less than 10 years prior to the date of such individual’s application under subparagraph (B); and

(II) prior to the implementation of all the remedial and removal actions specified in the Record of Decision for Operating Unit 4 and the Record of Decision for Operating Unit 7; or

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

(F) A nonprofit organization.

(G) Any other entity the Secretary determines appropriate.

(2) DEFINITIONS.—In this section:

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

(i) whose medical condition is caused by the exposure of the individual to a public health hazard to which an emergency declaration applies, based on such medical conditions, diagnostic standards, and other criteria as the Secretary determines;

(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 the emergency declaration involved, during a period determined appropriate by the Secretary;

(iii) files an application for benefits under this title (or has an application filed on behalf of the individual), including pursuant to this section; and

(E) is determined under this section to meet the criteria in this paragraph.

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

(1) PROGRAM ESTABLISHMENT.—The Secret-
“(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 response applies, based on such criteria and as established by such diagnostic standards as the Secretary specifies.


(5) SUPERFUND SITE.—The term ‘Superfund site’ means a site included on the National Priorities List developed by the President in accordance with section 105(a)(12) of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9605(a)(12)).

(d) HEALTH COVERAGE UNAFFECTED.—Nothing in this section shall be construed to affect any coverage obligation of a governmental or private health plan or program relating to an at-risk individual.

(e) FUNDING.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary, to carry out this section, $35,000,000 for each fiscal year beginning in the period 2011 through 2014; and

(2) AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available until expended.

(f) NONAPPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grants awarded under this section.

(2) LIMITATIONS ON USE OF GRANTS.—Section 10206(a) shall apply to a grant awarded under this section to the same extent and in the same manner as such section applies to amounts to States under title XIII, except that paragraph (4) of such section shall not be construed to prohibit grantees from conducting screening for environmental health conditions as authorized under this section.

SEC. 10324. PROTECTION FOR FRONTIER STATES.

(a) FLOOR ON AREA WAGE INDEX FOR HOSPITALS IN FRONTIER STATES.—

(1) IN GENERAL.—Section 1395w(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(A) in section 1395w(d)(3)(E)(I), by striking ‘‘2005’’ and inserting ‘‘2005’’; and

(B) in subsection (e)(1), by striking ‘‘2005’’ and inserting ‘‘2011’’.

(2) FLOOR FOR AREA WAGE INDEX.—

(A) IN GENERAL.—The wages paid to employees of a hospital in a frontier State (as defined in section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601)) shall be adjusted to an area wage index under section 1395w(d)(3)(E)(I) and shall be interpreted as delaying the implementation of section 13003 of the Minimum Data Sets (MDS) by 0.5 percentage points.

(b) FLOOR ON AREA WAGE INDEX FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

(A) IN GENERAL.—Section 1833(c)(1) of the Social Security Act (42 U.S.C. 1395l(c)(1)), as amended by section 310, is amended—

(1) in paragraph (4), by striking ‘‘the Secretary’’ and inserting ‘‘subject to paragraph (5), the Secretary’’; and

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

‘‘(5) FLOOR ON AREA WAGE INDEX FACTOR FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES IN FRONTIER STATES.—

(A) IN GENERAL.—Subject to subparagraph (B), with respect to OPD services furnished on or after January 1, 2011, the area wage adjustment factor applicable under the payment system established under subparagraph (A) with respect to OPD services furnished on or after January 1, 2011, that is located in a frontier State (as defined in section 108(e)(3)(D)(i)(I)(ii)) may not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) LIMITATION.—This paragraph shall not apply to OPD services furnished on or after January 1, 2011, but that is located in a State that receives a non-labor related share adjustment under section 1866(d)(5)(H).

(c) FLOOR FOR PRACTICE EXPENSE INDEX FOR PHYSICIANS’ SERVICES FURNISHED IN FRONTIER STATES.—

(A) IN GENERAL.—Subject to clause (i), for payments under this section for services furnished on or after January 1, 2011, the practice expense index shall not be less than 1.00. The preceding sentence shall not be applied in a budget neutral manner.

(B) LIMITATION.—This subparagraph shall not apply to payments under this section for services furnished on or after January 1, 2011, that is located in a frontier State (as defined in section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601)) that receives a non-labor related share adjustment under section 1866(d)(5)(H).

(d) FLOOR FOR PRACTICE EXPENSE INDEX FOR SERVICES FURNISHED IN FRONTIER STATES.—

(A) IN GENERAL.—Subject to clause (i), for purposes of payment for services furnished in a frontier State (as defined in section 1866(d)(5)(I)(I)(I)), on or after January 1, 2011, after calculating the practice expense index under section 1866(d)(5)(H), the Secretary shall increase such index by 0.5 percentage points.

(B) LIMITATION.—This subparagraph shall not apply to payments under this section for services furnished on or after January 1, 2011, that is located in a frontier State (as defined in section 101 of the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (42 U.S.C. 9601)) that receives a non-labor related share adjustment under section 1866(d)(5)(H).

SEC. 10325. REVISION TO SKILLED NURSING FACILITIES QUALITY REPORTING SYSTEM.

(a) TEMPORARY DELAY OF RUG-IV.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to October 1, 2011, implement Version 4 of the Resource Utilization Groups (RUG-IV) payment system as published in the Federal Register on August 11, 2009, entitled ‘‘Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2010: Minimum Data Set, Version 3.0 for Skilled Nursing Facilities and Medicaid Nursing Facilities’’ (74 Fed. Reg. 43734). On October 1, 2010, the Secretary of Health and Human Services shall implement the change specific to therapy furnished on a concurrent basis that is incorporated into RUG-IV and changes to the lookback period to ensure that only those services furnished after admission to a skilled nursing facility are used as factors in determining a case mix classification under the skilled nursing facility prospective payment system under section 1886(e) of the Social Security Act.

(b) CONSTRUCTION.—Nothing in this section shall be interpreted as delaying the implementation of version 3.0 of the Minimum Data Sets (MDS) by 0.5 percentage points.

SEC. 10326. PILOT TESTING PAY-FOR-PERFORMANCE FOR CERTAIN MEDICARE PROVIDERS.

(a) IN GENERAL.—Not later than January 1, 2016, the Secretary of Health and Human Services shall test the implementation of a value-based purchasing program for payments under title XVIII of the Social Security Act to test the implementation of a value-based purchasing program for payments under such title for the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))), and psychiatric units (as described in the matter following clause (v) of such section).

(2) Long-term care hospitals (as described in clause (iv) of such section).

(3) Rehabilitation hospitals (as described in clause (ii) of such section).

(4) PPS-exempt cancer hospitals (as described in clause (v) of such section).

(b) PROVIDERS DESCRIBED.—The providers described in this paragraph are the following:

(1) Psychiatric hospitals (as described in clause (i) of section 1885 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) and psychiatric units (as described in the matter following clause (v) of such section).

(c) LIMITATION.—Nothing in this section shall affect any other provision of law, the Secretary of Health and Human Services shall not, prior to January 1, 2011, implement the changes described in subsection (a), (b), or (c) for such year if such changes would not otherwise be required under such provision of law by virtue of the fact that such changes are implemented under this section.

(d) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary solely for purposes of carrying out the pilot program under this section.

SEC. 10327. EXPANSION OF PILOT PROGRAM.—The Secretary may, at any point after January 1, 2013, expand the duration and scope of a pilot program conducted under this subsection, to the extent so determined appropriate by the Secretary.

(a) IN GENERAL.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following:

‘‘(7) ADDITIONAL INCENTIVE PAYMENTS.—

(1) IN GENERAL.—From October 1, 2013 through 2014, if an eligible professional meets the requirements described in subsection (b), the applicable quality percent for such year, as described in clauses (i), (ii), and (III) of paragraph (1)(B), shall be increased by 0.5 percentage points.”
(B) REQUIREMENTS DESCRIBED.—In order to qualify for the additional incentive payment described in subparagraph (A), an eligible professional shall meet the following requirements:

(i) The eligible professional shall—

(1) satisfactorily submit data on quality measures for purposes of paragraph (i) for a year;

(ii) have such data submitted on their behalf through a Maintenance of Certification Program (as defined in subparagraph (C)(ii)) that meets the requirements of clause (ii) (which may be in the form of a structural measure);

(iii) participate in such a Maintenance of Certification program for a year; and

(iv) successfully complete a qualified Maintenance of Certification Program practice assessment (as defined in subparagraph (C)(ii)) for such year.

(iii) A Maintenance of Certification program under the Secretary, on behalf of the eligible professional, information—

(1) in a form and manner specified by the Secretary, that the eligible professional has successfully completed a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2));

(ii) for purposes of this paragraph:

(1) The term ‘Maintenance of Certification Program’ means a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary), that advances quality and the lifelong learning and self-assessment of board certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interprofessional communication skills and professionalism.

(iii) The program requires the physician to maintain a valid, unrestricted medical license in the United States.

(iv) The program requires a physician to participate in educational and self-assessment programs that require an assessment of what was learned.

(V) The program requires a physician to demonstrate, through a formalized, secure examination, that the physician has the fundamental diagnostic skills, medical knowledge, judgment to provide quality care in their respective specialty.

(VI) The program requires successful completion of a qualified Maintenance of Certification Program practice assessment as described in clause (i).

(ii) (I) The term ‘qualified Maintenance of Certification Program practice assessment’ means a measure of a physician’s practice that—

(1) includes an initial assessment of an eligible professional’s practice that is designed to determine the physician’s use of evidence-based medicine;

(2) includes a survey of patient experience with care; and

(3) 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 measure whether improvement is achieved at the end of the following new paragraph:

(3) AUTHORITY.—For years after 2014, if the Secretary determines that meets the requirements of clause (ii) (which may be in the form of a structural measure), the Secretary may incorporate participation in a Maintenance of Certification Program and successful completion of a qualified Maintenance of Certification Program practice assessment into the composite of measures of quality of care furnished pursuant to the physician fee schedule payment modifier, as described in section 1848(p)(2) of the Social Security Act (42 U.S.C. 1395w–4(p)(2)).

(iii) ELIMINATION OF MA REGIONAL PLAN STABILIZATION FUND.—

(1) IN GENERAL.—Section 1850 of the Social Security Act (42 U.S.C. 1395w–27a) is amended by striking subsection (c).

(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 Medicare Trust Fund.

SEC. 10328. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM.

(a) IN GENERAL.—Section 1860(d)(6)(A) of the Social Security Act (42 U.S.C. 1395w–104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (A), (B), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraph:

(A) MAINTENANCE OF EFFORT.—Any regional, or other action in consultation with the Secretary, shall develop a standardized 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 assess 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—

(1) plan and set in place a comprehensive medication review for Medicare and Medicaid beneficiaries described in subparagraph (A)(i) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

(I) an annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed practitioner for other qualified provider. The comprehensive medication review—

(ii) 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

(iii) shall include providing the individual with a written or printed summary of the results of the review;

(II) shall provide to the Secretary, in consultation with relevant stakeholders, a standardized format for the action plan under subclause (I) and the requirements for that plan;

(III) follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment program for Medicare and Medicaid beneficiaries (as defined by the Secretary);

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report concerning—

(1) the overall cost to enrollees under the plan;

(2) the quality of the care provided for under the plan;

(3) the efficiency of the plan in providing care;

(4) the relative risk of the plan’s enrollees as compared to other plans;

(5) the actuarial value or other comparable measure of the benefits covered under the plan; and

(6) other factors determined relevant by the Secretary.

(c) POSTING OF PLAN.—By not later than 12 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. 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 1395w–4 of title 18 (Social Security Act) that term for purposes of the Physician Compare Internet website developed under subsection (a)(2), the Secretary shall, to the extent practicable, 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; and

(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 website described in subsection (a)(2), the Secretary shall, to the extent practicable, include—

(1) processes to assure that data made public, either by the Centers for Medicare & Medicaid Services or by other entities, is statistically valid and reliable, including risk adjustment mechanisms used by the Secretary;

(2) processes by which a physician or other eligible professional whose performance on measures is being publicly reported has a reasonable opportunity, as determined by the Secretary, to review his or her individual results before they are made public;

(3) processes by the Secretary to assure that the website and the data made available on Physician Compare provide a robust and accurate portrayal of a physician's performance;

(4) data that reflects the care provided to all patients seen by physicians, under both the Medicare program and, to the extent practicable, other payers, to the extent such information would provide a more accurate portrayal of physician performance;

(5) processes to ensure appropriate attribution of care when multiple physicians and other providers are involved in the care of a patient;

(6) processes to ensure timely statistical performance feedback is provided to physicians and other providers using data reported under any program subject to public reporting under this section; and

(7) implementation of computer and data systems of the Centers for Medicare & Medicaid Services that support valid, reliable, and accurate public reporting activities authorized under this section.

(c) ENSURING PATIENT PRIVACY.—The Secretary shall ensure that information on physician performance and patient experience is not disclosed under this section in a manner that violates sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable health information.

(d) FEEDBACK FROM MULTI-STAKEHOLDER GROUPS.—The Secretary shall take into consideration feedback from multi-stakeholder groups, consistent with sections 1890(b)(7) and 1890A of the Social Security Act, as added by title II of the Patient Protection and Affordable Care Act, in selecting quality measures for use under this section.

(e) CONSIDERATION OF TRANSITION TO VALUE-BASED PURCHASING.—In developing the website under this subsection (a)(2), the Secretary shall, as the Secretary determines appropriate, provide for appropriate transition to a value-based purchasing program for physicians and other practitioners developed under section 131I of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–110).

(f) REPORT TO CONGRESS.—Not later than January 1, 2015, the Secretary shall submit a report to Congress on the Physician Compare Internet website developed under subsection (a)(1). Such report shall include in addition to the data made available on Physician Compare, 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.

(g) EXPANSION.—At any time before the date on which the report is submitted under subsection (f), the Secretary may expand (including expansion to other programs of services and suppliers, and the Medicare program under section 1874 of the Social Security Act) the information made available on such website.

(h) FINANCIAL INCENTIVES TO ENCOURAGE CONSUMERS TO CHOOSE HIGH QUALITY PROVIDERS.—The Secretary may establish a demonstration program, not later than January 1, 2013, to provide financial incentives to Medicare beneficiaries who are enrolled in Medicare Parts A and B and who are enrolled in or who have access to a beneficiary group for physician performance and patient experience data made available through Physician Compare, that are evidence-based and which provide a robust and accurate portrayal of a physician's performance.

(i) REQUIREMENTS.—(A) The Secretary shall ensure that the information made available under this section is accurate and reliable, consistent with each of the quality measures described in paragraph (4) and meets such other requirements as the Secretary may specify, such as ensuring security of data.

(B) The data described in this paragraph are standardized extracts (as determined by the Secretary) of claims data under parts A, B, and D and services furnished under such parts for one calendar year and the relevant time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary determines necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

(C) REQUIREMENTS.—(A) The term "eligible professional" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(B) The term "physician" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(C) The term "Secretary" means the Secretary of Health and Human Services.

SEC. 10332. AVAILABILITY OF MEDICARE DATA FOR PERFORMANCE MEASUREMENT.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

"(6) availability of medicare data.—

"(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make available to qualified entities (as defined in paragraph (2)) such data for use in 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 evaluate the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use; and

"(B) agrees to measures 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 under parts A, B, and D and services furnished under such parts for one calendar year and the relevant time periods requested by a qualified entity. The Secretary shall take such actions as the Secretary deems necessary to protect the identity of individuals entitled to or enrolled for benefits under such parts.

"(4) REQUIREMENTS.—(A) The term "eligible professional" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(B) The term "physician" has the meaning given that term for purposes of the Physician Quality Reporting Initiative under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(C) The term "Secretary" means the Secretary of Health and Human Services.

"(5) REQUIREMENTS.—(A) 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.

..
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 none of the information on the evaluation of performance of providers of services and suppliers. Such entity shall only use such data, and information derived from such evaluation, for the purposes under subparagraph (C).

‘(E) Data release.—Data released to a qualified entity under this subsection shall not be subject to discovery or admission as evidence in judicial or administrative proceedings without consent of the applicable provider of services or supplier.

‘(F) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2012.

SEC. 10333. COMMUNITY-BASED COLLABORATIVE CARE NETWORKS.

Part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following new subpart:

‘Subpart XI—Community-Based Collaborative Care Network Program

‘SEC. 3400I. 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 and coordinated 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 eliminated pursuant to the requirements on such grantees deemed necessary—

‘(A) a hospital that meets the criteria in section 1913(a)(1) of the Social Security Act;

‘(B) All Federally qualified health centers (as defined in section 1861(aa) of the Social Security Act) located in the community;

‘(C) Priority.—In awarding grants, the Secretary shall give priority to networks that include—

‘(A) the capability to provide the broadest range of services to low-income individuals;

‘(B) the broadest range of providers that currently serve a high volume of low-income individuals; and

‘(C) a county or municipal department of health.

‘(c) APPLICATION.—

‘(1) APPLICATION.—A network described in subsection (b) shall submit an application to the Secretary.

‘(2) RENEWAL.—In subsequent years, based on the performance of grantees, the Secretary may provide renewal grants to prior year grant recipients.

‘(d) USE OF FUNDS.—

‘(1) USE BY GRANTEES.—Grant funds may be used for the following activities:

‘(A) Assist low-income individuals to—

‘(i) access and appropriately use health services;

‘(ii) enroll in health coverage programs; and

‘(iii) obtain a regular primary care provider or a medical home.

‘(B) Provide case management and care management.

‘(C) Perform health outreach using neighborhood health workers or through other means.

‘(D) Provide transportation.

‘(E) Expand capacity, including through telehealth, after-hours services or urgent care.

‘(F) Provide direct patient care services.

‘(G) GRANT FUNDS TO HRSA GRANTEES.—The Secretary may limit the percent of grant funds that may be spent on direct care services provided by grantees of programs administered by the Health Resources and Services Administration or impose other requirements on such grantees deemed necessary.

‘(h) 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 of Health and Human Services may, by transfer of section 1707 of the Public Health Service Act (42 U.S.C. 300u-6) is amended—

‘(A) in subsection (a), by striking ‘‘within the Office of Public Health and Science’’ and all that follows through the end and inserting ‘‘The Office of Minority Health as existing on the date of enactment of the Patient Protection and Affordable Care Act shall be transferred to the Office of the Secretary in such manner that there is established in the Office of the Secretary an Office of Minority Health, which shall be headed by the Deputy Assistant Secretary for Minority Health who shall report directly to the Secretary, and shall assume all functions, duties, and responsibilities of the former Office established by the Secretary, and shall retain and strengthen the functions, duties, and responsibilities of the former Office established by the Secretary, 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 by this section shall be headed by a director, who shall be appointed by the Secretary, on the nomination of the President, by and with the advice and consent of the Senate.

‘(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 read to mean a reference to the Office of Minority Health in the Office of the Secretary.

‘(e) FUNDING.—Of the amounts appropriated for a fiscal year, the Secretary may designate an appropriate amount of funds for the purpose of carrying out activities described in this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage, the amount that otherwise would be available for each of the programs of the designated agency involved.

‘(2) AVAILABILITY OF FUNDS FOR STAFFING.—The purposes for which amounts made available under paragraph may be expended for staffing expenses (as defined in section 1709(a)) are—

‘(A) specifically identified by the minority health office of the designated agency involved;

‘(B) the head of the minority health office of the designated agency involved;

‘(C) to carry out this section.

‘(2) OFFICE OF MINORITY HEALTH.—

‘(a) IN GENERAL.—The purposes for which amounts made available under paragraph may be expended for staffing expenses (as defined in section 1709(a)) are—

‘(B) the head of the minority health office of the designated agency involved;

‘(C) to carry out this section.
(3) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of minority health or Federal appointed 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 have any of its powers 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. 299a-1 et seq.) is amended—

(A) by redesignating section 401(b)(1) of that title as section 401(b)(1)(A); and

(B) in subsection (d)(1), by striking ''section 299a-1(a)(1)(C)'' and inserting ''section 401(b)(1)(A)'';

(2) PURPOSE OF INSTITUTE; DUTIES.—Section 485E of the Public Health Service Act (42 U.S.C. 299a-19) is redesignated, is amended—

(A) by redesignating subpart 20, as so redesignated, as subpart 6 of part E as so redesignated, and by inserting ''Center'' in the first part of clause (i) of section 485E(a)(3); and

(B) by adding at the end the following:

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SEC. 402C. CURES ACCELERATION NETWORK.

(a) Short Title.—This section may be cited as the ‘‘Cures Acceleration Network Act of 2009’’.

(b) Requirement for the Director of NIH to Establish a Cures Acceleration Network.—Section 402(b) of the Public Health Service Act (42 U.S.C. 282b(b)) is amended—

(1) in paragraph (22), by striking ‘‘and’’ at the end;

(2) in paragraph (23), by striking the period at the end and inserting ‘‘; and’’; and

(3) by inserting after paragraph (23), the following:

‘‘(24) implement the Cures Acceleration Network described in section 402c.’’.}

(c) Accepting Grants for Cures Acceleration Network.—Section 402c 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.’’.

(d) Establishment of the Cures Acceleration Network.—Subject to the appropriation of funds as described in subsection (g), there is established within the Office of the Director of NIH a program to be known as the Cures Acceleration Network (referred to in this section as ‘‘CAN’’), which shall—

(1) be under the direction of the Director of NIH, taking into account the recommendations of a CAN Review Board (referred to in this section as the ‘‘Board’’), described in subsection (c); and

(2) award grants and contracts to eligible entities, as described in subsection (e), to accelerate the development of high need cures, including through the translation of medical products and behavioral therapies.

(2) Eligible Entities.—The functions of the CAN are to—

(1) conduct and support revolutionary advances in basic research, translating scientific discoveries from bench to bedside;

(2) award grants and contracts to eligible entities to accelerate the development of high need cures;

(3) provide the resources necessary for government agencies, independent investigators, research organizations, biotechnology companies, academic research institutions, and other entities to develop high need cures;

(4) reduce the barriers between laboratory discoveries and clinical trials for new therapies; and

(5) facilitate review in the Food and Drug Administration for the high need cures funded by the CAN, through activities that may include—

(1) the facilitation of regular and ongoing communication with the Food and Drug Administration to ensure the review and approval of activities conducted under this section;

(2) ensuring that such activities are coordinated with the approval requirements of the Food and Drug Administration with the goal of expediting the development and approval of countermeasures and products; and

(3) connecting interested persons with additional technical assistance made available under section 565 of the Federal Food, Drug, and Cosmetic Act.

(3) CAN Board.—

(1) Establishment.—There is established a Cures Acceleration Network Review Board (referred to in this section as the ‘‘Board’’), which shall advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network.

(2) Membership.—

(A) In General.—

(i) Appointment.—The Board shall be comprised of 24 members who are appointed by the Secretary and who serve at the pleasure of the Secretary.

(ii) Chairperson and Vice Chairperson.—The Secretary shall designate, from among the 24 members appointed under clause (i), one Chairperson of the Board (referred to in this section as the ‘‘Chairperson’’) and one Vice Chairperson.

(B) Terms.—

(i) In General.—Each member shall be appointed to serve a 4-year term, except that no member appointed to serve a term that begins prior to the expiration of the term of the member’s predecessor in office shall serve more than 2 such terms consecutively.

(ii) Consecutive Appointments; Maximum Terms.—A member may be appointed to serve not more than 3 terms on the Board, and not serve more than 2 such terms consecutively.

(C) Qualifications.—

(i) In General.—The Secretary shall appoint individuals to the Board based solely upon the individual’s established record of distinguished service in one of the areas of...
expertise described in clause (i). Each individual appointed to the Board shall be of distinguished achievement and have a broad range of disciplinary interests.

(ii) EXPERIENCE.—The Secretary shall select individuals based upon the following requirements:

(I) For each of the fields of—

(aa) basic research;

(bb) medicine;

(cc) biopharmaceuticals;

(dd) discovery and delivery of medical products;

(ee) bioinformatics and gene therapy;

(ff) medical instrumentation; and

(gg) regulatory review and approval of medical products.

(I) At least 4 individuals shall be recognized leaders in professional venture capital or private equity investing. The Secretary shall select at least 1 individual who is eminent in such fields.

(II) At least 4 individuals shall be ex-officio members, with diverse representation as described in subparagraphs (B) and (C) of paragraph (2), to—

(A) represent NIH under this section; and

(B) serve a 3-year term on the Board, except that initial ex-officio members shall serve intermittently by the Federal Government under standards and otherwise permit such matching requirement in any case where the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot adequately be carried out unless such requirement is waived.

(3) EX-OFFICIO MEMBERS.—

(A) APPOINTMENT.—In addition to the 24 Board members described in paragraph (2), the Secretary shall appoint as ex-officio members of the Board—

(i) a representative of the National Institutes of Health, recommended by the Secretary of the Department of Health and Human Services;

(ii) a representative of the Office of the Assistant Secretary of Defense for Health Affairs, recommended by the Secretary of Defense;

(iii) a representative of the Office of the Under Secretary for Health for the Veterans Health Administration, recommended by the Secretary of Veterans Affairs;

(iv) a representative of the National Science Foundation, recommended by the Chair of the National Science Board; and

(v) a representative of the Food and Drug Administration, recommended by the Commissioner of Food and Drugs.

(B) TERMS.—Each ex-officio member shall serve a 3-year term on the Board, except that the Chairperson may adjust the terms of the initial ex-officio members in order to provide for a staggered term of appointment for all such members.

(4) RESPONSIBILITIES OF THE BOARD AND THE DIRECTOR OF NIH.—

(A) RESPONSIBILITIES OF THE BOARD.—

(i) 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 Secretary of NIH indicates a recommendation of the Board will not be implemented, such Director shall provide an explanation of the reasons for not implementing such recommendation.

(5) MEETINGS.—

(A) IN GENERAL.—The Board shall meet 4 times per calendar year, at the call of the Chairperson.

(B) QUORUM; REQUIREMENTS; LIMITATIONS.—

(I) QUORUM.—A quorum shall consist of a total of 13 members of the Board, excluding ex-officio members, with diverse representation as described in clause (ii) of paragraph (4).

(II) CHAIRPERSON OR VICE CHAIRPERSON.—Each meeting of the Board shall be attended by either the Chairperson or the Vice Chairperson.

(III) DIVERSE REPRESENTATION.—At each meeting of the Board, there shall be not less than one scientist, one representative of a disease advocacy organization, and one representative of a professional venture capital or private equity organization.

(6) COMPENSATION AND TRAVEL EXPENSES.—

(A) COMPENSATION.—Members shall receive compensation at a rate to be fixed by the Chairperson but not to exceed a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel days) such 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 be reimbursed for travel expenses in addition to that received for their services as officers or employees of the United States.

(B) TRAVEL EXPENSES.—Members of the Board shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for persons employed intermittently by the Federal Government under section 5703(b)(2) of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Board.

(C) THE CURES ACCELERATION PARTNERSHIP AWARDS.—

(I) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than $15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

(II) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under clause (i) may apply for additional funding for any subsequent fiscal year to the Director of NIH for the award information required under subparagraphs (B) and (C) of paragraph (2). The Director may fund a portion of such eligible entity under paragraph (2) of not to exceed $15,000,000 for a fiscal year subsequent to the initial award under clause (i).

(III) MATCHING FUNDS.—As a condition for receiving an award under this section, an eligible entity shall contribute to the project non-Federal funds in the amount of $1 for every $3 awarded under clauses (i) and (ii), except that the Director of NIH may waive or modify such matching requirement in any case where the Director determines that the goals and objectives of this section cannot adequately be carried out unless such requirement is waived.

(B) THE CURES ACCELERATION GRANT PROGRAM.—

(I) INITIAL AWARD AMOUNT.—Each award under this subparagraph shall be not more than $15,000,000 per project for the first fiscal year for which the project is funded, which shall be payable in one payment.

(II) FUNDING IN SUBSEQUENT FISCAL YEARS.—An eligible entity receiving an award under this clause shall be entitled to additional funding for any subsequent fiscal year to the Director of NIH for the award information required under subparagraphs (B) and (C) of paragraph (2). The Director of NIH may fund a portion of such eligible entity in an amount not to exceed $15,000,000 for a fiscal year subsequent to the initial award under clause (i).

(C) THE CURES ACCELERATION FLEXIBLE RESEARCH AWARDS.—If the Director of NIH determines that the goals and objectives of this section cannot be carried out through a contract, grant, or cooperative agreement, the Director of NIH shall have flexible research authority to use other transactions to fund projects in accordance with the terms and conditions of this section. Awards made under such flexible research authority for a fiscal year shall not exceed 20 percent of the total funds appropriated under subsection (g)(1) for such fiscal year.

(4) SUSPENSION OF AWARDS FOR DEFAULTS, NONCOMPLIANCE WITH PROVISIONS AND PLANS, AND DIVERSION OF FUNDS; REPAYMENT OF FUNDS.—The Director of NIH may suspend the award to any eligible entity upon noncompliance with such entity's requirements under this section or diversion of funds under this section or diversion of funds.

(5) AUDITS.—The Director of NIH may enter into agreements with other entities to conduct periodic audits of projects funded by grants or contracts awarded under this subsection.
(6) Closeout procedures.—At the end of a grant or contract period, a recipient shall follow the closeout procedures under section 74.71 of title 45, Code of Federal Regulations (or any successor regulation).

(7) Review.—A determination by the Director of NIH as to whether a drug, device, or biological product is a high need product (for purposes of subsection (a)(3)) shall not be subject to judicial review.

(8) Competitive Basis of Awards.—Any grant, cooperative agreement, or contract awarded under this section shall be awarded on a competitive basis.

(9) Authorization of Appropriations.—

(1) In general.—For purposes of carrying out this section, there are authorized to be appropriated $500,000,000 for fiscal year 2010, and such sums as may be necessary for subsequent fiscal years. Funds appropriated under this section shall be available until expended.

(2) Limitation on use of funds otherwise appropriated.—No funds appropriated under this Act, other than funds appropriated under paragraph (1), may be allocated to the National Institute on Alcohol Abuse and Alcoholism for purposes of subsection (a)(3).

SEC. 10410. CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) Short Title.—This section may be cited as the “Establishing a Network of Health-Advancing National Centers of Excellence for Depression Act of 2009” or the “Enhanced Act of 2009”.

(b) Centers of Excellence for Depression.—Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 296h et seq.) is amended by inserting after section 520A the following:

SEC. 520B. NATIONAL CENTERS OF EXCELLENCE FOR DEPRESSION.

(a) Depressive Disorder Defined.—In this section, the term ‘depressive disorder’ means a mental or brain disorder relating to depression, including major depression, bipolar disorder, and related mood disorders.

(b) Grant Program.—

(1) In general.—The Secretary, acting through the Administrator, shall award grants on a competitive basis to eligible entities to establish national centers of excellence for depression (referred to in this section as ‘Centers’), which shall engage in activities related to the treatment of depressive disorders.

(2) Allocation of awards.—If the funds authorized to be appropriated in the amounts provided for under such subsection, the Secretary shall allocate such amounts so that—

(A) not later than 5 years after the date of enactment of the Enhanced Act of 2009, not more than 20 Centers may be established; and

(B) not later than September 30, 2016, not more than 30 Centers may be established.

(3) Grant Period.—

(A) IN GENERAL.—A grant awarded under this subsection shall continue 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 reports issued under subsection (e)(2).

(4) Use of Funds.—Grants awarded under this subsection shall be used for the establishment and ongoing activities of the recipient of such funds.

(b) Requirements.—

(A) Requirements.—To be eligible to receive a grant under this section, an entity shall—

(i) be an institution of higher education or a public or private nonprofit research institution; and

(ii) submit an application to the Secretary at such time and in such manner as the Secretary may require, as described in subparagraph (B).

(B) Application.—An application described in subparagraph (A)(ii) shall include—

(i) evidence that such entity—

(I) provides, or is capable of coordinating with other entities to provide, comprehensive health services with a focus on mental health services and subspecialty expertise for depressive disorders;

(II) collaborates with other mental health providers, as necessary, to address co-occurring mental health conditions; and

(III) is capable of training health professionals about mental health; and

(ii) such other information, as the Secretary may require.

(C) Priorities.—In awarding grants under this section, the Secretary shall give priority to entities that meet 1 or more of the following criteria:

(i) Demonstrated capacity and expertise to serve the targeted population.

(ii) Existing infrastructure or expertise to provide depressive disorders, including diagnostic and treatment, to underserved populations.

(iii) A location in a geographic area with disproportionate numbers of underserved and at-risk populations in medically underserved areas and health professional shortage areas.

(iv) Innovative approaches for outreach to initiative mental health services.

(v) Use of the most up-to-date science, practices, and interventions available.

(vi) Demonstrated capacity to establish collaborative and collaborative agreements with community mental health centers and other community entities to provide mental health, social 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 this paragraph.

(B) Application.—A Center that has been awarded a grant under paragraph (1) may apply for the role of coordinating center by submitting an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(C) Duties.—The coordinating center shall—

(i) develop, administer, and coordinate the network established under this section;

(ii) oversee and coordinate the national database described in subsection (d);

(iii) lead a strategy to disseminate the findings among members of the network to—

(I) develop and implement treatment standards, clinical guidelines, and protocols that emphasize primary prevention, early intervention, treatment for, and recovery from, depressive disorders;

(ii) foster communication with other providers attending to co-occurring physical health conditions such as cardiovascular, diabetes, cancer, and substance abuse disorders;

(iii) leverage available community resources, develop and implement improved self-management programs, and, when appropriate, involve family and other providers of social support in the development and implementation of care plans;

(iv) expand interdisciplinary, translational, and patient-oriented research and treatment; and

(v) coordinate with accredited academic programs to provide ongoing opportunities for the professional and continuing education of mental health providers.

(4) National Database.—

(1) In general.—The coordinating center shall establish and maintain a national, publicly available database to improve prevention programs, evidence-based interventions, and disease management programs for depressive disorders, using data collected from the Centers, as described in paragraph (2).

(2) Data Collection.—Each Center shall submit data gathered at such center, as appropriate, to the coordinating center regarding—

(A) the prevalence and incidence of depressive disorders;

(B) the health and social outcomes of individuals with depressive disorders.

(3) Effectiveness of Interventions Designed, Tested, and Evaluated...
PARTY REVIEW.—

(4) Publication using data from the database.—A Center, or an individual affiliated with a Center, may publish findings using the data described in paragraph (2) only if such center submits such data to the coordinating center, as required under such paragraph.

(e) Establishment of Standards; Report Cards and Recommendations; Third Party Review.—

(1) Establishment of standards.—The Secretary, acting through the Administrator, shall establish performance standards for—

(A) each Center; and

(B) the network of Centers as a whole.

(2) Report cards.—The Secretary, acting through the Administrator, shall—

(A) for each Center, not later than 3 years after the date on which such center's evidence is established and annually thereafter, issue a report card to the coordinating center to rate the performance of such Center; and

(B) not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, issue a report card to Congress to rate the performance of the network of centers of excellence as a whole.

(3) Recommendations.—Based upon the report cards described in paragraph (2), the Secretary shall, not later than September 30, 2015—

(A) make recommendations to the Centers regarding improvements such centers shall make; and

(B) make recommendations to Congress for expanding the Centers to serve individuals with other types of mental disorders.

(4) Third party review.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of Centers to ensure that such centers are meeting the goals of this section.

(1) Authorization of Appropriations.—

(2) In general.—To carry out this section, there are authorized to be appropriated—

(A) $100,000,000 for each of the fiscal years 2011 through 2015; and

(B) $150,000,000 for each of the fiscal years 2016 through 2020.

(2) Allocation of Funds Authorized.—Of the amount appropriated under paragraph (1) for a fiscal year, the Secretary shall determine the allocation of each Center receiving a grant under this section, but in no case may the allocation be more than $5,000,000, except that the Secretary may allocate not more than $10,000,000 to the coordinating center.

SEC. 10411. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.

(a) Short Title.—This subtitle may be cited as the “Congenital Heart Futures Act”.

(b) Programs Relating to Congenital Heart Disease.—

(1) National congenital heart disease surveillance system.—Part P of title III of the Public Health Service Act (42 U.S.C. 266g et seq.) is amended by adding by section 5485, is further amended by adding at the end the following:

"SEC. 399V-2. NATIONAL CONGENITAL HEART DISEASE SURVEILLANCE SYSTEM.

"(a) In General.—The Secretary, acting through the Directors of the Centers for Disease Control and Prevention, may—

"(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative, population-based surveillance system that compiles data concerning actual occurrences of congenital heart disease, to be known as the ‘National Congenital Heart Disease Surveillance System’; or

"(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

"(b) Purpose.—The purpose of the Congenital Heart Disease Surveillance System shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

"(c) Content.—The Congenital Heart Disease Surveillance System—

"(1) may include information concerning the incidence and prevalence of congenital heart disease for purposes of—

"(I) the network of Centers as a whole.

"(II) the network of Centers as a whole.

"(II) the network of Centers as a whole.

"(II) the network of Centers as a whole.

"(II) the network of Centers as a whole.

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"(II) the network of Centers as a whole.

"(II) the network of Centers as a whole.

"(2) use the data described in paragraph (1) to further research into the types of health services patients use and to identify possible areas for educational outreach and prevention.

"(d) Public Access.—The Congenital Heart Disease Surveillance System shall be made available to the public, as appropriate, including congenital heart disease researchers.

"(e) Patient Privacy.—The Secretary shall ensure the Congenital Heart Disease Surveillance System is maintained in a manner that complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

"(f) Third Party Review.—Not later than 3 years after the date on which the first grant is awarded under subsection (b)(1) and annually thereafter, the Secretary shall arrange for an independent third party to conduct an evaluation of the network of Centers to ensure that such centers are meeting the goals of this section.

"SEC. 10412. AUTOMATED DEFIBRILLATION IN ADAMS' MEMORY ACT.

Section 312 of the Public Health Service Act (42 U.S.C. 241) is amended—

(1) in subsection (c)(6), after “clearinghouse” insert “, that shall be administered by an organization that has special expertise in pediatric education, pediatric medicine, and electrophysiology and sudden death.”; and

(2) in the first sentence of subsection (e), by striking “fiscal year 2003” and all that follows through “2006” and inserting “for each of fiscal years 2003 through 2014”.

SEC. 10413. YOUNG WOMEN’S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

(a) Short Title.—This section may be cited as the “Young Women’s Breast Health Education and Awareness Requires Learning Young Act of 2009” or the “EARLY Act.”

(b) Amendment.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by this Act, is further amended by adding at the end the following:

"PART V—PROGRAMS RELATING TO BREAST HEALTH AND CANCER.

"SEC. 399N. YOUNG WOMEN’S BREAST HEALTH EDUCATION AND AWARENESS FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.

"(a) Public Education Campaign.—

"(1) In General.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness of young women’s knowledge regarding—

"(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

"(B) breast awareness and good breast health habits;

"(C) the occurrence of breast cancer and the critical and early factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

"(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancer;

"(E) the availability of health information and other resources for young women diagnosed with breast cancer;

"(F) 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 to 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 toward 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 paragraphs (a) and (b)(1).

"(B) MEMBERSHIP.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise in breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

"(b) HEALTH CARE PROFESSIONAL EDUCATION.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct education campaigns among physicians and other health care professionals to increase awareness.

"(1) In general.—The Secretary shall conduct education campaigns targeting 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) by 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;

"(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) identifying 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 predicting 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 toward women diagnosed with breast cancer and pre-neoplastic breast diseases.

"(2) PRIORITY.—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.

"(e) NO DUPLICATION OF EFFORT.—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

"(f) MEASUREMENT; REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

"(1) measure—

"(A) young women's awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women's proactive efforts at early detection;

"(B) the number of young women utilizing information regarding lifestyle interventions that foster healthy behaviors;

"(C) the number or percentage of young women receiving regular clinical breast exams; and

"(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

"(2) not less than every 3 years, measure the impact of such activities and

"(3) submit reports to the Congress on the results of such measurements.

"(g) DEFINITION.—In this section, the term 'young women' means women 15 to 44 years of age.

"(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out subsections (a), (b), (c), and (d), there are authorized to be appropriated $9,000,000 for each of the fiscal years 2010 through 2014.

Subtitle E—Provisions Relating to Title V SEC. 10501. AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT, THE SOCIAL SECURITY ACT, AND TITLE V OF THIS ACT

(a) Section 399V of the Public Health Service Act (42 U.S.C. 293b(a)(3)) is amended—

"(1) for the words "and, the Social Security Act and" in subsection (b)(3)(B) the words "and, the Social Security Act and" shall be inserted after "and, the Social Security Act and";

"(b) The Indian Health Service.

"(2) The Secretary of Defense shall appoint one representative of the TRICARE Management Activity.

"(c) The Secretary of the Army shall—

"(1) I N GENERAL.—The Secretary shall appoint one representative of the Army Medical Department;

"(2) 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;

"(3) 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.

"(3) The Secretary of Homeland Security shall appoint one representative of the United States Coast Guard.

"(d) CHAIRPERSON.—One chairperson of the Task Force shall be appointed by the Secretary at the time of appointment of members under subsection (c), selected from among the members appointed under paragraph (c).

"(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 Congress a report detailing the activities of the Task Force and containing the findings, strategies, recommendations, policies, and initiatives developed pursuant to the duty described in subsection (b)(2). In preparing such report, the Task Force shall consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.

"(g) TERMINATION.—The Task Force shall be terminated on the date of submission of the report required under 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 entitled ‘Family Nurse Practitioner Training Program’ (referred to in this section as the ‘program’) to employ and provide 1-year training for nurse practitioners who have graduated from a nurse practitioner program for careers as primary care providers in Federally qualified health centers (referred to in this section as ‘FQHCs’) and nurse-managed health clinics (referred to in this section as ‘NMHCs’).

(‘‘b) PURPOSE.—The purpose of the program is to enable each grant recipient to—

(1) provide new nurse practitioners with clinical training to enable them to serve as primary care providers in FQHCs and NMHCs;

(2) train new nurse practitioners to work under a model of primary care that is consistent with the principles set forth by the Institute of Medicine and the needs of vulnerable populations; and

(3) train additional numbers of FQHC and NMHC training for nurse practitioners that may be replicated nationwide.

(‘‘c) Guam.—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 residency training 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 1913(aa) of the Public Health Service Act (42 U.S.C. 1395aa(aa)); or

(2) be a nurse-managed health clinic, as defined in section 330A–1 of the Public Health Service Act (as added by section 5208 of this Act); and

(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 AWARDED 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 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 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 in any 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 an NMHC.

(‘‘2) PREFERENCE.—In selecting awardees under the program, each grant recipient shall give preference to bilingual candidates that meet the requirements described in paragraph (1).

(‘‘3) DEFERRAL OF CERTAIN SERVICE.—The starting date of required service of individuals in the National Health Service Corps Service program under title II of the Public Health Service Act (42 U.S.C. 202 et seq.) who receive training under this section shall be deferred until 22 months after the date of completion of the program.

(‘‘g) GRANT AMOUNT.—Each grant awarded under this section shall be in an amount not to exceed $300,000. A grant recipient may carry over funds from 1 fiscal year to another without obtaining approval from the Secretary.

(‘‘h) TECHNICAL ASSISTANCE GRANTS.—The Secretary may award technical assistance grants to 1 or more FQHCs or NMHCs that have demonstrated expertise in establishing a nurse practitioner residency training program. Such technical assistance grants shall be for the purpose of providing technical assistance to other recipients of grants under subsection (c).

(‘‘i) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2014.

(‘‘j) SECTION 399W OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5405, IS REPEALED.

(‘‘k) SECTION 399V–1 OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5405, IS REPEALED.

(‘‘1) ANDREW MURPHY NATIONAL SECURITY ACT, AS ADDED BY SECTION 5405, IS REPEALED.

(‘‘m) SECTION 399W–1(2) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘n) SECTION 399V–3 OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘o) SECTION 399W–1(3) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘p) SECTION 399V–1(4) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘q) SECTION 399W–1(5) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘r) SECTION 399V–1(6) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘s) SECTION 399W–1(7) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘t) SECTION 399V–1(8) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘u) SECTION 399W–1(9) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘v) SECTION 399V–1(10) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘w) SECTION 399W–1(11) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘x) SECTION 399V–1(12) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘y) SECTION 399W–1(13) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘z) SECTION 399V–1(14) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘aa) SECTION 399W–1(15) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘bb) SECTION 399V–1(16) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘cc) SECTION 399W–1(17) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.

(‘‘dd) SECTION 399V–1(18) OF THE PUBLIC HEALTH SERVICE ACT, AS ADDED BY SECTION 5505, IS REVISED.
funds allocated to such Medicaid program, the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), or the TRICARE program under chapter 73 of title 32, United StatesCode, may be used to award grants or to pay administrative costs associated with a grant program established under subsection (a)(1).

(1) Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended—

(a) in the case of grants under subsection (a)(1), by inserting at the end the following—

"(2) submits an application to the Secretary, who may certify that the entity can meet the requirements of this subsection; and

(2) an accredited 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).”.

(3) Section 337(b)(1) of the Public Health Service Act (42 U.S.C. 254j(b)(1)) is amended by striking “Members may not be reappointed to the Council.”.

(4) Section 338C of the Public Health Service Act (42 U.S.C. 254c) is amended by striking “$50,000” and inserting “$50,000,000”.

(5) Subsection (a) of section 338C of the Public Health Service Act (42 U.S.C. 254m), as amended by section 5506, is amended—
“(A) by striking the second sentence and inserting the following: ‘The Secretary may treat teaching and practice for up to 20 percent of such period of obligated service.’; and
“(B) by adding at the end the following: ‘Notwithstanding the preceding sentence, with respect to a member of the Corps participating in the teaching health centers graduate medical education program under section 340H, for the purpose of calculating time spent in full-time clinical practice under this section, up to 50 percent of time spent teaching by such member may be counted toward his or her service obligation.’.”.

SEC. 10502. INFRASTRUCTURE TO EXPAND ACCESS TO AFFORDABLE CARE

(a) AGENCY.—There are required to be appropriated, and there are appropriated, to the Department of Health and Human Services, $100,000,000 for fiscal year 2011, to be used by the Secretary to establish and carry out the demonstration project described in section 340H, for the purpose of evaluating outcomes research, inpatient tertiary care, or outpatient primary care clinical outcomes, as required in such a program; and

(b) REQUIREMENT.—Amount appropriated under subsection (a) may only be made available by the Secretary of Health and Human Services upon the receipt of an application from the Governor of a State that certifies that—
“(1) the new health care facility is critical for the provision of greater access to health care within the State;
“(2) such facility is essential for the continued financial viability of the State’s sole public medical and dental school and its academic health center;
“(3) the request for Federal support represents not more than 40 percent of the total cost of the proposed new facility; and
“(4) the State has established a dedicated funding mechanism to provide all remaining funds necessary to complete the construction or renovation of the proposed facility.

SEC. 10503. COMMUNITY HEALTH CENTERS AND THE NATIONAL HEALTH SERVICE CORPS FUND

(a) PURPOSE.—It is the purpose of this section to establish the Community Health Centers 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 funds for expanded and sustained national investment in community health centers under section 339 of the Public Health Service Act and the National Health Service Corps.

(b) FUNDING.—There is authorized to be appropriated, and there is appropriated, $2,000,000 to establish and carry out the demonstration project, an entity appointed to the Council.

SEC. 10504. DEMONSTRATION PROJECT TO PROVIDE ACCESS TO AFFORDABLE CARE

(a) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall transfer amounts in the CHC Fund to accounts within the Department of Health and Human Services for increase funding, over the fiscal year 2008 level, for community health centers and the National Health Service Corps.

(b) ENSURE ACCESS TO AFFORDABLE CARE.—(A) The Secretary shall use any monies in the Treasury not otherwise appropriated under subsections (b) and (c) shall remain available until expended.

(c) CONSTRUCTION.—There is authorized to be appropriated, and there is appropriated, of the Non-monies in the Treasury not otherwise appropriated under subsection (b).

Subtitle F—Provisions Relating to Title VI

SEC. 10601. REVISIONS TO THE PROVISION ON MEDICARE EXCLUSION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (as added by section 6001(b)(2) of this Act is amended—
“(1) in paragraph (1)(A), by striking ‘February 1, 2010’ and inserting ‘January 1, 2012’; and
“(2) in paragraph (1)(B), by striking ‘February 1, 2010’ and inserting ‘January 1, 2012’.”

(b) CONFORMING AMENDMENT.—Section 6001(a)(2) of this Act is amended by striking “November 1, 2011” and inserting “May 1, 2012”.

SEC. 10602. CLARIFICATIONS TO PATIENT-CENTERED OUTCOMES RESEARCH.

(a) IN GENERAL.—Section 1181 of the Social Security Act (as added by section 6001(a) of this Act is amended—
“(3) Members, selected by the Secretary, may only be made available by the Secretary 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.

(b) ENSURE ACCESS TO AFFORDABLE CARE.—(A) The Secretary shall use any monies in the Treasury not otherwise appropriated under subsections (b) and (c) shall remain available until expended.
(ii) by inserting ‘‘, as long as the re-
searcher enters into a data use agreement with the Institute for use of the data from the original research, as appropriate’’ after ‘‘publication’’; and

(B) by amending clause (iv) to read as fol-
lows:

‘‘(iv) SUBSEQUENT USE OF THE DATA.—The
Institute shall—(A) maintain confidentiality of the data from original research in work-for-
hire contracts with individuals, entities, or
instrumentalities that have a financial in-
terest in the results, unless approved under a
data use agreement with the Institute;’’;

(2) in subsection (d)(8)(A)(iv), by striking ‘‘not be construed as mandates for’’ and ‘‘in-
serting ‘‘or, as defined in’’; and

(3) in subsection (f)(1)(C), by amending clause
(ii) to read as follows:

‘‘(ii) 7 members representing physicians and
providers, including 4 members rep-
 resenting physicians (at least 1 of whom is a
surgeon), 1 nurse, 1 State-licensed integra-
tive health care practitioner, and 1 re-
presentative of a hospital.’’

SEC. 10603. STRIKING PROVISIONS RELATING TO
INDIVIDUAL PROVIDER APPLICA-
TIONS

(a) IN GENERAL.—Section 1866((2)(C) of the
Social Security Act, as added by section
6401(a), is amended—

(1) by striking clause (i);

(2) by redesignating clauses (ii) through (iv),
respectively, as clauses (i) through (iii); and

(3) by amending clause (ii), as redesignated by
paragraph (2), by striking ‘‘case’’ and in-
serting ‘‘case’’.

(b) TECHNICAL CORRECTION.—Section
6401(a)(2) of this Act is amended to read as
follows:

‘‘(2) by redesignating paragraph (2) as para-
graph (8); and’’.

SEC. 10604. TECHNICAL CORRECTION TO
SECTION 6405.

Paragraphs (1) and (2) of section 6405(b) are
amended to read as follows:

‘‘(1) PART A.—Section 1814(a)(2) of the
Social Security Act (42 U.S.C. 1395a(2)) is
amended in the matter preceding para-
graph (A) by inserting ‘‘, or, in the case of
services described in subparagraph (C), a
physician enrolled under section 1866(j),’’,
in collaboration with a physician.’’

‘‘(2) PART B.—Section 1815(a)(2) of the
Social Security Act (42 U.S.C. 1395a(2)) is
amended in the matter preceding para-
graph (A) by inserting ‘‘, or, in the case of
services described in subparagraph (A), a
physician enrolled under section 1866(j),’’,
after ‘‘physician’’.

SEC. 10605. CERTAIN OTHER PROVIDERS
PERMITTED TO CONDUCT FACE TO FACE
ENCOUNTER FOR HOME HEALTH SERVICES

(a) PART A.—Section 1814(a)(2)(C) of the
Social Security Act (42 U.S.C. 1395a(2)(C)),
as amended by section 6401(a)(1), is amended
by inserting ‘‘, or a nurse practitioner or
clinical nurse specialist (as those terms are
defined in section 1861(aa)(5)) who is work-
ing in collaboration with the physician in ac-
count with State law, or a certified nurse-
midwife (as defined in section 1861(4)(g)) as au-
thorized by State law, or a physician assistant
(as defined in section 1861(aa)(5)) under the supervision of the
physician,’’ after ‘‘must document that the
physician’’.

(b) INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1347 of title 18, United States Code, is amended—

(1) by inserting ‘‘(a)’’ before ‘‘Whoever
knowingly’’; and

(2) by adding at the end the following:

‘‘(b) With respect to violations of this sec-
tion, a person need not have actual know-
ledge of this section or specific intent to com-
mit a violation of this section.’’.

(c) HEALTH CARE FRAUD OFFENSE.—Section
217(a) 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. 1295h-b);’’ or;

and

(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),’’
before ‘‘title.’’

(d) SUBPOENA AUTHORITY RELATING TO
HOME HEALTH CARE.—

(1) SUBPOENA UNDER THE HEALTH INSUR-
ANCE PORTABILITY AND ACCOUNTABILITY ACT
OF 1996.—Section 1510(b) of title 18, United States Code, is amended—

(A) in paragraph (1), by striking ‘‘to the
grand jury’’;

and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ‘‘grand
jury subpoena’’ and inserting ‘‘subpoena for
records’’; and

(ii) in the matter following subparagraph
(B), by striking ‘‘to the grand jury’’.

(2) SUBPOENAS UNDER THE CIVIL RIGHTS OF
INSTITUTIONALIZED PERSONS ACT.—The Civil
Rights of Institutionalized Persons Act (42 U.S.C. 1997 et seq.) is amended by
inserting after section 1835

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 in-
vestigation under this Act and to any docu-
ments, record, material, file, report, memo-
randum, policy, procedure, investigation, video or audio recording, or quality assur-
ance report relating to any institution that is the subject of an investigation under this Act to determine whether there are condi-
tions which deprive persons residing in or
confined to the institution of any rights, privileges, or immunities secured or pro-
tected by the Constitution or laws of the
United States.

(b) ISSUANCE AND ENFORCEMENT OF SUB-
POENAS.—

‘‘(1) ISSUANCE.—Subpoenas issued under this sec-
tion—

(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) may be served by any person or class of
designated by the Attorney General or a
designated officer or employee for
that purpose.

(2) ENFORCEMENT.—In the case of contnu-
macy 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 re-
quiring compliance. Any failure to obey the
order of the court may be punished by the
court as a contempt that court.

(3) PROTECTION OF SUBPOENA RECORDS
AND INFORMATION.—Any document, record, material, file, report, memorandum, policy, procedure, investigation, video or audio rec-
ording, or quality assurance report or other
information obtained under a subpoena issued under this section—
(1) may not be used for any purpose other than to protect the rights, privileges, or immunities secured or protected by the Constitution or laws of the United States of persons who reside, 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, or will reside, in an institution; and
(3) shall be redacted, obscured, or otherwise altered if used in any publicly available manner so as to prevent the disclosure of any personally identifiable information.

SEC. 10607. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part D of title III of the Public Health Service Act (42 U.S.C. 290j 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 medical 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) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

"(B) encourages the efficient resolution of disputes;

"(C) encourages the disclosure of health care errors;

"(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors as part of improving the availability of prompt and fair resolution of disputes;

"(E) improves access to liability insurance;

"(F) fully informs patients about the differences in the alternative and current tort litigation systems; and

"(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative.

"(2) Alternative to Current Tort Litigation.—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative is described in paragraph (1)(A).

"(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

"(B) encourages the efficient resolution of disputes;

"(C) encourages the disclosure of health care errors;

"(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors as part of improving the availability of prompt and fair resolution of disputes;

"(E) improves access to liability insurance;

"(F) fully informs patients about the differences in the alternative and current tort litigation systems; and

"(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative.

"(3) Sources of Compensation.—Each State desiring a grant under subsection (a) shall identify the sources from which compensation would be paid for the claims and 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 available 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 the health care services that fall within such scope, and the provisions of which would be voluntarily withdrawn from participating in the alternative. The decision of the patient whether to participate or continue participating shall be made at any time and shall not be limited in any way.

"(B) 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 experience 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 a proposal that—

"(A) is in a form and includes the 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 Secretary.

"(6) Reports.—

"(1) By State.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

"(2) By Secretary.—The Secretary shall submit to Congress, within 1 year after Congress receives the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences 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.

"(1) Technical Assistance.—

"(1) In General.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

"(2) Requirements.—Technical assistance under paragraph (1) shall include—

"(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

"(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting the effectiveness of activities funded with 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 (b)(2), enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of the 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).

"(B) reports submitted under paragraph (1).

"(C) an analysis of 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, within 1 year after Congress receives the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences 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.

"(1) Technical Assistance.—

"(1) In General.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

"(2) Requirements.—Technical assistance under paragraph (1) shall include—

"(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

"(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting the effectiveness of activities funded with 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 (b)(2), enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of the 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).

"(B) reports submitted under paragraph (1).

"(C) an analysis of 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, within 1 year after Congress receives the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences 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.

"(1) Technical Assistance.—

"(1) In General.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

"(2) Requirements.—Technical assistance under paragraph (1) shall include—

"(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

"(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting the effectiveness of activities funded with 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 (b)(2), enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of the 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).

"(B) reports submitted under paragraph (1).

"(C) an analysis of 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, within 1 year after Congress receives the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences 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.
the medical liability environment; and
organization satisfaction with the alter-
ners and adverse events;
 Costs to all parties;
(1); (a)
State to provide planning grants to such
 receiving grants approved under subsection (a) and similar States not receiving such
and (E) a comparison, regarding to the
described in paragraph (3), of—
(i) States receiving grants under subsec-
(ii) States that enacted, prior to the date
of enactment of the Patient Protection and
Affordable Care Act, a requirement that
the complaintant 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 com-
parisons 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 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 alter-
native under subsection (a) and with the medical
liability environment; and
(H) impact on utilization of medical serv-
ces, 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 grants under subsection (a) to determine the
impact of such alternatives on the Medicare
program under title XVIII of the Social
Security Act, and its beneficiaries.
(2) MACPAC. The Medicaid and CHIP
Payment and Access Commission shall con-
duct an independent review of the alter-
natives to current tort litigation that are
implemented under grants under subsection
(a) to determine the impact of such alter-
natives on the Medicaid or CHIP programs
under titles XIX and XXI of the Social
Security Act, and its beneficiaries.
(c) 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 re-
spective Commission based on independent
reviews conducted under paragraphs (1) and
(2), including an analysis of the impact of
the alternatives reviewed on the efficiency
and effectiveness of the respective programs.
(d) Comparison. Considering the meas-
ures described in paragraph (3), of States
receiving grants approved under subsection (a) and similar States not receiving such
grants and—
(1) a comparison among the States rece-
ing grants under subsection (a) of the ef-
ficacy of the various alternatives devel-
oped by such States under subsection (c)(1);
(2) a comparison, considering the meas-
ures described in paragraph (3), of States
receiving grants approved under subsection (a) and similar States not receiving such
grants and—

**SEC. 10609. EXTENSION OF MEDICAL MAL-
PRACTICE COVERAGE TO FREE CLINICS.**

(a) In General. Section 224(o)(1) of the
Public Health Service Act (42 U.S.C. 295d(o)(1)) is amended—
(i) in subsection (a), by adding at the end the
following:
(ii) The Medicare Payment Advisory
Commission shall conduct an inde-
pendent review of the alternatives to
current tort litigation that are implemented under grants under subsection (a) to
determine the impact of such alternatives on the Medicare
program under title XVIII of the Social
Security Act, and its beneficiaries.

**Section 10901. MODIFICATIONS TO EXCISE TAX ON
HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.**

(a) Longshore Workers Treated as Employees
Engaged in High-Risk Professions. Paragraph (3) of section 4980(f) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by in-
serting “individuals whose primary work is
longshore work (as defined in section 258(b)
of the Immigration and Nationality Act (8 U.S.C. 1252(b)), determined under paragraph (2) thereof),” before “and
individuals engaged in the construction, mining—”

**Subtitle II—Provisions Relating to Title IX**

**SEC. 10901. MODIFICATIONS TO EXCISE TAX ON
HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.**

(a) Longshore Workers Treated as Employees
Engaged in High-Risk Professions. Paragraph (3) of section 4980(f) of the Internal Revenue Code of 1986, as added by section 9001 of this Act, is amended by in-
serting “individuals whose primary work is
longshore work (as defined in section 258(b)
of the Immigration and Nationality Act (8 U.S.C. 1252(b)), determined under paragraph (2) thereof),” before “and
individuals engaged in the construction, mining—”

**Effective Date.**—The amendments
made by this section shall apply to taxable years beginning after December 31, 2012.

**SEC. 10902. INFLATION ADJUSTMENT OF LIMITA-
TIONS PLANS.**

(a) In General. Subsection (l) of section
125 of the Internal Revenue Code of 1986, as

**Sec. 10609. LABELING CHANGES.**

Section 305(j) of the Federal Food, Drug,
and Cosmetic Act (21 U.S.C. 355(j)) is amend-
ed by adding at the end the
following:
(10)(A) If the proposed labeling of a drug
that is the subject of an application under
this subsection differs from the listed drug
due to a labeling revision described under
clause (i), the drug that is the subject of
such application shall, notwithstanding any
other provision of this Act, be eligible for ap-
approval and shall not be considered mis-
branded under section 502.
(i) the application is otherwise eligible
for approval upon submission but for ex-
piration of patent, an exclusivity period, or
of a delay in approval described in paragraph
(5)(B)(iii), and a revision to the labeling of
the listed drug has been approved by the Sec-
retary within 60 days of such expiration;
(ii) the labeling revision described under
clause (i) does not include a change to the
‘Warning’ section of the labeling; and
(iii) the sponsor of the application under
this subsection agrees to submit revised la-
beling of the drug that is the subject of such
application not later than 60 days after
the notification of any changes to such labeling
required by the Secretary; and

**Subtitle G—Provisions Relating to Title VIII**

**SEC. 10801. PROVISIONS RELATING TO TITLE VIII**

(a) Title XXXII of the Public Health Serv-
ice Act, as added by section 802(a)(1), is amended—
(1) in section 3203—
(A) in subsection (a)(1), by striking sub-
paragraph (E);
(B) in subsection (b)(1)(C)(i), by striking
“for enrollment” and inserting “for reenroll-
ment”; and
(C) in subsection (c)(1), by striking “as
part of their automatic enrollment in the
CLASS program,”; and
(2) in section 3204—
(A) in subsection (c)(2), by striking sub-
paragraph (A) and inserting the following:
(i) A receives wages or income on which
there is imposed a tax under section 3101(a)
of the Internal Revenue Code of 1986; or
(ii) a health care provider, that relate to—
(A) the nature and number of disputes
and claims, including the length of time and estimated
costs to all parties;
(B) the medical liability environment;
(C) the disposition of disputes and claims,
including the length of time and estimated
costs to all parties;
(D) the medical liability environment;
(E) patient safety in terms of detecting,
analyzing, and helping to reduce medical
errors and adverse events;
(F) patient and health care provider and
organization satisfaction with the alter-
native under subsection (a) and with the medical
liability environment; and
(G) impact on utilization of medical serv-
ces, appropriately adjusted for risk.

(b) EFFECTIVE DATE. The amendment
made by this section shall take effect on the
date of enactment of this Act and apply to
any act or omission which occurs on or after
that date.

**SEC. 10608. EXTENSION OF MEDICAL MAL-
PRACTICE COVERAGE TO FREE CLINICS.**

(a) In General. Section 224(o)(1) of the
Public Health Service Act (42 U.S.C. 295d(o)(1)) is amended by inserting after “to
individual” the following: “or, an officer,
governing board member, employee, or con-
tractor of a free clinic shall in providing
services for the free clinic.”

(b) EFFECTIVE DATE. The amend-
ment made by this section shall take effect on the
date of enactment of this Act and apply to
any act or omission which occurs on or after
that date.

**SEC. 10902. INFLATION ADJUSTMENT OF LIMITA-
TIONS PLANS.**

(a) In General. Subsection (l) of section
125 of the Internal Revenue Code of 1986, as
added by section 8002(d) of this Act, is amended by striking
“and coverage available” and all that fol-

**Effective Date.**—The amendments
made by this section shall apply to taxable years beginning after December 31, 2012.

**SEC. 10902. INFLATION ADJUSTMENT OF LIMITA-
TIONS PLANS.**

(a) In General. Subsection (l) of section
125 of the Internal Revenue Code of 1986, as

(b) EFFECTIVE DATE. The amend-
ments made by this section shall apply to taxable
years beginning after December 31, 2012.
added by section 9005 of this Act, is amended to read as follows:

“(1) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

“(i) of section 9010(c)(2) of the Internal Revenue Code of 1986, as added by section 9007 of this Act, is amended by striking ‘‘the lowest amounts charged’’ and inserting ‘‘the amounts generally billed’’.

“(ii) of section 9010(c)(3) of the Internal Revenue Code of 1986, as added by section 9007 of this Act, is amended by striking ‘‘the lowest amounts charged’’ and inserting ‘‘the amounts generally billed’’.

“(iii) The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 10903. MODIFICATION OF LIMITATION ON CHARGES BY CHARITABLE HOSPITALS.

“(a) In General.—Subparagraph (A) of section 501(r)(5) of the Internal Revenue Code of 1986, as added by section 9007 of this Act, is amended by inserting ‘‘the lowest amounts charged’’ and inserting ‘‘the amounts generally billed’’.

“(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

SEC. 10904. MODIFICATION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND PROVIDERS.

“(a) In General.—Section 9009 of this Act is amended—

“(1) by striking ‘‘2009’’ in subsection (a)(1) and inserting ‘‘2010’’; and

“(2) by inserting ‘‘($3,000,000,000 after 2017)’’ after ‘‘$2,000,000,000’’, and

“(b) EFFECTIVE DATE.—The amendment made by this section shall take effect as if included in the enactment of section 9009.

The percentage of net premiums written that are taken into account is:

<table>
<thead>
<tr>
<th>Calendar year</th>
<th>Applicable amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$2,000,000,000</td>
</tr>
<tr>
<td>2010</td>
<td>$4,000,000,000</td>
</tr>
<tr>
<td>2011</td>
<td>$7,000,000,000</td>
</tr>
<tr>
<td>2012</td>
<td>$9,000,000,000</td>
</tr>
<tr>
<td>2013 and 2014</td>
<td>$10,000,000,000</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 entity—

“(i)(I) which is incorporated as a nonprofit corporation under a State law, or

“(ii) which is described in section 501(c)(4) of the Internal Revenue Code of 1986 and the activities of which consist of providing commercial-type insurance (within the meaning of section 501(m) of such Code),

“(D) any entity—

“(i) which is a mutual insurance company,

“(ii) which for the period reported on the 2008 Accident and Health Policy Experience Exhibit of the National Association of Insurance Commissioners had—

“(I) a market share of the insured population of a State of at least 40 but not more than 60 percent, and

“(II) with respect to all markets described in subparagraph (D)(i)(I), a medical loss ratio not more than 90 percent; and

“(E) any entity—

“(i) which is a mutual insurance company,

“(ii) which for the period reported on the 2008 Accident and Health Policy Experience Exhibit of the National Association of Insurance Commissioners had—

“(I) a market share of the insured population of a State of at least 40 but not more than 60 percent, and

“(II) with respect to all markets described in subparagraph (D)(i)(I), a medical loss ratio not more than 90 percent; and

“(iii) with respect to annual payment dates in calendar years after 2011, for which the medical loss ratio (determined in a manner consistent with the determination of such ratio under section 271(b)(1)(A) of the Public Health Service Act) with respect to all markets for such entity for the preceding calendar year is not less than 90 percent (except that with respect to such annual payment date for 2012, the calculation under 271(b)(1)(B)(i) of such Act is determined by reference to the previous year, and with respect to such annual payment date for 2013, such calculation is determined by reference to the average for the previous 2 years), or

“(F) any insurance company.

The term ‘‘medical loss ratio’’ 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, or

“(B) any insurance for long-term care, or

“(C) any Medicare supplemental health insurance (as defined in section 1857(c)(1) of the Social Security Act).

(e) Anti-Avoidance Guidance.—Subsection (i) of section 9010 of this Act is amended by inserting ‘‘and shall prescribe such regulations as may be necessary to prevent avoidance of the purposes of this section, including inappropriate actions taken
to qualify as an exempt entity under sub-
section (c)(2)(A) after ‘‘section’’.

CONFORMING AMENDMENTS.—
(a) Section 9010(a)(1) of this Act is amended by
striking ‘‘2008’’ and inserting ‘‘2009’’.
(b) Section 9010(c)(2)(H) of this Act is amended by
striking ‘‘except’’ and all that follows through ‘‘1233’’.
(c) Section 9010(b)(1) of this Act is amended by
adding at the end the following new sen-
tence: ‘‘If any entity described in subparagraph
(C)(1)(I), (D)(1)(I), or (E)(1) of paragraph
(2) is an exempt entity by reason of the
application of the preceding sentence, the
net premiums written with respect to
health insurance for any United States
health risk of such entity shall not be taken
into account for purposes of this section.’’.
(d) Section 9010(b)(1)(C) of this Act is amended
by striking ‘‘and third party administration
agreement fees’’.
(e) Section 9010(b)(1)(D) of this Act is amended
by striking ‘‘and third party administration
agreement fees received after such date’’.
(f) 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 AND MEDICARE TAX ON HIGH-INCOME TAXPAYERS.
(a) FICA.—Section 3101(b)(2) of the Internal Revenue Code of 1986, as added by section 9010(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 9010(b)(1) of this Act, is amended by striking ‘‘0.5 percent’’ and inserting ‘‘0.9 percent’’.
(c) EFFECTIVE DATE.—The amendments
made by this section shall apply to remuneration received, and taxable years beginning, after December 31, 2012.

SEC. 10907. EXCISE TAX ON INDOOR TANNING SERVICES IN LIEU OF ELECTIVE COSMETIC MEDICAL PROCEDURES.
(a) IN GENERAL.—The provisions of, and amendments made by, section 9017 of this Act are hereby deemed null, void, and of no effect.

(b) EXCISE TAX ON INDOOR TANNING SERVICES.—Subtitle D of the Internal Revenue Code of 1986, as added by this Act, is amended by adding at the end the following new chapter:

‘‘CHAPTER 49—COSMETIC SERVICES’’

‘‘Sec. 5000B. Imposition of tax on indoor tanning services.’’

‘‘Sec. 5000B. IMPOSITION OF TAX ON INDOOR TANNING SERVICES.’’

‘‘(a) IN GENERAL.—There is hereby imposed on any indoor tanning service a tax equal to 10 percent of the amount paid for such service (determined without regard to this section), whether paid by insurance or otherwise.

‘‘(b) INDOOR TANNING SERVICE.—For pur-
poses of this section—

‘‘(1) IN GENERAL.—The term ‘‘indoortanning service’’ includes the use of any electronic product designed to incorporate 1 or more ultraviolet lamps and intended for the irradiation of an individual by ultra-
violet radiation, with wavelengths in the air be-
tween 200 and 400 nanometers, to induce skin
tanning.

‘‘(2) EXCLUSION OF PHOTOGRAPHY SERVICES.—Exclusion of any service does not include any phototherapy service performed by a li-
censed medical professional.

(c) PAYMENT OF TAX.—The tax imposed by this section shall be paid by the individual on whom the service is performed.

‘‘(2) COLLECTION.—Every person receiving a payment for services on which a tax is im-
posed 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.

‘‘(B) 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) CERCLICAL AMENDMENT.—The table of chapter for subtitle D of the Internal Revenue
Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 49 the following new item:

‘‘CHAPTER 49—COSMETIC SERVICES’’.

(d) EFFECTIVE DATE.—The amendments
made by this section shall apply to services performed on or after July 1, 2010.

SEC. 10908. EXCLUSION FOR ASSISTANCE PROVIDED TO PARTICIPANTS IN STATE STUDENT LOAN REPAYMENT PROGRAMS FOR CERTAIN HEALTH PROFESSIONAL EDUCATION DEBTS.
(a) IN GENERAL.—Subsection (b) of section
9015(a)(1) of this Act, is amended by striking
‘‘0.5 percent’’ and inserting ‘‘0.9 percent’’.
(b) SECA.—Section 1401(b)(2)(A) of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to chapter 48 the following new item:

‘‘CHAPTER 49—COSMETIC SERVICES’’.

SEC. 10909. EXPANSION OF ADOPTION CREDIT PROGRAM.
(a) INCREASE IN DOLLAR LIMITATION.—
(i) ADOPION CREDIT.—(A) IN GENERAL.—Paragraph (1) of section
105(f) of the Internal Revenue Code of 1986 is amended to read as follows:
‘‘(1) DOLLAR LIMITATIONS.—In the case of a
parent or individual who incurs expenses for
such adoption, the credit allowed by section 212 shall be increased by—

‘‘(A) such dollar amount, multiplied by

‘‘(B) the cost-of-living adjustment deter-

‘‘(2) INCOME LIMITATION.—In the case of a
taxable year beginning after December 31, 2002, the dollar amount in subsection
(b)(2)(A) shall be increased by an amount equal to—

‘‘(A) such dollar amount, multiplied by

‘‘(B) the cost-of-living adjustment deter-

‘‘(3) AFF DENTS FOR INFLATION.—Subsection (b) of section
105(e) of the Internal Revenue Code of 1986 is amended to read as follows:
‘‘(b) INCOME LIMITATION.—In the case of a
parent or individual who incurs expenses for
such adoption, the credit allowed by section 212 shall be increased by—

‘‘(A) such dollar amount, multiplied by

‘‘(B) the cost-of-living adjustment deter-

‘‘(c) CREDIT MADE REFUNDABLE.—(1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue
Code of 1986 is amended—

‘‘(A) by redesignating section 23, as amended by section 9010, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

‘‘(B) by moving section 36C (as so redesign-
ated) from subpart A of part IV of sub-
chapter A of chapter 1 to the location imme-
diately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(c) CREDITS.—(1) ADOPION CREDIT.—(A) Section
212(b)(3)(B) of this Code is amended by striking ‘‘23’’, both places it ap-
ppears.

(B) Section 25A(1)(b)(5)(B) of such Code is amended by striking ‘‘23, 25B’’, and ‘‘25BD’’.}
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(D) Section 35B(c)(2) of such Code is amended by striking “23”.
(E) Section 36(a)(1) of such Code is amended by striking “25”.
(F) Section 36(c)(2)(B)(i) of such Code is amended by striking “23, 25D,” and inserting “25D”.
(G) Section 30B(b)(2)(B) of such Code is amended by striking “23”.
(H) Section 30D(c)(2)(B)(i) of such Code is amended by striking “sections 23 and” and inserting “section 36C(d)”.
(I) Section 36C of such Code, as so redesignated, is amended—
   (i) by striking paragraph (4) of subsection (b), and
   (ii) by striking subsection (c).
(J) Section 137 of such Code is amended—
   (i) by striking “section 23(d)” in subsection (d) and inserting “section 36C(d)”.
   (ii) by striking “section 23” in subsection (e) and inserting “section 36C”.
(K) Section 904(1) of such Code is amended by striking “24”.
(L) Section 1016(a)(26) is amended by striking “23(g)” and inserting “36C(g)”.
(M) Section 1400C(d) of such Code is amended by striking “23”.
(N) Section 6211(b)(4)(A) of such Code is amended by inserting “36C,” before “36E(c)”.
(O) The tables of sections for part I of subpart A of chapter 1 of such Code of 1986 are amended by striking the item relating to section 23.
(P) Paragraph (2) of section 1324(b) of title 31, United States Code, as amended by this Act, is amended by inserting “36C,” after “36B,”.
(Q) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986, as amended by this Act, is amended by inserting after the item relating to section 36B the following new item:
   “Sec. 36C. Adoption expenses.”.
(c) APPLICATION AND EXTENSION OF EGTRRA SUNSET.—Notwithstanding section 901 of the Economic Growth and Tax Relief Reconciliation Act of 2001, this section shall apply to the amendments made by this section and the amendments made by section 202 of such Act by substituting “December 31, 2011” for “December 31, 2010” in subsection (a)(1) thereof.
(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3277. Mr. REID proposed an amendment to amendment SA 3276 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the amendment SA 2786 proposed by Mr. REID, to provide that Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of the amendment, add the following:

The provisions of this Act shall become effective 5 days after enactment.

SA 3278. Mr. REID proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end of the language proposed to be stricken, insert the following:

This section shall become effective 4 days after enactment.

SA 3279. Mr. REID proposed an amendment to amendment SA 3278 proposed by Mr. REID to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

In the amendment, strike “4” and insert “3”.

SA 3280. Mr. REID proposed an amendment to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

At the end, insert the following:

The provisions of this Act shall become effective 2 days after enactment.

SA 3281. Mr. REID proposed an amendment to amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Strike “2 days” and insert “1 day”.

SA 3282. Mr. REID proposed an amendment to amendment SA 3281 proposed by Mr. REID to the amendment SA 3280 proposed by Mr. REID to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; as follows:

Strike “1 day” and insert “immediately”.

SA 3283. Mr. COBURN submitted an amendment intended to be proposed to amendment SA 3280 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 after the enacting clause and insert the following:

SECTION II.—STATE-BASED HEALTH CARE EXCHANGES

Sec. 201. State-based health care exchanges.
Sec. 712. Exception to limitation on certain physician referrals (under Stark) for provision of health information technology and training, and referral to health care professionals.

Sec. 713. Rules of construction regarding use of consortia.

TITLES VIII—HEALTH CARE SERVICES COMMISSION

Subtitle A—Establishment and General Duties

Sec. 801. Establishment.

Sec. 802. General authorities and duties.

Sec. 803. Dissemination.

Subtitle B—Forum for Quality and Effectiveness in Health Care

Sec. 811. Establishment of office.

Sec. 812. Membership.

Sec. 813. Duties.

Sec. 814. Adoption and enforcement of guidelines and standards.

Sec. 815. Additional requirements.

Subtitle C—General Provisions

Sec. 821. Certain administrative authorities.

Sec. 822. Funding.

Sec. 823. Definitions.

Subtitle D—Terminations and Transition

Sec. 831. Termination of Agency for Healthcare Research and Quality.

Sec. 832. Transition.

Subtitle E—Independent Health Record Trust

Sec. 841. Short title.

Sec. 842. Purpose.

Sec. 843. Definitions.

Sec. 844. Establishment, certification, and membership of Independent Health Record 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. Transformation of Federal health care services.

Sec. 906. National priorities for healthy Americans.

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 referrals for preventive health services, including mammograms and cervical cancer screening, without intermediate coverage 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.

TITLES I—INVESTING IN PREVENTION

SEC. 101. STRATEGIC APPROACH TO OUTCOME-BASED PREVENTION.

(a) INTERAGENCY COORDINATING COMMITTEE.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this title as the ‘‘Secretary’’) shall convene an interagency coordinating committee to develop a national strategic and grading of outcomes to disease prevention and health promotion initiatives, programs, and agencies. Such reviews shall be evaluated based on effectiveness in meeting science-based goals and posted on such agencies’ public Internet websites.

(b) FEDERAL MESSAGING ON HEALTH PROMOTION AND DISEASE PREVENTION.—

(1) MEDIA CAMPAIGNS.—

(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(B) REQUIREMENTS OF CAMPAIGN.—The campaign implemented under subparagraph (A) shall include—

(i) a nationwide 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 and the public.

(ii) may include the use of humor and national recognition goals with marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(iii) may include the use of humor and national recognition goals with marketing venues and may be targeted to specific age groups based on peer-reviewed social research;

(iv) shall not be duplicative of any other Federal efforts relating to health promotion and disease prevention; and

(v) may include the use of humor and national recognition goals with marketing venues and may be targeted to specific age groups based on peer-reviewed social research.

(C) EVALUATION.—The Secretary shall ensure that the campaign implemented under paragraph (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 the public information on guidelines for nutrition, regular exercise, obesity reduction, the leading disease killers in the United States, and secondary prevention through disease screening promotion.

(3) DISSEMINATION OF INFORMATION THROUGH EMPLOYERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of health promotion and disease prevention information consistent with national priorities described in the strategic and implementing plan under subsection (a)(3)(A), to health care providers and the public.

(D) PERSONALIZED PREVENTION PLANS.—

(a) CONTRACT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall enter into a contract with a qualified entity for the development and operation of a Federal Internet website personalized prevention plan tool.

(b) USE.—The website developed under sub-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 relevant information) relating to the leading diseases in the United States, and obtain personalized suggestions for preventing such diseases.

(5) Internet portal.—The Secretary shall establish an Internet portal for accessing risk-assessment tools developed and maintained by private and academic entities.

(6) In general.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants and other efforts to achieve similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this Act.

SEC. 102. STATE GRANTS FOR OUTCOME-BASED PREVENTION EFFORT.

(a) In general.—If the Secretary determines that it is essential to meeting the national priorities described in the plan required under section 101(a)(3)(A), the Secretary may award grants to States for the conduct of specific health promotion and disease prevention activities.

(b) Eligibility.—To be eligible to receive a grant under subsection (a), a State shall submit, for each application, at the time, in such manner, and containing such information as the Secretary may require, including a strategic plan that shall—

(1) describe the specific health promotion and disease prevention activities to be carried out under this grant;

(2) include a list of the barriers that exist within the State to achieving specific goals of Healthy People 2010;

(3) include targeted demographic indicators and measurable objectives with respect to health promotion and disease prevention;

(4) contain a set of process outcomes and milestones, based on the process outcomes and milestones developed by the Secretary, for measuring the effectiveness of activities carried out under the grant in the State; and

(5) outline the manner in which interventions to be carried out under this grant will reduce mortality or morbidity within the State over a 5-year period or (over a 10-year period, if the Secretary determines such period appropriate for adequately measuring progress towards program goals)

(c) Process Outcomes and Milestones.—

(1) In general.—The Secretary shall develop process outcomes and milestones to be used in measuring the effectiveness of activities carried out under a grant under this section by a State.

(2) Determinations.—If, beginning 2 years after the date on which a grant is awarded to a State under this section, the Secretary determines that the State is failing to make adequate progress in meeting the outcomes and milestones contained in the State plan under subsection (b)(4) over a 5-year period, the Secretary shall terminate all funding to the State under a grant under this section.

(d) Regional activities.—A State may use an amount, not to exceed 15 percent of the total grant amount to such State, to carry out regional activities in conjunction with other States.

(e) Targeted activities.—A State may use grant funds to target specific populations, to achieve specific outcomes described in Healthy People 2010.

(f) Innovative Incentive Structures.—The Secretary may award grants to States for the purposes of developing innovative incentive structures to encourage individuals to adopt specific prevention behaviors such as reducing their body mass index or for smoking cessation.

(g) Wellness Bonuses.—

(1) In general.—The Secretary shall award wellness bonuses payments to at least 5 but not more than 10 States that demonstrate the greatest progress in reducing disease rates and risk factors and increasing healthy behaviors.

(2) Requirement.—To be eligible to receive a bonus payment under paragraph (1), a State shall demonstrate—

(A) the progress described in paragraph (1); and

(B) that the State has met a specific floor for progress outlined in the science-based metrics of Healthy People 2010.

(3) Use of Payments.—Bonus payments under this subsection may only be used by a State for the purposes of health promotion and disease prevention.

(4) Funding.—Out of funds appropriated to the Secretary of the Treasury for the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, the Secretary shall—

(a) set a benchmark of 90 percent or greater coverage of Healthy People 2010; and

(b) develop a process outcomes and milestones to be achieved by the States to meet such benchmark.

(5) Internet Portal.—The Secretary shall establish an Internet portal for accessing personalized suggestions for prevention of leading diseases in the United States, and establishment of personal health and family history, BMI, and other relevant information as the Secretary may require under section 101(a)(3)(A), the Secretary may award grants to States for the conduct of specific health promotion and disease prevention activities.

(6) In general.—Funding for the activities authorized under this section shall take priority over funding from the Centers for Disease Control and Prevention provided for grants and other efforts to achieve similar purposes and goals as provided for in this section. Not to exceed $500,000,000 shall be expended on the campaigns and activities required under this Act.

SEC. 103. FUNDING FOR THE FOOD STAMP PROGRAM ON NUTRITION.

(a) Counseling Brochure.—The Director of the Centers for Disease Control and Prevention and the Secretary of Agriculture shall distribute to each individual and family enrolled in the Food Stamp Program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.) the science-based nutrition counseling brochure.

(b) Limitations on Food Stamp Purchases.—

(1) In general.—Not later than 6 months after the date of enactment of this Act, the Secretary of Agriculture shall, based on scientific, peer-reviewed recommendations provided by a Commission that includes public health, medical, and nutrition experts and the Director of the Centers for Disease Control and Prevention, develop lists of foods that do not meet science-based standards for proper nutrition and that may not be purchased under the food stamp program. Such list shall be updated on an annual basis to allow for the use of science-based recommendations that are applied to the food stamp program.

(2) Automated Enforcement.—The Secretary, if a State through regulations, ensure that the limitations on food purchases under paragraph (1) is enforced through the food stamp program’s automated system.

(3) Implementation.—The Secretary of Agriculture shall promulgate the regulations described in paragraph (2) not later than 1 year after the date of enactment of this section.

SEC. 104. IMMUNIZATION PROGRAMS AND QUANTITY PURCHASE VACCINES.

Notwithstanding any other provision of law, a State may use amounts provided under section 317 of the Public Health Service Act (42 U.S.C. 247a) for immunization programs to purchase vaccines for use in health care provider offices and schools.

(a) Technical Assistance and Reduction in Barriers.—If the Secretary determines that States achieve a benchmark of 80 percent coverage within the State for Centers for Disease Control and Prevention-recommended vaccines, the Director of the Centers shall provide technical assistance to the State for a period of 2 years. If after the expiration of such period the State continues to fail to achieve such benchmark, the Secretary shall reduce funding provided under section 317 of the Public Health Service Act to such State by 5 percent.

(b) Bonus Grant.—A State achieving a benchmark of 90 percent or greater coverage within the State for Centers for Disease Control and Prevention-recommended vaccines shall be eligible to receive from amounts appropriated under subsection (d).

(c) Authorization of Appropriations.—Out of funds appropriated to the Director of the Centers for Disease Control and Prevention for each fiscal year beginning with fiscal year 2010, there shall be made available to carry out this section, $50,000,000 for each fiscal year.

(d) Funding for Section 317.—Section 317(f)(1) of the Public Health Service Act (42 U.S.C. 247f(1)) is amended by striking “2005” and inserting “2012.”

TITLE II—STATE-BASED HEALTH CARE EXCHANGES

SEC. 201. STATE-BASED HEALTH CARE EXCHANGES.

(a) In general.—The Secretary of Health and Human Services (referred to in this title as the “Secretary”) shall establish a process for certification of alternative exchanges consistent with the requirements of States for the establishment and implementation of State-based health care exchanges (referred to in this title as a “State Exchange”) and for the operation of such State Exchanges. The Secretary shall certify a State Exchange if the Secretary determines that such Exchange meets the requirements of this section.

(b) Continued Certification.—The certification of a State Exchange under subsection (a) shall remain in effect until the Secretary determines that the Exchange has failed to meet any of the requirements under this title.

SEC. 202. REQUIREMENTS.

(a) General Requirements for Certification.—An application for certification under section 201(a) shall demonstrate compliance with the following:

(1) Purpose.—The primary purpose of a State Exchange shall be the facilitation of the individual purchase of innovative private health insurance and the creation of a marketplace where private health plans compete for enrollees based on price and quality.

(2) Administration.—A State Exchange for exchanges that participate in the health insurance plans that are participating in the State Exchange through direct contracts with the health insurance plans that are participating in the State Exchange or through a contract with a third party administrator for the operation of the State Exchange.

(3) Plan Participation.—A State shall not restrict or otherwise limit the ability of
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 and applicable to all benefits insurance issuers in the State and otherwise comply with the requirements of this title.

(4) PREMIUMS.—

(A) IN GENERAL.—The monthly State shall not determine premium or cost sharing amounts for health insurance coverage offered through the State Exchange.

(B) FUNDING METHOD.—A State shall ensure the existence of an effective and efficient method for the collection of premiums for health insurance coverage offered through the State Exchange.

(c) BENEFIT PARITY WITH MEMBERS OF CONGRESS.—With respect to health insurance issuers offering health insurance coverage through the State Exchange, the State shall not impose any requirement that such issuers provide coverage that includes benefits different than requirements on plans offered to Members of Congress under chapter 89 of title 5, United States Code.

(d) FACILITATING UNIVERSAL COVERAGE FOR AMERICANS.—

(1) AUTOMATIC ENROLLMENT.—The State Exchange shall ensure that health insurance coverage offered through the Exchange provides for the application of uniform mechanisms to encourage and facilitate the enrollment of all eligible individuals in Exchange-based health insurance coverage. Such mechanisms shall include automatic enrollment through various venues, which may include emergency rooms, the submission of State tax forms, places of employment in the State, and State departments of motor vehicles.

(2) OTHER ENROLLMENT OPPORTUNITIES.—

(A) IN GENERAL.—The State Exchange shall ensure that health insurance coverage offered through the Exchange permits eligible individuals to annually enroll among the coverages offered through the Exchange, subject to subparagraph (A).

(B) INCENTIVES FOR CONTINUOUS ANNUAL COVERAGE.—The Exchange shall include an incentive for eligible individuals to remain insured from plan year to plan year, and may include incentives such as State tax incentives or rebates based on continuous enrollment through the Exchange.

(C) GUARANTEED ACCESS FOR INDIVIDUALS.—The State Exchange shall ensure that, with respect to health insurance coverage offered through the Exchange, all eligible individuals are able to enroll in the coverage of their choice provided that such individuals agree to make applicable premium and cost sharing payments.

(3) LIMITATION ON PRE-EXISTING CONDITION EXCLUSIONS.—The State Exchange shall ensure that health insurance coverage offered through the Exchange meets the requirements of section 9801 of the Internal Revenue Code of 1986 in the same manner as if such coverage was a group health plan.

(4) OPT-OUT.—Nothing in this title shall be construed to require that an individual be enrolled in health insurance coverage.

(d) LIMITATION ON EXORBITANT PREMIUMS.—

(1) GRANTS.—The Secretary may award grants, pursuant to subsection (b), to States for the development, implementation, and evaluation of certified State Exchanges and expansions of premium assistance programs for individuals purchasing health insurance coverage.

(2) MECHANISM OPTIONS.—The mechanisms referred to in paragraph (1) may include the following:

(A) INDEPENDENT RISK ADJUSTMENT.—The State Exchange may establish an independent risk adjustment mechanism among health insurance coverage offered through the State Exchange through a contract entered into with a private, independent board. The State Exchange may establish a formulaic basis of payment for health insurance issuers and State officials but shall be independently controlled. The State Exchange shall ensure that risk-adjustment mechanisms shall be based on a blend of patient diagnoses and estimated costs.

(B) HEALTH SECURITY POOLS.—The establishment and operation under section 2745 of the Public Health Service Act of a health security pool to guarantee high-risk individuals access to affordable, quality health care.

(C) REINSURANCE.—The implementation of a successful reinsurance mechanism to guarantee high-risk individuals access to affordable, quality health care.

(e) MIDCAID AND SCHIP BENEFICIARIES.—

The State Exchange shall include procedures to permit eligible individuals who are receiving (or who are eligible to receive) health care under title XIX or XXI of the Social Security Act to enroll in health insurance coverage offered through the Exchange.

(f) DISSEMINATION OF EXCHANGE INFORMATION.—The State Exchange shall ensure that each health insurance issuer that provides health insurance coverage through the Exchange disseminate to eligible individuals and employers within the State information concerning health insurance coverage options, including the plans offered and premium and cost-sharing amounts for such plans.

(g) REGIONAL OPTIONS.—

(1) INTERSTATE COMPACTS.—Two or more States that establish a State Exchange may enter into interstate compacts for the purpose of implementing regulations of health insurance coverage offered within such States.

(2) MODEL LEGISLATION.—States adopting legislation as developed by the National Association of Insurance Commissioners shall be eligible to enter into an interstate compact as provided for in this section.

(h) PURCHASE ACROSS STATE LINES.—Notwithstanding any other provision of law, an eligible individual may enroll in health insurance coverage offered through the Exchange in any State. The regulation of such coverage (and the addressing of grievances relating to such coverage) shall be subject to the laws of the State in which such coverage is purchased, regardless of the State in which the eligible individual resides.

(i) ELIGIBLE INDIVIDUALS.—In this title, the term ‘‘eligible individual’’ means an individual who is—

(1) a citizen or national of the United States or an alien lawfully admitted to the United States for permanent residence or otherwise residing in the United States under color of law;

(2) not incarcerated; and

(3) not eligible for coverage under parts A and B (or C) of the Medicare program under title XVIII of the Social Security Act.

SEC. 203. STATE EXCHANGE INCENTIVES.

(a) GRANTS.—The Secretary may award grants, pursuant to subsection (b), to States for the development, implementation, and evaluation of certified State Exchanges and expansions of premium assistance programs for individuals purchasing health insurance coverage.

(b) ONE-TIME INCREASE IN MEDICAID PAYMENT.—In the case of a State awarded a grant to carry out this section, the total amount of the Federal payment determined for the State for the fiscal year 2010 under title XIX of the Social Security Act (as amended by section 401) for fiscal year 2011 shall be increased by an amount equal to 1 percent of the total amount of payments made to the State for fiscal year 2010 under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for purposes of carrying out a grant awarded pursuant to section 1913 of title 19 of subtitle 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.

(b) MONTHLY LIMITATION.—

(1) IN GENERAL.—The monthly limitation for each month during the taxable year for an eligible individual is—

(A) the applicable adult amount, in the case that the eligible individual is the taxpayer or the taxpayer’s spouse;

(B) the applicable adult amount, in the case that the eligible individual is an adult dependent, and

(C) the applicable child amount, in the case that the eligible individual is a child dependent.

(2) LIMITATION ON AGGREGATE AMOUNT.—Notwithstanding paragraph (1), the aggregate monthly limitations for the taxpayer and the taxpayer’s spouse and dependents for any month shall not exceed 4 x the applicable aggregate amount for such month.

(3) NO CREDIT FOR INELIGIBLE MONTHS.—With respect to any individual, the monthly limitation shall be zero for any month for which such individual is not an eligible individual.

(4) APPLICABLE AMOUNT.—

(A) IN GENERAL.—For purposes of this section—

(i) APPLICABLE ADULT AMOUNT.—The applicable adult amount is $2,290.

(ii) APPLICABLE CHILD AMOUNT.—The applicable child amount is $1,325.

(iii) APPLICABLE AGGREGATE AMOUNT.—The applicable aggregate amount is $5,710.

(b) COST-OF-LIVING ADJUSTMENTS.—

(1) IN GENERAL.—For each calendar year after December 19, 2009, the applicable aggregate amount for the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to such dollar amount multiplied by the blended cost-of-living adjustment.

(2) BLENDED COST-OF-LIVING ADJUSTMENT.—In this section, ‘‘blended cost-of-living adjustment’’ means one-half of the sum of—

(iii) INCREASES.—In the case of any tax-
``(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 preceding calendar year.

(3) HEALTH INSURANCE.—For purposes of this section—

(1) Qualified health insurance.—The term ‘qualified health insurance’ means any insurance constituting medical care which (as determined under regulations prescribed by the Secretary) is—

(A) a reasonable annual and lifetime benefit maximum, and

(B) provides coverage for inpatient and outpatient care, emergency benefits, and physician care.

Such term does not include any insurance substantially all of the coverage of which is coverage described in section 223(c)(1)(B).

(2) Qualified refund eligible health insurance.—The term ‘qualified refund eligible health insurance’ means any qualified health insurance which is coverage under a group health plan (as defined in section 5000(b)(1)).

(3) Designated account.—For purposes of this section, the term ‘designated account’ means any specified account with respect to whom a credit under section 223(c)(1) is determined to be allowable to the taxpayer under subsection (a) or (b).

(4) 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.

(5) Health insurance reserve account.—For purposes of this section, the term ‘health insurance reserve account’ means any trust created or organized in the United States as a health insurance reserve account trust created or organized in the United States as a health insurance reserve account (as determined under regulations prescribed by the Secretary), but only if the written governing instrument creating the trust meets the requirements of subparagraphs (B), (C), (D), and (E) of section 223(d)(1). Rules similar to the rules under subparagraphs (g) and (h) of section 408 shall apply for purposes of this subparagraph.

(6) 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).

(7) Definitions.—For purposes of this section—

(1) DEPENDENT.—The term ‘dependent’ has the meaning given such term by section 152 (as determined without regard to subparagraphs (B), (b)(1), (b)(2), and (d)(1)(B) thereof). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the taxpayer if the individual is—

(A) entitled to benefits under part A of title XVIII of the Social Security Act, and

(B) covered under qualified health insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under subsection (a) or (b), or

(2) MARRIED COUPLES MUST FILE JOINT RETURNS.—No credit shall be allowed under this section to any married individual who files a separate return (a) only if the taxpayer and his spouse file a joint return for the taxable year, or

(3) MARRIED COUPLES AND DEPENDENTS TREATMENT OF PAYMENTS.—Rules similar to the rules of paragraphs (7) and (8) of section 35(g) shall apply for purposes of this section.

(4) COORDINATION WITH 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 such excess shall be increased by the sum of—

(A) such excess, plus

(B) interest on such excess determined at the underpayment rate established under section 6621 for the period from the date of the payment under section 7527A to the date such excess is paid.

(5) DEPENDENT.—The term ‘dependent’ has the meaning given such term by section 152 (as determined without regard to subparagraphs (B), (b)(1), (b)(2), and (d)(1)(B) thereof). An individual who is a child to whom section 152(e) applies shall be treated as a dependent of the taxpayer if the individual is—

(A) entitled to benefits under part A of title XVIII of the Social Security Act, and

(B) covered under qualified health insurance which is taken into account for purposes of determining the credit allowable to the taxpayer under subsection (a) or (b), or

(6) 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(a).

(7) Coordination with health care tax credit.—No credit shall be allowed under this section (a) for any taxable year to any taxpayer and qualifying family members with respect to whom a credit under section 35 is allowed for such taxable year.
any amount imposed by reason of subparagraph (B) if such excess was not the result of the actions of the taxpayer."

(b) ADVANCE PAYMENT OF CREDIT.—Chapter 77 (relating to 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 establish a program for making payments on behalf of individuals to providers of qualified refund eligible health insurance (as defined in section 25E(f)) for any individual for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.

(b) Limitation.—The Secretary may make payments under subsection (a) only to the extent that the Secretary determines that the amount of such payments made on behalf of any taxpayer for any month does not exceed the sum of the monthly limitations determined under section 25E(b) for the taxpayer’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 6050W the following new section:

SEC. 6050X. RETURNS RELATING TO CREDIT FOR QUALIFIED REFUND ELIGIBLE HEALTH INSURANCE.

(a) Required Form of Return.—Every person who is entitled to receive payments for any month of any calendar year under section 7527A (relating to advance payment of credit for qualified refund eligible health insurance) with respect to any individual shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to each such individual.

(b) Form and Manner of Returns.—A return described in this subsection if such return—

(1) is in such form as the Secretary may prescribe, and

(2) contains, with respect to each individual referred to in subsection (a)—

(A) the name, address, and TIN of such individual,

(B) the months for which amounts payments under section 7527A were received,

(C) the amount of such payment,

(D) the type of insurance coverage provided by such payment, and

(E) the name, address, and TIN of the spouse and each dependents covered under such coverage.

(3) include any premium for coverage by an accident and health plan or any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(f)) for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.

(c) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 202. REQUIRING EMPLOYER TRANSPARENCY ABOUT EMPLOYER BENEFITS.

(a) In general.—Section 6051(a) (relating to W–2 requirement) is amended by striking "and" and at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting "and", and by inserting after paragraph (13) the following new paragraph:

"(14) the aggregate cost (within the meaning of section 4980B(f)(4)) of coverage for the employee under an accident or health plan which is excludable from the gross income of the employee under section 106(a) (other than coverage under a health flexible spending arrangement)."

(b) Effective Date.—The amendments made by this section shall apply to statements filed after December 31, 2009.

SEC. 303. CHANGES TO EXISTING TAX PRE- EXCLUSION RULES FOR PERSONAL HEALTH COVERAGE, ETC., FOR INDIVIDUALS ELIGIBLE FOR QUALIFIED HEALTH INSURANCE CREDITS.

(a) Exclusion for Contributions by Employer to Accident and Health Plans.—

(1) In general.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

"(f) Exclusion for Contributions by Employer to Accident and Health Plans.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.

(2) Reporting Requirement.—Subsection (a) is amended by striking "and" and at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting "and", and by inserting after paragraph (13) the following new paragraph:

"(14) the total amount of employer-provided coverage under an accident or health plan which is includable in gross income by reason of sections 106(f) and 106(f)."

(g) Retired Public Safety Officers.—Section 402(l)(4)(D) is amended by adding at the end the following new paragraph:

"(3) an amount described in section 25E(e) for such month.

"(g) Exclusion for Contributions by Employer to Accident and Health Plans.—

(1) In general.—Section 106 (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsection:

"(f) Exclusion for Contributions by Employer to Accident and Health Plans.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.

(2) Reporting Requirement.—Subsection (a) is amended by striking "and" and at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting "and", and by inserting after paragraph (13) the following new paragraph:

"(14) the total amount of employer-provided coverage under an accident or health plan which is includable in gross income by reason of sections 106(f) and 106(f)."

(3) an amount described in section 25E(e) for such month.

(2) Exclusion for Contributions by Employer to Accident and Health Plans.—The term 'medical care' does not include any amount paid as a premium for coverage of an eligible individual (as defined in section 25E(e)) for any month unless such individual is described in paragraph (2) or (5) of section 25E(e) for such month.
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.

(2) SEC. 1901. PURPOSE; APPROPRIATION.

(a) IN GENERAL.—Except as provided under section 1901 for a fiscal year, the Secretary shall provide for fiscal year 2011 and each fiscal year thereafter.

(b) PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

(1) IN GENERAL.—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.

(c) SEC. 1902. PAYMENTS TO STATES FOR ACUTE CARE MEDICAL ASSISTANCE.

(1) IN GENERAL.—Except as provided under section 1901 for a fiscal year, the Secretary shall provide for fiscal year 2011 and each fiscal year thereafter.

(2) ADMINISTRATIVE EXPENSES.—Each State with a plan approved under this part shall receive a payment determined in accordance with paragraph (2) and (3) of section 1902(b) of the Omnibus Budget Reconciliation Act of 1989.

(3) SEC. 1903. DEFINITIONS OF ELIGIBLE INDIVIDUALS AND ACUTE CARE MEDICAL ASSISTANCE.

(a) ELIGIBLE INDIVIDUALS.

(1) IN GENERAL.—In this part, the term ‘eligible individual’ means an individual—

(A) who is—

(i) a blind or disabled individual; or

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

(B) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements as are imposed under title V, including the documentation of citizenship or government-issued identification card which have been determined by the Secretary under title V.

(2) IN GENERAL.—In this title, the term ‘eligible individual’ means an individual—

(A) who is—

(i) a blind or disabled individual; or

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

(B) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements as are imposed under this title, including the documentation of citizenship or government-issued identification card which have been determined by the Secretary under this title.

(3) SEC. 1904. STATE PLAN REQUIREMENTS FOR ACUTE CARE MEDICAL ASSISTANCE.

(a) ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—In this part, the term ‘eligible individual’ means an individual—

(A) who is—

(i) a blind or disabled individual; or

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

(B) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements as are imposed under this title, including the documentation of citizenship or government-issued identification card which have been determined by the Secretary under this title.

(b) ADMINISTRATIVE EXPENSES.—Each State with a plan approved under this part shall receive a payment determined in accordance with paragraph (2) and (3) of section 1902(b) of the Omnibus Budget Reconciliation Act of 1989.

(c) SEC. 1905. DEFINITIONS.

(a) ELIGIBLE INDIVIDUALS.

(1) IN GENERAL.—In this part, the term ‘eligible individual’ means an individual—

(A) who is—

(i) a blind or disabled individual; or

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

(B) who the State determines satisfies—

(i) the income and resources eligibility requirements established by the State under the State plan under this part; and

(ii) such other requirements as are imposed under this title, including the documentation of citizenship or government-issued identification card which have been determined by the Secretary under this title.

(b) ADMINISTRATIVE EXPENSES.—Each State with a plan approved under this part shall receive a payment determined in accordance with paragraph (2) and (3) of section 1902(b) of the Omnibus Budget Reconciliation Act of 1989.
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) of this part (other than paragraph (16)).

(3) EXCLUSIONS.—

(A) CERTAIN SERVICES LIMITED TO PART B.—Services described in paragraphs (15), (22), (23), and (24) of old section 1905(a) shall only be provided under the State plan under part B.

(B) LIMIT ON PROVISION OF LONG-TERM CARE SERVICES AND SUPPORTS.—A care or service that the Secretary determines is a long-term care service and support (including nursing facility services described in old section 1905(a)(10)(D)) 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. The provisions of this part, other than the old provisions, shall not be less restrictive than the relevant old provisions.

(b) FEDERAL MEDICAL ASSISTANCE PERCENTAGE. The Federal medical assistance percentage shall be that percentage of the Federal medical assistance percentage that the State bears to the square of the per capita income of the continental United States (including Alaska and Hawaii, except that the State medical assistance percentage shall in no case be less than 50 percent or more than 83 percent. The Federal medical assistance percentage shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

(c) AMOUNT, DURATION, AND SCOPE. The State plan shall provide that the acute care medical assistance made available to any eligible individual shall not be less restrictive than the relevant old provisions, including the amount, duration, and scope of covered items and services.

(d) METHODS OF SERVICE DELIVERY. The State 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.

(e) PUBLIC AVAILABILITY OF STATE PLAN. The State shall make available to the public the State plan under this part and any amendments submitted by the State to the plan.

(f) FEDERAL MEDICAL ASSISTANCE REQUIREMENT FOR THE STATE PLAN. The provisions of old section 1902 shall apply under this part:

(1) OLD SECTION 1905 PROVISIONS. The following provisions of old section 1902 shall apply to payment for covered outpatient drugs and pharmaceutical services under this part:

(A) Old section 1902(a)(10)(C) (relating to nonapplication of certain supplemental security income eligibility criteria).

(B) Old section 1902(a)(10)(D) (relating to home health services).

(C) Old section 1902(a)(10)(G) (relating to nonapplication of certain supplemental security income eligibility criteria).

(D) The subclauses in the flush matter following old section 1902(a)(10)(G) (relating to the provision of certain services other than subclauses (V), (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 the month of application).

(H) 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).

(J) Old section 1902(a)(51) (relating to the definition of an intermediate care facility for the mentally retarded).

(K) Old section 1902(a)(60)(A) (relating to definition of an intermediate care facility for the mentally retarded).

(2) OLD TITLE XIX REQUIREMENTS.—

(A) State must have an approved State plan for acute care medical assistance. The provisions of this part, parts B, C, D, E, and F.

(B) Old section 1902(a)(10)(D) (relating to the definition of an intermediate care facility for the mentally retarded).

(C) Old section 1902(a)(19) (relating to the definition of a medicaid managed care organization).
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 tiers of service (presumptive, 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 methodology 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) Protection of Spousal impoverishment Protections.—The State plan shall provide that the State shall comply with the requirements of section 1916 (relating to spousal impoverishment protections).

"(C) State-Widens.—The State plan shall provide that, except with respect to methods used for determining heavy care exemptions, the income and asset standards and methodologies shall be in effect in all political subdivisions of the State.

"(4) Transition Assistance.—The State plan shall specify how the State will provide transition assistance for individuals who, on December 31, 2010, are enrolled under the State plan under old title XIX or PACE (or a waiver providing for 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 the standardized assessment process for purposes of this part).

"(5) 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 for the State that the State shall make publicly available—

"(A) the payment methodologies applicable under the plan; and

"(B) the name of any provider that receives $1,600,000 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) Application of Old Title XIX Requirements.—The first old title XIX provisions shall apply to a State plan under this part.

"(A) Subsections (a)(50) and (q) of old section 1922 (relating to a monthly personal needs allowance for certain institutionalized individuals and couples).

"(B) Old section 1922(a)(67) (relating to payment for certain services furnished to a PACE program eligible individual).

"(C) Public Availability of State Plan.—The State plan shall make publicly available to the public the State plan under this part and any amendments submitted by the State to the plan.

"(E) Application of Old Title XIX Requirements.—The first old title XIX provisions shall apply to a State plan under this part.

"(F) Public Funding of State Plan.—The State plan shall specify how the State will provide the methodologies used to determine the long-term care services and supports available—

"(1) for fiscal year 2013, $65,274,560,000;

"(2) for fiscal year 2012, $67,885,540,000;

"(3) for fiscal year 2013, $70,600,964,100;

"(4) for fiscal year 2014, $73,425,000,000;

"(5) for fiscal year 2015, $76,362,000,000;

"(6) for fiscal year 2016, $79,416,480,000;

"(7) for fiscal year 2017, $82,583,140,000;

"(8) for fiscal year 2018, $85,986,570,000; and

"(9) for fiscal year 2019, $89,332,743,000.

"(G) Allocation to States and the District of Columbia.—

"(1) Fiscal Year Allotments.—Subject to subsection (e), the Secretary shall allot to each State with a long term care plan approved under this title an amount in fiscal year 2011 equal to the Federal expenditures made by the State for long-term care as defined in section 1916 in fiscal year 2008, increased by 8 percent.

"(2) Subsequent Fiscal Year Allotments.—For fiscal year 2012 and each subsequent fiscal year through fiscal year 2019, the allotment for a State under this section is equal to the allotment for the State determined for the preceding fiscal year, increased by 4 percent.

"(H) 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 on 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.

"(C) Maintenance of Effort.—In order to qualify for the grant payable under this section, the State must demonstrate in each fiscal year that it made long-term care service and support expenditures (including funding from local government sources) equal to the amount of not less than 95 percent of the nonfederal share amount spent in fiscal year 2009 under the State plan under old title XIX on long term care services and supports (as defined in section 1916). Expenditures not made under this part shall not be recognized by the Secretary for purposes of this requirement.

"(D) Grants Reduced If Insufficient Appropriations.—

"(1) In General.—If the amount appropriated for fiscal year 2011 under subsection (a)(1) is less than the amount necessary to fund each State's allotment for that fiscal year, the Secretary shall reduce the allotment for each State for that fiscal year based on the applicable percentage determined for the State under paragraph (2).

"(2) Applicable Percentage.—For purposes of paragraph (1), the applicable percentage determined with respect to a State is as follows:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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<tr>
<td>50 percent or greater</td>
<td>at least 46, but less than 50 percent</td>
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<tr>
<td>at least 40, but less than 46 percent</td>
<td>at least 43, but less than 40 percent</td>
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<tr>
<td>at least 30, but less than 36 percent</td>
<td>at least 36, but less than 30 percent</td>
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<tr>
<td>less than 30 percent</td>
<td>at least 29 percent</td>
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"(I) Administrative Expenses.—

"(1) In General.—Each State with a plan approved under this part shall receive a payment determined in accordance with amounts appropriated for part E for administrative expenses incurred in carrying out the plan under this part and part A.

"(2) Assignment of Costs.—Costs attributable to providing an individualized needs-based assessment for purposes of identifying the long-term care services and support to be provided under the State plan to an individual shall be considered a long-term care service and support and shall not be treated as an administrative expense.
"SEC. 1914. USE OF GRANTS.
(a) In general.—A State shall use funds for long-term care services and supports as defined in section 1916.
(b) The individual to be served.—A State shall offer individuals the opportunity to self-direct their long-term care services and supports.

"SEC. 1915. ADMINISTRATIVE PROVISIONS.
(a) Funding for a waiver or a new plan.—The Secretary shall make payments to States in equal amounts of a State's annual allotment on a quarterly basis. Each quarterly payment shall remain available for use by the State for twelve succeeding fiscal year quarters.
(b) Publication.—The Secretary shall publish each State's allotment—
(1) for fiscal year 2011 not later than December 15, 2009; and
(2) for each subsequent fiscal year, not later than December 15 of the calendar year 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 terms 'long-term care services and supports' means any of the services or supports listed in subparagraphs (A) through (W) that may be provided in a nursing facility, an institution, a home, or other setting.

(b) 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 individual in maintaining independence, training of family members including foster parents in supportive and behavioral modification skills, and periodic training to maintain life skills, transitional care including room and board not to exceed 60 days within a 12-month period.

(b) Services and supports may also include any of the following services:
(A) Old section 1965(a)(15) (relating to services in an intermediate care facility for the mentally retarded).
(B) Services described in subsections (a)(15) and (h) of old section 1965, but without regard to any restriction on such services on the basis of age (relating to inpatient psychiatric hospital services).
(C) Old section 1965(a)(22) (relating to home and community care (to the extent allowed and as defined in old section 1929) for functionally disabled elderly individuals).
(D) Old section 1965(a)(23) (relating to community supported living arrangements for individuals with mental illness, home health services, services provided in an institution for mental disease, and may include any of the following services:
(E) Old section 1965(a)(15) (relating to services in an intermediate care facility for the mentally retarded).
(F) Old section 1965(a)(16) and (h) of old section 1965, but without regard to any restriction on such services on the basis of age (relating to inpatient psychiatric hospital services).
(G) Old section 1965(a)(22) (relating to home and community care (to the extent allowed and as defined in old section 1929) for functionally disabled elderly individuals).
(H) Old section 1965(a)(23) (relating to community supported living arrangements for individuals with mental illness, home health services, services provided in an institution for mental disease, and may include any of the following services:
(I) Self-directed services and support.
(J) Program eligible individuals enrolled under the program under such old section.
(K) Old section 1913(c)(5) (relating to the definition of habilitation services).
(L) Intermediate care services and supports cannot be used for services and administrative costs provided through the foster care (with the exception of training of foster parents), child welfare, adult protective services, juvenile justice, public guardianship, or correctional systems.
(M) Reimbursement for care.—For purposes of rehabilitation due to acute care medical needs, a State may claim rehabilitative services provided in an institutional setting, home health services, and medical expenses 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.
(N) Managed care.—If a State provides long-term care services and supports through managed care, the plan shall submit a methodology for determining the level of expenditures attributed to long term care for approval by the Secretary.
(O) Application of Part A Definitions.
A definition specified in section 1905 shall apply to the same extent in this part, and unless the Secretary otherwise specifies, the application of such definition would be inconsistent with the purpose of this part.

"(b) Exclusion.—No payments shall be made under the State plan under this part with respect to long-term care supports and services provided for any individual who is an inmate of a public institution. Nothing in the preceding sentence shall be construed as precluding the provision of long-term care services and supports under the State plan under this part for an individual who is a patient in an institution for mental diseases.

"SEC. 1917. PROVISION REQUIREMENTS FOR LONG-TERM CARE SERVICES AND SUPPORT, INCLUDING OPTION FOR SELF-DIRECTED SERVICES AND SUPPORT.

(A) Requirements for the Provision of Long-Term Care Services and Supports.—
(1) In general.—Subject to the succeeding provisions of this subsection, a State or the individual may provide through a State plan amendment, or the individual may provide through an independent evaluation for the individual, or the individual's representative to perform such activities.

(B) Criteria for Institutionalized versus Non-Institutionalized Services.—In establishing needs-based criteria, the State may establish criteria that would 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, and

(C) Authority to Limit Number of Eligible Family Members for Purposes of Section 1906(c)(2)(B) of the Internal Revenue Code of 1986 or the need for significant assistance to perform such activities.

(D) Criteria Based on Individual Assessment.—
ties and the requirements of subclauses (II) and (III) of section 1915(b), the State plan consistent with the following:

(i) PLAN REQUIREMENTS.—The State ensures that the individualized care plan for an individual—

(I) is developed—

(aa) in consultation with the individual, the individual’s treating physician, health care or support professional, or other appropriate individuals, as defined by the State, and, with the individual’s family, caregiver, or representative; and

(bb) taking into account the extent of, and need for, any family or other supports for the individual;

(II) identifies the long-term care services and supports to be furnished to the individual (or, if the individual elects to self-direct the plan, controls the receipt of, such services and supports, funded for the individual); and

(iii) is reviewed at least annually and as needed when there is a significant change in the individual’s circumstances.

(iii) STATE REQUIREMENT TO OFFER ELECTION FOR SELF-DIRECTED SERVICES AND SUPPORTS.—

(I) INDIVIDUAL CHOICE.—The State shall allow an individual or the individual’s representative the opportunity to elect to receive self-directed long-term care services and supports in a manner which gives them the control over such services and supports, funded for the individual, and need for, any family or other supports for the individual;

(II) SELF-DIRECTED.—The term ‘self-directed’ means, with respect to the long-term care service 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 localization of such services and supports, under the State plan consistent with the following requirements:

(aa) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services and supports;

(bb) BUDGET PROCESS.—With respect to individualized budgets described in subsection (III)(ii), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization; and

(bb) provides a procedure to evaluate adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(III) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

(I) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

(II) CONFLICT OF INTEREST STANDARDS.—

The State establishes standards for the conduct of the independent assessment and the independent assessment to safeguard against conflicts of interest.

(III) REDETERMINATIONS AND APPEALS.—The State allows at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(IV) BUDGET PROCESS.—With respect to individualized budgets described in subsection (III)(ii), the State plan amendment—

(aa) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization; and

(bb) provides a procedure to evaluate adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(cc) provides a procedure to evaluate expenditures under such budgets.

(V) QUALITY ASSURANCE; CONFLICT OF INTEREST STANDARDS.—

(I) QUALITY ASSURANCE.—The State ensures that the provision of long-term care services and supports meets Federal and State guidelines for quality assurance.

(II) CONFLICT OF INTEREST STANDARDS.—

The State establishes standards for the conduct of the independent assessment and the independent assessment to safeguard against conflicts of interest.

(III) REDETERMINATIONS AND APPEALS.—The State allows at least annual redeterminations of eligibility, and appeals in accordance with the frequency of, and manner in which, redeterminations and appeals of eligibility are made under the State plan.

(VI) PRESCRIPTIVE ELIGIBILITY FOR ASSESSMENT.—The State, at its option, elects to provide for a period of presumptive eligibility (not to exceed a period of 60 days) only for those individuals that the State has reason to believe may be eligible for long-term care services and supports. The 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 services. An individual is no longer eligible for an individual’s evidence of need for such medical assistance if the individual is no longer eligible for an individual’s evidence of need, a continuing need for such medical assistance if the State determines that the individual is no longer eligible for an individual’s evidence of need, or that the State determines that the individual is no longer eligible for an individual’s evidence of need.

(VII) 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.

(VIII) SELF-DIRECTED PERSONAL ASSISTANCE SERVICES.—If a State includes personal care or personal assistance services in the long-term care services and supports available under the State plan, the State shall comply with the requirements of old section 1915(c)(1) to the extent that the individual who elects to self-direct receives a certificate of self-direction, a certificate of professional assistance, or a certificate of personal care (or personal assistance) services. (2) and (4)(A) of subsection (a) of such section, shall apply under this part.

SEC. 1811. TREATMENT OF INCOME AND RECEIPTS OF CERTAIN INSTITUTIONALIZED SPOUSES.

‘Old section 1924 (relating to treatment of income and resources for certain institutionalized spouses), as added by subsections (2) and (4)(A) of section 1915(c)(1) shall apply under this part.

SEC. 1919. ANNUAL REPORTS.

(a) IN GENERAL.—Each State that receives payments under this part shall submit an annual report to the Secretary, in such form and manner as the Secretary shall specify.

(b) REQUIREMENTS.—The report shall include the following with respect to the most recent fiscal year ended:

(1) The number of individuals served under the plan.

(2) The number of individuals served by tier (preventive, emergency, low, medium, high needs).

(3) The number of individuals known to the State on waiting lists for services (if any) and the number, by type of disability (physical, developmental, mental health) or aged.

(4) Expenditures by service category.

PART C—GRANTS TO STATES FOR SURVEY AND CERTIFICATION OF MEDICAL FACILITIES AND OTHER REQUIREMENTS

SEC. 1831. 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 2002, $12,000,000; and

(2) for each succeeding fiscal year, such sums as may be necessary for the purpose of carrying out this part, such sums to remain available until expended.

SEC. 1922. APPLICATION OF REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

The following old provisions shall apply under this part:

(1) Old section 1902(a)(9) (relating to health standards and applicable requirements for laboratory services).

(2) Old section 1915(b)(2) (relating to nursing facilities and nursing facility services).

(3) Old sections 1902(a)(29) and 1908 (relating to a State program for the licensing of administrators of nursing homes).

(4) Old section 1902(a)(33)(B) (relating to licensing health institutions).

(5) Old section 1902(d) (relating to medical or utilization review functions).

(6) Old section 1902(1) (relating to intermedicate care facilities for the mentally retarded).

(7) Old section 1902(y) (relating to psychiatric hospitals).

(8) Old sections 1903(g) (relating to the definition of a board and care facility).

(9) Old section 1903(h) (relating to the definition of a board and care facility).

(10) Old section 1910 (relating to certification and approval of rural health clinics and intermediate care facilities for the mentally retarded).

(11) Old section 1911 (relating to Indian Health Service facilities).

(12) Old section 1913 (relating to hospital providers of nursing facility services).

(13) Old section 1919 (relating to requirements for nursing facilities).

PART D—GRANTS TO STATES FOR PROGRAM INTEGRITY

SEC. 1941. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—For the purpose of carrying out Federal activities under this part and providing grants to States for expenses necessary to carry out this part, there is authorized to be appropriated—

(1) for fiscal year 2011, $100,000,000; and

(2) for each succeeding fiscal year, the amount authorized under this section for the preceding fiscal year increased by 5 percent.

(b) AVAILABILITY; AUTHORITY FOR USE OF FUNDS.
"(1) AVAILABILITY.—Amounts appropriated pursuant to subsection (a) shall remain available until expended.

"(2) AUTHORITY FOR USE OF FUNDS FOR TRANSPORTATION, TRAVEL, EDUCATION, AND CONSULTATIVE ACTIVITIES.—

"(A) IN GENERAL.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies of the United States Government under chapter 57 of title 5, United States Code, while away from their homes or regular places of business, described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

"(B) PUBLIC DISCLOSURE.—The Secretary shall make available on a website of the Centers for Medicare & Medicaid Services that is accessible to the public—

"(i) the total amount of funds expended for each conference conducted under the authority of subsection (b)(4); and

"(ii) the amount of funds expended for each such conference for transportation and for travel expenses.

"(c) ANNUAL REPORT.—Not later than 180 days after the close of each fiscal year, the Secretary shall submit a report to Congress which identifies—

"(1) the use of funds appropriated pursuant to subsection (a); and

"(2) the effectiveness of the use of such funds.

"SEC. 1942. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

"The following old provisions shall apply under this title to a medicaid program described in subsection (a) for the preceding fiscal year (as such section was in effect for the preceding fiscal year, increased by 3 percent for fiscal year 2008 (as such section was in effect for fiscal year 2007))—

"(1) Old sections 1902(a)(25) (other than subparagraph (E)) and (g) of section 1902 and section 1903(o) (relating to third party liability).

"(2) Old section 1902(a)(30)(B) (relating to holding of Federal share of recoveries).

"(3) Old section 1902(a)(32) (relating to certain payment requirements).

"(4) Old section 1902(a)(35) (relating to disbursement of payments to individuals for covered services offered in an intermediate care facility for the mentally retarded, or hospital for mental diseases admission screening and review requirements).

"(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 section 1902(a)(49) and 1921 (relating to claims payment procedures concerning sanctions taken by State licensing authorities against health care practitioners and providers).

"(9) Old sections 1902(a)(61) and 1903(q) (relating to requirements for a Medicaid fraud and abuse control unit).

"(10) Old section 1902(a)(64) (relating to reports from beneficiaries and others and data compilation requirements concerning alleged instances of waste, fraud, and abuse).

"(11) Old section 1902(a)(65) (relating to provisions concerning the Medicare IME Bond Program).

"(12) Old section 1902(a)(66) (relating to requirements concerning the Medicare IME Bond Program).

"(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.

"(14) Old section 1902(a)(70)(B)(iv) (relating to prohibitions on referrals and conflict of interest for certain brokers of non-emergency medical transportation).

"(15) Old sections 1902(a)(71) and 1940 (relating to a required asset verification program).

"(16) Old section 1902(x) (relating to exclusion of certain individuals or entities).

"(17) Old section 1902(x) (relating to unique identifiers for physicians).

"(18) Old section 1903(x)(2) (relating to requirements for mechanism for ensuring timely return of recoveries).

"(19) Old section 1903(x)(3) (relating to requirements for mechanism for ensuring timely return of recoveries).

"(20) Old section 1903(u) (relating to erroneous excess payments), other than clause (i) of paragraphs (1) through (3) of subsection (a) and (b) of paragraph (4).

"(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 citizen 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.—The Secretary may use amounts appropriated pursuant to subsection (a) to pay for transportation and the travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies of the United States Government under chapter 57 of title 5, United States Code, while away from their homes or regular places of business, described in subsection (b)(4) who attend education, training, or consultative activities conducted under the authority of that subsection.

"(b) PAYMENTS TO STATES.—

"(1) In General.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B with the amount authorized under subparagraph (A) for fiscal year 2011, $7,000,000, and for each succeeding fiscal year, the amount authorized under this subsection for the preceding fiscal year, increased by 3 percent.

"(2) Payments to States.—

"(i) In General.—From the amount appropriated pursuant to subsection (a) for a fiscal year, the Secretary shall pay each State with approved plans under parts A and B for the fiscal year an amount equal to the product of the amount appropriated for the fiscal year and the ratio of the total amount of payments made to the State under paragraphs (2) through (7) of section 1903(a)(3) for fiscal year 2011 that was in effect for that fiscal year to the total amount of such payments made to all States for such fiscal year.

"(ii) PRO RATE ADJUSTMENT.—The Secretary shall make pro rata adjustments to the amounts determined under paragraph (1) for a fiscal year so as to not exceed the amount appropriated pursuant to subsection (a) for the fiscal year.

"SEC. 1952. COST-SHARING PROTECTIONS.

"(a) In General.—The Secretary 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 (in a uniform manner) require payment of monthly premiums or other cost-sharing charges based on a sliding scale based on family income.

"(2) A premium or other cost-sharing requirement imposed under paragraph (1) may only apply when the premium or other cost-sharing charges imposed under the plan do not exceed 5 percent of the individual’s annual income; and

"(B) exceeds 250 percent of the poverty line, the aggregate annual amount of such premium and other cost-sharing charges do not exceed 7.5 percent of the individual’s annual income.

"(3) A State shall not require prepayment of any premium or cost-sharing imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual under the State plan on the basis of failure to pay any such premium or cost-sharing until such failure continues for a period of at least 60 days from the date on which the premium or cost-sharing became past due. The State may waive payment of any such premium or cost-sharing in any case where the State determines that requiring such payment would create an undue hardship.

"(b) APPLICATION TO INSTITUTIONALIZED INDIVIDUALS.—A State may impose cost-sharing consistent with subsection (a) to individuals who are patients in, or residents of, a medical institution or nursing facility except that for a resident to the post-eligibility treatment of income (including a minium monthly personal needs allowance) applicable to institutionalized individuals under title XIX shall be applied in the same manner to individuals eligible for long-term care services and supports under a State plan under part B.

"(c) POVERTY LINE DEFINED.—In this section, the term ‘poverty line’ has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

"SEC. 1953. APPLICATION OF CERTAIN REQUIREMENTS UNDER PRE-MODERNIZED MEDICAID.

"The following old provisions shall apply to the State plans under this title—

"(1) Old State Plan Requirements.—

"(A) Old section 1902(a)(1) (relating to the requirement for plans to be in effect in all political subdivisions of the State).

"(B) Old section 1902(a)(2) (relating to State financial participation).

"(C) Old section 1902(a)(3) (relating to prepayment for a fiscal year).

"(D) Old section 1902(a)(4) (relating to administrative).

"(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 reclassification 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 or blindness).

"(K) Old section 1902(a)(13) (relating to determination of rates of payment for certain services).

"(L) Old sections 1902(a)(14) and 1902(a)(15) (relating to rates of payment for certain services).

"(M) Old section 1902(a)(16) (relating to furnishing services to individuals when absent from the State).

"(N) Old section 1902(a)(17) (relating to administrative provisions).

"(O) Paragraphs (23) and (25)(D) of old section 1902(a) (relating to any willing provider requirements).

"(P) Old section 1902(a)(24) (relating to consultative services by other agencies).

"(Q) Old section 1902(a)(28) (relating to reimbursement for intermediate care facilities for the mentally retarded and written plan for care requirements).

"(R) Old section 1902(a)(35) (relating to payment for services furnished by rural health clinics and federally qualified health centers).

"(S) Old section 1902(a)(36) (relating to written plan for care requirements).
“(b) REPEAL OF TITLE XXI.—Effective January 1, 2011, title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) is repealed.

SEC. 402. OUTREACH.

(a) AUTHORIZATION OF APPROPRIATIONS.—The following amounts are authorized to be appropriated to the Secretary of Health and Human Services:

(1) For fiscal year 2009, $100,000,000 for the design and implementation of a public outreach campaign to inform the public about the changes to the programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) For each of fiscal years 2010 and 2011, $200,000,000 to carry out such public outreach campaign.

For fiscal year 2012, $50,000,000 to carry out such public outreach campaign.

(b) AVAILABILITY.—Funds appropriated under subsection (a) shall remain available for expenditure through September 30, 2012.

(c) AUTHORIZATION FOR USE OF FUNDS.—The Secretary may use funds made available under subparagraphs (2) and (3) of subsection (a) to award grants to, or enter into contracts with, public or private entities, including States, local and tribal governments, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, outlying areas, and Indian tribes, for the purposes of carrying out such public outreach campaign by:

(1) Making information about the changes to the programs under such titles readily available to the public through public media campaigns, written materials, Web sites, and other public means.

(2) Providing education and training for public and private entities on the changes to the programs under such titles.

(3) Conducting or funding public outreach efforts in any of the States.

SEC. 403. TRANSITION RULES; MISCELLANEOUS PROVISIONS.

(a) IN GENERAL.—

(1) Not later than June 30, 2010, a State that is one of the 50 States or the District of Columbia shall approve any applications for medical assistance or child health assistance under a State plan under title XIX or XXI of the Social Security Act on such date (and any new enrollees after such date) of the changes to such programs under such titles that take effect on January 1, 2011, as a result of the amendment made by section 401.

(2) Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a legislative proposal for such technical and conforming amendments as are necessary to carry out the amendments made by this Act.

Subtitle B—Supplemental Health Care Assistance for Low-Income Families

SEC. 411. SUPPLEMENTAL HEALTH CARE ASSISTANCE FOR LOW-INCOME FAMILIES.

(a) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall supplement the costs of private health insurance for eligible low-income families through the distribution of supplemental debit cards to eligible families, which may be used to pay for costs associated with health care for the members of such eligible families and provide direct support to such families in obtaining health care.

(b) ELIGIBILITY.—

(1) ELIGIBLE FAMILIES.—To be eligible for financial assistance under this section—

(A) a family shall—

(i) consist of 2 or more individuals living together who are related by marriage, birth, adoption, or guardianship;

(ii) have total resources that do not exceed 200 percent of the poverty line, as applicable to a family of the size involved; and

(iii) include at least 1 individual who is a dependent under the age of 19; and

(B) no member of the family shall be covered by private health insurance.

(c) IMPLEMENTATION AND DURATION OF ASSISTANCE.—The gross income of a family shall be determined by taking the sum of the income of each family member who is at least age 21 but not more than age 65, except of any member of the family who qualifies for coverage under Medicaid Part A or B shall not be counted.

(d) PROVISION ON INDIVIDUAL ELIGIBILITY; ASSISTANCE.—

(A) IN GENERAL.—No individual who is a member of an eligible family under paragraph (1) is eligible to qualify separately for financial assistance under this section.

(B) ALIENS.—The Secretary shall ensure that financial assistance under this section is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

(C) SUPPLEMENTAL DEBIT CARD FOR HEALTH CARE EXPENDITURES.—

(1) IN GENERAL.—The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card that is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

(2) USE OF THE DEBIT CARD.—

(A) QUALIFYING HEALTH CARE EXPENSES.—A supplemental debit card issued under this section may be used by members of the eligible family to pay for—

(i) the purchase of health care insurance for any member of the family;

(ii) cost sharing expenses related to health care, including deductibles, copayments, and coinsurance, for any member of the family; and

(iii) the direct purchase of health care services and supplies for any member of the family.

(B) GEOGRAPHIC RANGE.—Each supplemental debit card may be used to pay for qualifying health care expenses incurred anywhere in the 50 States or the District of Columbia.

(C) LIMITATIONS.—No supplemental debit card shall be used to make a payment for any cost—

(i) incurred prior to the determination of the family’s eligibility for assistance under this section; or

(ii) that is not a health-related expense.

(D) ROLLOVER OF UNUSED AMOUNTS.—Not more than one-quarter of the annual dollar amount of a supplemental debit card that is unexpended at the end of each 12-month period may rollover.

(E) TO THE FAMILY.—A family’s supplemental debit card for expenditure during the subsequent 12-month period, provided that the family to which the supplemental debit card was issued in the previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

(F) TO THE FAMILY’S HEALTH SAVINGS ACCOUNT.—To the extent that is defined in section 223(e)(2) of the Internal Revenue Code of 1986.

(2) DETERMINATION OF GROSS INCOME.—The Secretary shall determine the gross income of an eligible family as follows:

(3) LIMITATION ON INDIVIDUAL ELIGIBILITY.

340A-1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

SEC. 340A-1. FINANCIAL ASSISTANCE TO LOW-INCOME FAMILIES.

(a) A UTHORIZATION OF APPROPRIATIONS.—

(1) For fiscal year 2009, $100,000,000 for the provision of information described in section 1128(b)(9) by certain entities.

(b) ELIGIBILITY.—

(1) ELIGIBLE FAMILIES.—To be eligible for financial assistance under this section—

(A) a family shall—

(i) consist of 2 or more individuals living together who are related by marriage, birth, adoption, or guardianship;

(ii) have total resources that do not exceed 200 percent of the poverty line, as applicable to a family of the size involved; and

(iii) include at least 1 individual who is a dependent under the age of 19; and

(B) no member of the family shall be covered by private health insurance.

(c) IMPLEMENTATION AND DURATION OF ASSISTANCE.—The gross income of a family shall be determined by taking the sum of the income of each family member who is at least age 21 but not more than age 65, except of any member of the family who qualifies for coverage under Medicaid Part A or B shall not be counted.

(d) PROVISION ON INDIVIDUAL ELIGIBILITY; ASSISTANCE.—

(A) IN GENERAL.—No individual who is a member of an eligible family under paragraph (1) is eligible to qualify separately for financial assistance under this section.

(B) ALIENS.—The Secretary shall ensure that financial assistance under this section is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

(C) SUPPLEMENTAL DEBIT CARD FOR HEALTH CARE EXPENDITURES.—

(1) IN GENERAL.—The Secretary shall issue to each eligible family that enrolls in the program in accordance with subsection (f) a supplemental debit card that is not provided for costs associated with health care for any member of an eligible family who is an alien individual who is not a lawful permanent resident of the United States.

(2) USE OF THE DEBIT CARD.—

(A) QUALIFYING HEALTH CARE EXPENSES.—A supplemental debit card issued under this section may be used by members of the eligible family to pay for—

(i) the purchase of health care insurance for any member of the family;

(ii) cost sharing expenses related to health care, including deductibles, copayments, and coinsurance, for any member of the family; and

(iii) the direct purchase of health care services and supplies for any member of the family.

(B) GEOGRAPHIC RANGE.—Each supplemental debit card may be used to pay for qualifying health care expenses incurred anywhere in the 50 States or the District of Columbia.

(C) LIMITATIONS.—No supplemental debit card shall be used to make a payment for any cost—

(i) incurred prior to the determination of the family’s eligibility for assistance under this section; or

(ii) that is not a health-related expense.

(D) ROLLOVER OF UNUSED AMOUNTS.—Not more than one-quarter of the annual dollar amount of a supplemental debit card that is unexpended at the end of each 12-month period may rollover.

(E) TO THE FAMILY.—A family’s supplemental debit card for expenditure during the subsequent 12-month period, provided that the family to which the supplemental debit card was issued in the previous 12-month period is eligible to receive a supplemental debit card in the subsequent 12-month period; or

(F) TO THE FAMILY’S HEALTH SAVINGS ACCOUNT.—To the extent that is defined in section 223(e)(2) of the Internal Revenue Code of 1986.

(2) DETERMINATION OF GROSS INCOME.—The Secretary shall determine the gross income of an eligible family as follows:

(3) LIMITATION ON INDIVIDUAL ELIGIBILITY.
family during the calendar year 2011 shall be determined as follows:

“(A) Each family whose annual income does not exceed 100 percent of the poverty level, as applicable to a family of the size involved, shall receive $5,000.

“(B) Each family whose annual income exceeds 100 percent but does not exceed 120 percent of the poverty level, as applicable to a family of the size involved, shall receive an amount as follows:

(i) For families whose annual income exceeds 100 percent but does not exceed 115 percent of the poverty level, $2,000.

(ii) For families whose annual income exceeds 115 percent but does not exceed 120 percent of the poverty level, $2,500.

“(C) For families whose annual income exceeds 120 percent but does not exceed 140 percent of the poverty level, $3,000.

“(D) For families whose annual income exceeds 140 percent but does not exceed 150 percent of the poverty level, $3,500.

“(E) For families whose annual income exceeds 150 percent but does not exceed 180 percent of the poverty level, $4,500.

“(F) For families whose annual income exceeds 180 percent but does not exceed 200 percent of the poverty level, $5,500.

“(2) Additional amounts.—In addition to the amounts under paragraph (1), subject to paragraph (2) of section 25E(b)(3) of the Internal Revenue Code of 1986 are increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased in the same manner as the dollar amounts provided in excess of such annual dollar amount.

“(3) Cost of living adjustments.—In the case of any taxable year beginning in a calendar year after 2011, each dollar amount contained in paragraphs (1) and (2) shall be increased in the same manner as the dollar amounts specified in section 25E(b)(3) of the Internal Revenue Code of 1986 are increased by the blended cost-of-living adjustment determined under subsection (k)(2) of section 25E of the Internal Revenue Code for the taxable year involved.

“(4) State option to increase amounts.—At the option of each State, amounts in excess of the annual dollar amounts under paragraphs (1) and (2) may be provided through the supplemental debit card to eligible families in that State, but no Federal funds shall be paid to any State for any amount provided in excess of such annual dollar amount.

“(5) Risk adjustment.—The Secretary may adjust the amount of financial assistance available to an eligible family for a calendar year under this section based on age, health indicators, and other factors that represent the degree 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 or SCHIP, a 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 to the time that the family resides in that State. For purposes of this section, the residency of a family is determined by the residency the legally responsible head of the household.

“(2) Payments from states.—

“(A) BILLING NOTIFICATION.—

“(i) Timing.—On June 30th and December 31st of each year, the Secretary shall send written notification to each State of that State’s 50 percent share of expenses, as determined during each six month period ending on the last day of the month previous to such notification.

“(ii) CONTENTS.—Each such notification to a State shall contain—

(A) the amount of payment due from the State;

(B) the name of each individual for whom payment was made through the supplemental debit card program;

(C) the health care provider to whom each payment was made;

(D) the amount of each payment; and

(E) any other information, as the Secretary requires.

“(B) PAYMENTS.—Each State shall make a payment to the Secretary, in the amount billed, not later than 30 days after the billing notification date, in accordance with subparagraph (A)(i).

“(C) Penalties.—If a State fails to pay to the Secretary an amount required under subparagraph (B), interest shall accrue on such amount at the annual rate provided under section 1903(d)(5) of the Social Security Act. The amount so owed and applicable interest shall be immediately offset against amounts otherwise payable to the State under this section, in accordance with the Federal Claims Collection Act of 1986 and applicable regulations.

“(f) Enrollment.—

“(1) IN GENERAL.—The Secretary shall establish procedures and times for enrollment in the supplemental debit card program. Open enrollment shall be available not less than 4 times per calendar year.

“(2) Transition of individuals enrolled in Medicaid or SCHIP children’s health insurance program.—

“(A) Information from the States.—Each State shall—

(i) not later than June 30, 2010, inform all individuals then enrolled in Medicaid or the State Children’s Health Insurance Program (SCHIP), of the changes in effect beginning on January 1, 2011; and

(ii) not later than October 31, 2010, redefine the eligibility of each individual enrolled in Medicaid or SCHIP, other than those individuals enrolled in Medicaid or SCHIP as disabled, elderly, or a special population, for the supplemental debit card program, according to the eligibility criteria under subsection (j).

“(B) AUTOMATIC ENROLLMENT.—The Secretary shall provide for the automatic enrollment in the supplemental debit card program of all individuals who are enrolled in Medicaid or SCHIP and who have been redefined by a State under subparagraph (A) to be eligible for Medicaid or SCHIP. Any individual who is determined by a State not to qualify for the supplemental debit card program may retain coverage under Medicaid or SCHIP until July 1, 2011.

“(C) Assistance with qualified health insurance credit.—Each State shall, to the extent practicable, provide individuals residing within the State with information regarding the qualified health insurance credit described in section 25E of the Internal Revenue Code of 1986, including information regarding eligibility for, and how to claim, such credit.

“(g) Administration.—

“(1) NATIONAL SYSTEM.—The Secretary may enter into contracts or agreements with a State, a consortium of States, or a private entity, including a bank, enrollment broker, or similar entity, to establish and maintain a uniform system to support the processes and transactions necessary to administer this section.

“(2) Automated system.—The Secretary shall establish an automated means, such as an electronic benefit transfer system, by which the benefits under this section shall be transferred to eligible families.

“(3) Verification of applicant information.—The Secretary may verify information provided by applicants with the appropriate Federal, State, or local government agency or entity, including an enrollment broker or community organization or other organization, to educate eligible families about their options and to assist in their enrollment in the supplemental debit card plan.

“(4) Choice counseling.—The Secretary may enter into contracts or agreements with a State, a consortium of States, or a private entity, including a bank, enrollment broker, or similar entity, to establish and maintain a uniform system to support the processes and transactions necessary to administer this section.

“(5) Appeals.—The Secretary shall establish an independent appeals process, to be administered by an entity separate from the entity that makes initial eligibility determinations, which shall be available to individuals who are denied benefits under the supplemental debit card program.

“(6) Coordination.—The Secretary shall provide for a reconciliation process with the States to resolve any errors and adjudicate disputes due to incomplete or false information regarding eligibility determination or in the billing process described in subsection (e).

“(7) Penalties for false information.—Any person who provides false information to qualify for the supplemental debit card program shall pay a penalty in the amount of 110 percent of the amount of assistance paid on behalf of such person and all members of such person’s family.

“(8) Implementation plan.—Not later than 6 months after the enactment of this section, the Secretary shall submit to Congress a plan for implementing this program during fiscal years 2009–2012.

“(8) Authorization of appropriations.—

“(1) Administration of the supplemental debit card program.—To administer the program under this section, there are authorized to be appropriated—

(A) for fiscal year 2009, $300,000,000, for the design of a unified, national system of conducting the supplemental debit card program;

(B) for fiscal year 2010, $1,000,000,000 for start-up costs, including, contracting, hiring and training employees, and testing the program; and

(C) for fiscal year 2011 and each subsequent fiscal year, $3,000,000,000.

“(2) Authorization of benefits under the supplemental debit card program.—To provide the supplemental debit card benefits described in this section, there are authorized to be appropriated—

(A) for fiscal year 2011, $24,020,000,000;

(B) for fiscal year 2012, $25,220,000,000;

(C) for fiscal year 2013, $26,480,000,000;

(D) for fiscal year 2014, $27,810,000,000; and

(E) for fiscal year 2015, $29,200,000,000.

TITLE V—FIXING MEDICARE FOR AMERICAN SENIORS

Subtitle A—Increasing Programmatic Efficiency, Economy, and Accountability

SEC. 501. ELIMINATING INEFFICIENCIES AND INCREASING CHOICE IN MEDICARE AVERAGE.

Part C of title XVII of the Social Security Act is amended by adding at the end the following new section:

“SEC. 1520C-2. (a) Competitive Bidding.—

“(1) In general.—In order to promote competition among Medicare Advantage plans and to increase the quality of care furnished
under such plans, the Secretary shall establish and implement a competitive bidding mechanism under this part.

(2) MECHANISM TO BEGIN IN 2011.—The mechanism established under paragraph (1) shall apply to all MA organizations and plans beginning in 2011.

(3) NO EFFECT ON PART D BENEFITS.—The mechanism established under paragraph (1) shall not affect the provisions of this part relating to benefits under part D, including the bidding mechanism used for benefits under such part.

(b) RULES FOR COMPETITIVE BIDDING MECHANISM.—Notwithstanding any other provision of law, 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 at least 5 percent more actuarial equivalent to 196 or higher of the value of the original Medicare fee-for-service program option. MA plan bid submissions shall include data on plan average provider network discount 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 mechanism established under subsection (a).

(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 as a rebate on their premiums under this title. The MA monthly basic beneficiary premium for a beneficiary who enrolls in an MA plan whose plan bid is above the benchmark shall be equal to the amount by which the bid exceeds the benchmark.

(5) BENCHMARK AMOUNTS FOR RURAL COUNTIES.—The Secretary may adjust the benchmark amount established under paragraph (1) for any rural county (as identified by the Secretary after consultation with the Secretary of Agriculture) to encourage plan participation in such county.

(6) EXISTING REQUIREMENTS.—Requirements relating to licensure, quality, and beneficiary protections that would otherwise apply under this part shall apply under the competitive bidding mechanism established under subsection (a).

(c) WAIVER.—In order to implement the competitive bidding mechanism established under subsection (a), the Secretary may waive or modify requirements under this part.

SEC. 502. MEDICARE ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to promote innovative care coordination and delivery that is cost-effective, the Secretary of 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");

(B) providers participating in ACOs are eligible for bonuses based on performance.

(2) MEDICARE FEE-FOR-SERVICE BENEFICIARY DEFINED.—In this section, the term "Medicare fee-for-service beneficiary" means an individual who is enrolled in the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act and not enrolled in an MA plan under part C of such title.

(b) ELIGIBLE ACOS.—

(1) IN GENERAL.—Subject to paragraph (2), the following provider groups are eligible to participate as ACOs under the demonstration program under this section:

(A) Physicians in group practice arrangement.

(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 employing physicians.

(F) Integrated delivery systems.

(G) Community-based coalitions of providers.

(2) REQUIREMENTS.—An ACO shall meet the following requirements:

(A) The ACO shall have a formal legal structure that would allow the organization to receive and distribute bonuses to participating providers.

(B) The ACO shall include the primary care providers of at least 5,000 Medicare fee-for-service beneficiaries.

(C) The ACO shall be willing to become accountable for the overall care of the Medicare fee-for-service beneficiaries.

(D) The ACO shall provide the Secretary with a list of primary care and specialist physicians participating in the ACO to support the beneficiary assignment, implementation of performance measures, and the determination of bonus payments under the demonstration program.

(E) The ACO shall have in place contracts with a core group of primary care specialist physicians, a leadership and management structure, and processes to promote evidence-based medicine and to coordinate care.

(F) The ACO must participate as ACOs under the demonstration program.

(g) BONUS PAYMENTS.—

(1) IN GENERAL.—Under the demonstration program under this section, each Medicare fee-for-service beneficiary shall be automatically assigned to a primary care provider. Such assignment shall be based on the physician from whom the beneficiary received the most primary care in the preceding year.

(2) BENEFICIARIES MAY CONTINUE TO SEE PROVIDERS OUTSIDE OF THE ACO.—Under the demonstration program under this section, a Medicare fee-for-service Medicare beneficiary may continue to see providers in and outside of the ACO to which they have been assigned.

(h) BONUS PAYMENTS.—

(1) IN GENERAL.—Under the demonstration program, Medicare payments shall continue to be made to providers under the original Medicare fee-for-service program in the same manner as they would otherwise be made except that a participating ACO is eligible for bonuses for:

(A) it meets certain quality performance measures; and

(B) spending for their Medicare fee-for-service beneficiaries meets the requirement under paragraph (3).

(2) QUALITY.—Under the demonstration program under this section, participating ACOs must meet the requirement under paragraph (1)(A) if they generally follow consensus-based guidelines established by non-government professional medical societies for the treatment and risk-adjusted outcomes shall be determined through an independent entity with medical expertise.

(i) REQUIREMENT RELATING TO SPENDING.—

(A) IN GENERAL.—An ACO shall only be eligible to receive a bonus payment if the average Medicare expenditures under the ACO for beneficiaries meeting the requirement under paragraph (1)(A) for a two-year period is at least 2 percent below the average benchmark for the corresponding two-year period. The benchmark for each ACO shall be set using the most recent three years of total per-beneficiary spending for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be updated by the projected rate of growth in national per capita spending for the original Medicare fee-for-service program, as projected (using the most recent three years of data) by the Chief Actuary of the Centers for Medicare & Medicaid Services.

(j) 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 106 percent of the average benchmark. The bonus amount, in dollars, shall be equal to the bonus share multiplied by the benchmark for the most recent year.

(k) LIMITATION.—Bonus payments may only be made to an ACO if the primary care provider to which the Medicare fee-for-service beneficiary has been assigned under subsection (c) elects to participate in such ACO.

(l) 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.

(i) REPORT.—Upon completion of the demonstration program under this section, the Secretary shall submit to Congress a report on the program together with such recommendations as the Secretary determines appropriate.

SEC. 503. REDUCING GOVERNMENT HANDBURDMENTS TO WEALTHIER SENIORS.

(a) ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART B PREMIUM SUBSIDIES.—

(1) IN GENERAL.—Paragraph (5) of section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is repealed.

(b) EFFECTIVE DATE.—The repeal made by paragraph (1) shall apply to premiums for months beginning after December 2010.

(c) ELIMINATION OF ANNUAL INDEXING OF INCOME THRESHOLDS FOR REDUCED PART D PREMIUM SUBSIDIES.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

(7) REDUCTION IN PREMIUM SUBSIDY BASED ON INCOME.

(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income exceeds the threshold amount applicable under paragraph (2) of section 1860D–13(a) (including application of paragraph (5) of such section for the calendar year), the monthly amount of the premium subsidy applicable to such individual under paragraph (1) for benefits for a month after December 2010 shall be reduced (and the monthly premium subsidy shall...
be increased) by the monthly adjustment amount specified in subparagraph (B).

(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

(i) the quotient obtained by dividing—

(II) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

(II) the applicable percentage determined under paragraph (2) of such section (including application of paragraph (5) of such section).

(II) the base beneficiary premium (as computed under paragraph (2)).

(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the term ‘modified adjusted gross income’ has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related reduction in premium subsidy under this paragraph.

(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED REDUCTION IN PREMIUM SUBSIDY.—

(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—By 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 for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year.

(ii) ADDITIONAL DISCLOSURE.—Not later than October 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the following information for the purpose of carrying out the income-related reduction in premium subsidy under this paragraph with respect to the following year:

(I) The modified adjusted gross income threshold applicable under paragraph (2) of section 1839(i) (including application of paragraph (3)(C) of such section).

(II) The applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section).

(III) THE MONTHLY ADJUSTMENT AMOUNT SPECIFIED IN SUBPARAGRAPH (B).

(IV) ANY OTHER INFORMATION THE COMMISSIONER OF SOCIAL SECURITY DETERMINES TO BE 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 1860D-1(b)(3) of the Social Security Act (42 U.S.C. 1395w-101c) is amended—

(i) in paragraph (1), by striking “(2)” and “(3)” and inserting “(2), (3), and (4)”;

(ii) at the end of the following new subparagraph:

“(IV) Collection of Monthly Adjustment Amount.—Section 1860D-1(b)(3) of the Social Security Act (42 U.S.C. 1395w-101c) is amended—

(i) in subsection (a)(2), by striking ‘‘(i)’’ and inserting ‘‘(i), (j), and (k)’’; and

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

“(k) Collection of Monthly Adjustment Amount.—’’

(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1834(h)(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 have been reduced by 25.5 percent, the Commissioner of Social Security shall enter into agreements with 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, which was not withheld under such subparagraph.”.

(2) CONFORMING AMENDMENTS.—

(A) MEDICARE PART XVIII OF THE SOCIAL SECURITY ACT (42 U.S.C. 1395w-101 et seq.) is amended—

(i) in section 1860D-18(a)(1)—

(1) by redesignating subparagraph (F) as subparagraph (G);

(2) in subparagraph (G), as redesignated by subparagraph (A), by striking “(D) and (E)” and inserting “(D), (E), and (F)”;

and

(3) by inserting after subparagraph (E) the following new subparagraph:

“(F) INCREASE BASED ON INCOME.—The beneficiary premium shall be increased pursuant to paragraph (7).”; and

(ii) in section 1860D-15(a)(1)(B), by striking “paragraph (1)(B)” and inserting paragraphs (1)(B), (1)(C), and (1)(F); and

(iii) in subsection (c), by striking “(I) as amended by clause (i), by inserting” and inserting “(I) as amended by clause (i), by inserting” and inserting “PARTS B AND D PREMIUM SUBSIDY ADJUSTMENTS”;

and

(iv) in subparagraph (A)—

(1) by inserting “or such section 1860D-15(a)(7)” before the period at the end;

(2) by adding at the end the following new sentence: “Officers, employees, and contractors of the Social Security Administration may disclose such reimbursement information to officers, employees, and contractors of the Department of Health and Human Services, the Office of Personnel Management, the Railroad Retirement Board, the Department of Justice, and the courts of the United States to the extent necessary to carry out the purposes described in the preceding sentence.”;

and

(3) by adding at the end the following new subparagraph:

“(c) TIMING OF DISCLOSURE.—Return information shall be disclosed to officers, employees, and contractors of the Social Security Administration under subparagraph (A) not later than the date that is 90 days prior to the date on which the taxpayer first becomes entitled to benefits under part A of title XVIII of the Social Security Act or eligible to enroll for benefits under part B of such title.”.

(3) SEC. 504. REWARDING PREVENTION.

Sec. 1839 of the Social Security Act (42 U.S.C. 1395w-101) is amended—

(i) in subsection (a)(2), by striking “and” and inserting “and” and inserting “(i), (j), and (k)”;

and

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

“(j) With respect to the monthly premium amount for months after December 2010, the Secretary may adjust (under procedures established by the Secretary) the amount of such premium for an individual based on whether or not the individual participated in certain health behaviors, such as weight management, exercise, nutrition counseling, refraining from tobacco use, designing a health care home, and other behaviors determined appropriate by the Secretary.

(2) In making the adjustments under paragraph (1) for a month, the Secretary shall ensure that the total amount of premium subsidies paid for such an individual for a month is equal to the total amount of premiums that would have been paid under this part for the month if no such adjustments had been made, as estimated by the Secretary.”.

SEC. 505. PROMOTING HEALTHCARE PROVIDER TRANSPARENCY.

(a) TRANSPARENCY.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

“PRICE TRANSPARENCY REQUIREMENTS

‘‘SEC. 1899. (a) PRE-TREATMENT DISCLOSURE.—A provider of services (as defined in section 1861(u)) and a supplier (as defined in section 1861(d)) shall provide to each individual (regardless of whether or not the individual is a beneficiary) to whom is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition the estimated price that the provider or supplier will charge for the treatment (or course of treatment). Such price shall be determined at the time of scheduling.

(b) POST-TREATMENT DISCLOSURE.—A provider of services (as so defined) and a supplier (as so defined) shall include with any bill that includes the charges for a treatment with respect to which the absence of an individual (regardless of whether or not the individual is a beneficiary under this title) is scheduled to receive a treatment (or to begin a course of treatment) that is not for an emergency medical condition the estimated price that the provider or supplier will charge for the treatment (or course of treatment). Such price shall be determined at the time of billing. With respect to each item included on such list, the provider of services or supplier shall include the price charged for the item.”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to providers of services and suppliers on and after January 1, 2011.

SEC. 506. AVAILABILITY OF MEDICARE AND MEDICAID CLAIMS AND PATIENT ENCOUNTER DATA.

(a) PUBLIC AVAILABILITY.—Not later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services (in this section referred to as the ‘‘Secretary’’), shall make available to the public (including through an Internet website) data on claims and patient encounters under titles XVIII and XIX of the Social Security Act during the preceding calendar year. Such data shall be appropriately deidentified, as determined necessary by the Secretary in order to comply with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

(b) COLLECTION OF DATA TO STATE EXCHANGES AND HEALTH INSURANCE ISSUERS UNDER THE STATE EXCHANGE.—The Secretary shall submit such data directly to a State Exchange under title XIX and to health insurance issuers under such Exchange (in a form and manner determined appropriate by the Secretary).

(c) MATCHING OF DATA.—The Secretary shall ensure that the total amount of claims under such titles during the preceding year.
for which data is made available under subsection (a) is equal to the reported outlays under such titles during the preceding years.

Subtitle D—Reducing Fraud and Abuse

SEC. 511. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED FOR 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 shall implement procedures to change the Medicare beneficiary identifier used to identify entitled beneficiaries 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) IMPLEMENTATION.—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 used to identify entitled beneficiaries under such title to a different identifier in the case of the discovery of fraud, including identity theft.

(b) IN GENERAL.—

(A) SUBJECT TO SUBPARAGRAPHS (B) AND (C), THE SECRETARY MAY PHASE IN THE CHANGE UNDER PARAGRAPH (1) IN SUCH MANNER AS THE SECRETARY DETERMINES APPROPRIATE.

(B) LIMIT.—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) NEWLY ENTITLED AND ENROLLED INDIVIDUALS.—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(c) DATA MATCHING.—

(1) ACCESS TO CERTAIN INFORMATION.—Section 1861 of such Act (42 U.S.C. 1395x(s)), and such sections as defined in subsection (d) of such section on the change under paragraph (1).

(2) DATA MATCHING.—

(i) The Inspector General of the Department of Health and Human Services shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

(ii) Investigation of Claims Involving Certain Individuals Who Are Not Entitled to Benefits or Are Not Eligible Providers of Services or Suppliers.

(A) DATA AGREEMENT.—The Secretary shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

(B) INVESTIGATION OF CLAIMS INVOLVING CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.

(i) IN GENERAL.—The Secretary shall, in the case where a provider of services or a supplier under the program under title XVIII, XIX, or XXI submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of such investigation, is not entitled to benefits under such program, or where the Secretary determines, as a result of such information, that the entity is not eligible for payment under such program, the Secretary shall establish procedures for the use of technology for real-time data review

SEC. 512. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW

The Secretary shall establish procedures for the use of technology (including front-end, pre-payment, and retrospective technology) to identify such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services under such program.
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 a description and evaluation 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 carry out the activities specified under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year.

SEC. 514. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.

(a) EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.—Section 1834(a)(1) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following paragraph:

"(B) implement policies that provide for a pharmacist of the State more reliable through the prompt and fair resolution of disputes; and

(b) EXEMPTION OF PHARMACISTS FROM SURGEON BOND REQUIREMENT.—Section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) is amended, in the second sentence, by inserting "and shall waive such requirement for a pharmacist" before the period at the end.

SEC. 515. GAO STUDY AND REPORT ON EFFECTIVENESS AND COMPLIANCE REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT IN SUBSEQUENT FISCAL YEARS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) in combating fraud.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall report containing the results of the study conducted under subsection (a), together with recommendations for such legislative or administrative changes as the Comptroller General determines appropriate.

TITLE VI—ENDING LAWSUIT ABUSE

SEC. 601. STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the following:

"(4) STATE GRANTS TO CREATE HEALTH COURT SOLUTIONS.—

(a) IN GENERAL.—The Secretary may award grants to States for the development, implementation, and evaluation of alternatives to current tort litigation that comply with this section, for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (c).

(b) CONDITIONS FOR DEMONSTRATION GRANTS.—

"(1) APPLICATION.—To be eligible to receive a grant under this section, a State shall submit to the Secretary an application at such time, in such manner, and containing such information as may be required by the Secretary. The application shall be awarded under this section on such terms and conditions as the Secretary determines appropriate.

"(2) STATE REQUIREMENTS.—To be eligible to receive a grant under this section, a State shall—

(A) develop and implement an alternative to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations based on one or more of the models described in subsection (b); and

(B) implement policies for a reduction in health care errors through the collection and analysis by organizations that engage in voluntary efforts to improve patient safety and the quality of health care delivery, of patient safety data related to disputes resolved under the alternatives described in subsection (b).

"(3) DEMONSTRATION OF EFFECTIVENESS.—To be eligible to receive a grant under subsection (a), a State shall demonstrate how the proposed alternative to be implemented in a manner that reduces, and otherwise improves, the mechanic and costs of resolving such disputes under paragraph (2)(A).

(4) SOURCES OF COMPENSATION.—To be eligible to receive a grant under subsection (a), a State shall identify the sources from which compensation is paid for the resolution of disputes concerning injuries allegedly caused by health care providers or health care organizations.

"(5) SCOPE.—

(A) IN GENERAL.—To be eligible to receive a grant under subsection (a), a State shall identify the proposed alternative described in subsection (b) as an alternative to current tort litigation implemented under paragraph (2)(A). Funding methods shall, to the extent practicable, provide financial incentives for activities that improve patient safety.

(B) STATE REQUIREMENTS.—

(1) IN GENERAL.—Nothing in this section shall be construed to limit the efforts that any State has made prior to the date of enactment of this section to establish any alternative to current tort litigation.

(2) ALTERNATIVE FOR PRACTICE AREAS OR INJURIES.—In the case of a State that has established an alternative to current tort litigation for a certain area of health care practice or a certain category of injuries, the alternative selected as provided for in this section shall supplement, not replace or invalidate such established alternative unless the State intends otherwise.

(3) NOTIFICATION OF PATIENTS.—To be eligible to receive a grant under subsection (a), the Secretary shall notify patients when they are receiving health care services that fall within the scope of the alternative selected under this section by the State to current tort litigation.

(c) REPRESENTATION BY COUNSEL.—A State that receives a grant under this section shall not prohibit or discourage a patient from filing a claim that falls within the jurisdiction of the alternative to current tort litigation that is implemented under the grant from obtaining legal representation during the consideration of the claim under such alternative.

(3) MODELS.—

"(1) IN GENERAL.—The models in this section are the following:

(A) EXPERT PANEL REVIEW AND EARLY OFFERING OF MEDIATION.—

(A) IN GENERAL.—A State may use amounts received under a grant under this
section to develop and implement an expert panel and early offer review system that meets the requirements of this paragraph.

(B) ESTABLISHMENT OF PANEL.—Under the system established under this paragraph, the State shall establish an expert panel to review any dispute concerning injuries allegedly caused by health care providers or health care organizations, as the guidelines described in this paragraph.

(1) COMPOSITION.—

(ii) FAILURE TO ACCEPT DETERMINATION OF EXPERT PANEL.—

(iii) ABSENCE OF EXPERT PANEL.—

(iv) DETERMINATION.—

(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel, and administrative health care tribunal combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such a system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in subparagraph (A) to the submission of such dispute to a State court.

(B) GENERAL PROCEDURE.—

(i) ESTABLISHMENT OF EXPERT PANEL.—

(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tribunal established under this paragraph. The State shall establish an expert panel in accordance with subparagraph (C) to review the allegations involved in such dispute.

(E) ACCEPTANCE.—If the parties to a dispute accept the determination of the expert panel, the dispute shall be referred to an administrative health care tribunal established under this paragraph. The State shall establish an expert panel in accordance with subparagraph (C) to review the allegations involved in such dispute.

(C) ADMINISTRATIVE HEALTH CARE TRIBUNAL COMBINATION MODEL.—

(A) IN GENERAL.—A State may use amounts received under a grant under this section to develop and implement an expert panel, and administrative health care tribunal combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such a system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in subparagraph (A) to the submission of such dispute to a State court.

(B) GENERAL PROCEDURE.—

(i) ESTABLISHMENT OF EXPERT PANEL.—

(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tribunal under the system established under this paragraph. The State shall establish an expert panel in accordance with subparagraph (C) to review the allegations involved in such dispute.

(C) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the liability of the parties involved and the amount of compensation that should be paid based on a schedule of compensation developed by the tribunal. Such a schedule shall be available to the parties in the form of a schedule to be included in the record of the tribunal.

(iv) DETERMINATION.—

(A) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert review panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

(B) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party objecting to the determination of the expert panel under this subparagraph refuses to accept the panel’s determination, the dispute shall be referred to an administrative health care tribunal under paragraph (D).

(D) 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 administrative health care tribunal combination system to review any dispute concerning injuries allegedly caused by health care providers or health care organizations. Under such a system, a dispute concerning injuries allegedly caused by health care providers or health care organizations shall proceed through the procedures described in subparagraph (A) to the submission of such dispute to a State court.

(B) GENERAL PROCEDURE.—

(i) ESTABLISHMENT OF EXPERT PANEL.—

(ii) REFERRAL TO TRIBUNAL.—If either party to a dispute described in clause (i) fails to accept the determination of the expert panel, the dispute shall then be referred to an administrative health care tribunal under the system established under this paragraph. The State shall establish an expert panel in accordance with subparagraph (C) to review the allegations involved in such dispute.

(C) DETERMINATION.—After a tribunal conducts a review under this paragraph, the tribunal shall make a determination as to the liability of the parties involved and the amount of compensation that should be paid based on a schedule of compensation developed by the tribunal. Such a schedule shall be available to the parties in the form of a schedule to be included in the record of the tribunal.

(iv) DETERMINATION.—

(A) IN GENERAL.—The provisions of paragraph (2) shall apply with respect to the establishment and operation of an expert review panel under this subparagraph, except that the subparagraphs (F) and (G) of such paragraph shall not apply.

(B) FAILURE TO ACCEPT DETERMINATION OF PANEL.—If any party objecting to the determination of the expert panel under this subparagraph refuses to accept the panel’s determination, the dispute shall be referred to an administrative health care tribunal under paragraph (D).
‘(1) IN GENERAL.—Upon the failure of any party to accept the determination of the expert panel under subparagraph (C), the parties shall request a hearing concerning the liability for personal damage caused by health care professional negligence. The hearing shall be conducted by the administrative health care tribunal established by the State involved under this subparagraph.

‘(ii) by striking the period at the end and

‘(C) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 273)—

‘(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 2011 under section 1905(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 2003) 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 1905(a) of the Social Security Act (42 U.S.C. 1396(a)) for purposes of carrying out a grant awarded under this section. Amounts paid to a State pursuant to this subsection shall remain available until expended.

‘(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for any fiscal year such sums as may be necessary for purposes of making payments to States pursuant to paragraph (1).

TITLE VII—PROMOTING HEALTH INFORMATION TECHNOLOGY

Subtitle A—Assisting the Development of Health Information Technology

SEC. 701. PURPOSE.

It is the purpose of this subtitle to promote the utilization of health record banking by improving the coordination of health information through an infrastructure secure and authorized exchange and use of healthcare information.

SEC. 702. HEALTH RECORD BANKING.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate regulations to provide for the certification and auditing of the banking of electronic medical records.

(b) GENERAL RIGHTS.—An individual who has a health record contained in a health record bank shall maintain ownership over the health record and shall have the right to review the contents of the record.

SEC. 703. APPLICATION OF FEDERAL AND STATE SECURITY AND CONFIDENTIALITY STANDARDS.

(a) IN GENERAL.—Current Federal security and confidentiality standards and State security and confidentiality laws shall apply to this subtitle until such time as Congress acts to amend such standards.

(b) CROSS-REFERENCE:

(1) CURRENT FEDERAL SECURITY AND CONFIDENTIALITY STANDARDS.—The term ‘current Federal security and confidentiality standards’ means the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note) and security standards established under section 117(d) of the Social Security Act (42 U.S.C. 1320d–2(d)).

(2) STATE SECURITY AND CONFIDENTIALITY LAWS.—The term ‘State security and confidentiality laws’ means State laws and regulations relating to the privacy and confidentiality of individually identifiable health information or to the security of such information.

(3) STATE.—The term ‘State’ has the meaning given such term for purposes of title XI of the Social Security Act, as provided under section 1311(a) of such Act (42 U.S.C. 1310(a)).

Subtitle B—Removing Barriers to the Use of Health Information Technology to Better Coordinate Health Care

SEC. 711. SAFE HARBORS TO ANTIKICKBACK CIVIL PENALTIES AND CRIMINAL PENALTIES.

(a) FOR CUSTOMARY AND REASONABLE REMUNERATION.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

(2) For purposes of this subsection, inducements to reduce or limit services described in clause (i) shall include the practical or other advantages resulting from health information technology or related information, maintenance, support, or training services.”; and

(2) in subsection (i), by adding at the end the following new paragraph:

(2) For purposes of this subsection, inducements to reduce or limit services described in clause (i) shall include the practical or other advantages resulting from health information technology or related information, maintenance, support, or training services.”; and

(2) in subsection (i), by adding at the end the following new paragraph:

(2) By amending—

(1) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(a)(8), or related installation, maintenance, support or training services) made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research.”.

(b) FOR CRIMINAL PENALTIES.—Section 1128B of such Act (42 U.S.C. 1320a–7b) is amended—

(1) in subsection (b)(3)(A) in subparagraph (G), by striking “and” at the end;

(2) in the subparagraph (H) added by section 237(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 273)—

(1) by moving such subparagraph 2 ems to the left; and

(2) by striking the period at the end and inserting “; and”;

(3) in the subparagraph (H) added by section 431(a) of such Act (117 Stat. 2287)—

(1) by redesigning such subparagraph as subparagraph (1); (2) by moving such subparagraph 2 ems to the left; and

(3) by striking the period at the end and inserting “; and”;

(4) by inserting “(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(a)(8), or related installation, maintenance, support or training services) made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research.”.

(c) SPECIFIED ENTITY DEFINED.—For purposes of subparagraph (J) of section 1128A(a)(8) of such Act, the term ‘specified entity’ means an entity that is a component of a system of care or critical to patient care, that is not a covered entity, that provides health information technology services at the specified entity, and that specifies the remuneration solicited or received or paid or received (as defined in subsection (g)) in—

(1) the provision of such remuneration is without an agreement between the parties or legal condition that—

(1) the provision of such remuneration is without an agreement between the parties or legal condition that—

(2) the purpose or arrangement for the remuneration is not to or improve health care quality, efficiency, or research.”.

(2) by striking the period at the end and

(3) by striking the period at the end and inserting “; and”;

(4) by inserting “(J) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(a)(8), or related installation, maintenance, support or training services) made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research.”.

(3) any nonmonetary remuneration (in the form of health information technology, as defined in section 1128A(a)(8), or related installation, maintenance, support or training services) made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research.”.

(1) in subsection (b)(3)(A) in subparagraph (G), by striking “and” at the end;
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, shall conduct a study to 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.—

(i) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall be effective on the date that is 120 days after the date of the enactment of this Act.

(ii) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1320a–7(a)(3) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for the conduct described in subsection 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(iii) STUDY AND REPORT TO ASSESS EFFECT OF SAFE HARBOURS ON HEALTH SYSTEM.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine the impact of each of the safe harbors described in subsection (b). In particular, the study shall examine the following:

(1) The effectiveness of each safe harbor in increasing the adoption of health information technology.

(B) The types of health information technology provided under each safe harbor.

(C) The extent to which the financial or other business relationships between providers under each safe harbor have changed as a result of the safe harbor in a way that adversely affects or benefits the health care system as a whole and is available to consumers.

(D) The impact of the adoption of health information technology on health care quality, cost, and access under each safe harbor.

(ii) EFFECTIVE DATE; EFFECT ON STATE LAWS.—

(A) 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.

(B) PREEMPTION OF STATE LAWS.—No State (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1320a–7(a)(3) for purposes of title XI of such Act) shall have in effect a State law that imposes a criminal or civil penalty for the conduct described in subsection 1128A(b)(4) or section 1128B(b)(3)(J) of such Act, as added by subsections (a)(1) and (b), respectively, if the conditions described in the respective provision, with respect to such transaction, are met.

(iii) SAFE HARBOURS DESCRIBED.—For purposes of paragraphs (1) and (2), the safe harbors described in this paragraph are—

(A) The safe harbor under section 1128A(b)(4) of such Act (42 U.S.C. 1320a–7a(b)(4)), as added by subsection (a)(1); and

(B) the safe harbor under section 1128B(b)(3)(J) of such Act (42 U.S.C. 1320a–7b(b)(3)(J)), as added by subsection (b).

SEC. 712. EXCEPTION TO LIMITATION ON CERTAIN REIMBURSEMENT PRACTICES (UNDER STARK) FOR PROVISION OF HEALTH INFORMATION TECHNOLOGY AND TRAINING SERVICES TO HEALTH CARE PROFESSIONALS.

(a) IN GENERAL.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395nn(b)) is amended by adding at the end of the section the following new paragraph:

"(6) 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 provider of such services is not subject to section 1877(b) if—

(i) the provision of such remuneration is without an agreement between the parties or legal condition that—

(A) provides that the use of the health information technology to services provided by the physician to individuals receiving services at the specified entity;

(B) prohibits the use of the health information technology in conjunction with other health information technology; or

(C) conditions the provision of such remuneration on the referral of patients or business to the specified entity;

(ii) such remuneration is arranged for in a written agreement that is signed by the parties involved (or their representatives) and that specifies the remuneration made by such provider, equals or exceeds the fair market value of such remuneration is made for the primary purpose of better coordination of care or improvement of health quality, efficiency, or research; and

(D) the remuneration is provided primarily for the electronic creation, maintenance, or exchange of health information to better coordinate care or improve health care quality, efficiency, or research.

(B) The extent to which the financial or other business relationships between providers under such section (as defined in section 1101(a) of the Social Security Act (42 U.S.C. 1320a–7(a)(3)) for purposes of title XI of such Act) has not taken any action to disable any basic feature of any hardware or software component of such remuneration that would be required to take into account the varying needs of such providers receiving such products.".

(b) APPLICATION TO STARK EXCEPTION.—

(A) APPLICABILITY OF EXCEPTION.—In the case of a transaction described in section 1121(b)(1), the following: For purposes of subparagraph (A), nothing in such subparagraph shall be construed as preventing a specified entity, consistent with the specific requirements of such subparagraph, from 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 COMMISSION

Subtitle A—Establishment and General Duties

SEC. 801. ESTABLISHMENT.

(a) IN GENERAL.—There is hereby established a Health Care Services Commission in this title, referred to as the "Commission" to be composed of 5 commissioners (in this title referred to as the "Commissioners") to be appointed by the President by and with the advice and consent of the Senate. No more than 3 of such Commissioners shall be members of the same political party, and in making appointments members of different political parties shall be appointed alternately as nearly as may be practicable. No Commissioner shall engage in any other business, vocation, or employment than that of serving as Commissioner. Each Commissioner shall hold office for a term of 5 years and until a successor is appointed and has qualified, except that the Commissioner shall not so continue to serve beyond the expiration of the next session of Congress subsequent to the expiration of said fixed term of office.

(b) APPOINTMENT OF CHAIRMAN.—The Commissioners shall fill any vacancy occurring prior to the expiration of the term for which a predecessor was appointed and shall be appointed for the remainder of such term, and the Commissioners shall fill a vacancy occurring prior to the expiration of said term for which a successor is appointed and has qualified, except that the Commissioner shall not so continue to serve beyond the expiration of the next session of Congress subsequent to the expiration of said fixed term of office.

(c) APPOINTMENT OF MEMBERS.—The Commissioners shall make such rules as they deem necessary for the performance of their duties.

(d) GIFT OF COMMISSIONERS.—The Commissioners shall have the power to accept gifts for the use of the Commission and keep records of the same for the period of 4 years after the date of receipt of such gifts.

(e) ORGANIZATION OF COMMISSION.—The Commissioners shall meet at the call of the Chairman, and at least one Commissioner shall be present before any meeting of the Commission shall be held.

(f) OFFICE.—The Commissioners shall have such office, equipment, and facilities as the President shall prescribe.

(g) REMUNERATION.—The Commissioners shall be paid such compensation as Congress shall provide.

(h) MEETINGS.—The Commissioners shall meet at such times and place as may be determined by the Commission, and at least one Commissioner shall be present before any business of the Commission shall be transacted.

(i) RULES OF PROCEDURE.—The Commission shall adopt such rules of procedure as it shall determine.

(j) AUDIT.—The Secretary of Health and Human Services shall, at the expiration of each fiscal year, examine the financial accounts of the Commission, and the accounts of the Commission shall be open to the inspection of the Comptroller General of the United States.

(k) COMMISSIONER TERMINATION.—(1) For purposes of this paragraph, "commissioner" means a Commissioner appointed under this section.

(2) A commissioner shall not complete the term for which a predecessor was appointed if the Commissioner appointed under this section:

(A) has acted contrary to the best interest of the Commission;

(B) has engaged in any activity that is prohibited by section 1877(b) of the Social Security Act; or

(C) has been convicted of a crime that involves an act of moral turpitude.

(3) The Commission shall conduct an investigation of a Commissioner's performance after the date of the enactment of this Act and shall conduct such investigation in accordance with section 1877(b) of the Social Security Act.

SEC. 802. DUTIES OF COMMISSION.

(a) IN GENERAL.—The Commission shall carry out the purposes of this title in accordance with the provisions of this title and the rules and regulations of the Commission, and shall perform such other activities as it deems necessary to carry out the purposes of this title.

(b) FORMATION OF COMMISSION.—The Commission shall be organized and shall function as a commission as provided in section 1101(a) of the Social Security Act.

SEC. 803. APPOINTMENT OF MEMBERS.—The President shall, by and with the advice and consent of the Senate, appoint the members of the Commission.

SEC. 804. PERIOD OF OFFICE.—The members of the Commission shall hold office for a term of 5 years, and until the expiration of the term of the successor appointed in their place.
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 services, including activities with respect to—

(1) the effectiveness, efficiency, and quality of health care services;

(2) outcomes of health care services and procedures;

(3) clinical practice, including primary care and practice-oriented research;

(4) health care technologies, facilities, and equipment;

(5) health care costs, productivity, and market forces;

(6) health promotion and disease prevention;

(7) health statistics and epidemiology; and

(8) medical liability.

(b) To State and Local Support for Rural Areas and Underserved Populations.—In carrying out subsection (a), the Commissioners shall undertake and support research, as described in projects, and evaluations with respect to—

(1) the delivery of health care services in rural areas (including frontier areas); and

(2) health care for the elderly, minority groups, minority groups, and the elderly.

SEC. 803. DISSEMINATION.

(a) In General.—The Commissioners shall—

(1) promptly publish, make available, and otherwise disseminate, in a form understandable and on as broad a basis as practicable so as to maximize its use, the results of research, demonstration projects, and evaluations conducted or supported under this title and the standards, criteria, 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 appropriate entities to foster dissemination.

(b) Prohibition Against Restrictions.—Except as provided in subsection (c), the Commissioners may not restrict the publication or dissemination of data from, or the results of, projects conducted or supported under this title.

(c) Limitation on Use of Certain Information.—No information, if an establishment or person supplying the information or description thereof, obtained as a result 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 described under regulations of the Secretary) to its publication or release in other form.

(d) Certain Interagency Agreements.—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 FORUMS.

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 the Secretary, not exceeding 5 from any single region, who represent the delivery of health care services in an appropriate manner, and appointed by the Commission and shall include representation from at least the following:

(1) Health insurance industry.

(2) Health care provider groups.

(3) Non-profit organizations.

(4) Rural health organizations.

(b) Terms.—(1) In General.—Except as provided in paragraph (2), members of the Office of the Forum for Quality and Effectiveness in Health Care shall serve for a term of 5 years.

(2) Staggered Rotation.—Of the members first appointed to the Office of the Forum for Quality and Effectiveness in Health Care, the Commission shall appoint 5 members to serve for a term of 2 years, 5 members to serve for a term of 3 years, and 5 members to serve for a term of 4 years.

(c) Treatment of Other Employment.—Each member of the Office of the Forum for Quality and Effectiveness in Health Care shall serve the Office concurrently from any other position of employment.

SEC. 813. DUTIES.

(a) Establishment of Forum Program.—The Commissioners, acting through the Director, shall establish a program to be known as the Forum for Quality and Effectiveness in Health Care.

(b) Certain Requirements.—Guidelines, standards, performance measures, and review criteria under subsection (a) shall—

(1) be based on the best available research and professional judgment regarding the effectiveness and appropriateness of health care services and procedures; and

(2) be presented in formats appropriate for use by physicians, health care practitioners, providers, medical educators, and medical review organizations and in formats appropriate for use by consumers of health care.

(c) 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 list of recommendations 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 such year in the final report of the Office of the Forum for Quality and Effectiveness in Health Care. The 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 participation in Federally funded health care programs (as defined in section 1122(b)(1) of the Social Security Act (42 U.S.C. 1320a-7(b)(1))).

(2) Imposition of a civil money penalty on such provider.

SEC. 815. ADDITIONAL REQUIREMENTS.

(a) Program Agenda.—The Commissioners shall provide for an annual forum to develop of the guidelines, standards, performance measures, and review criteria described in section 814(a), including with respect to the standards, performance measures, and review criteria 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 AUTHORITY.

The Commissioners, in carrying out this title, accept voluntary and uncompensated services.

SEC. 822. FUNDING.

For the purpose of carrying out this title, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

SEC. 823. DEFINITIONS.

For purposes of this title:

(1) The term “Commissioners” means the Commissioners of the Health Care Services Commission.

(2) The term “Commission” means the Health Care Services Commission.

(3) The term “Director” means the Director of the Office of the Forum for Quality and Effectiveness in Health Care.

(4) The term “Secretary” means the Secretary of Health and Human Services.

Subtitle D—Terminations and Transition

SEC. 831. TERMINATION OF AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.

As of the date of the enactment of this Act, the Agency for Healthcare Research and Quality is terminated, and title IX of the Public Health Service Act is repealed.

SEC. 832. TRANSITION.

(1) Exclusions, grants, contracts, privileges, and other determinations or actions of the Agency for Healthcare Research and Quality that are effective as of the date before the date of the enactment of this Act, shall be transferred to the Secretary and shall continue in effect according to their terms unless changed pursuant to law.


Subtitle E—Independent Health Record Trust Act

SEC. 841. SHORT TITLE.

This subtitle may be cited as the “Independent Health Record Trust Act of 2009”.

SEC. 842. PURPOSE.

(a) Purpose of this subtitle to provide for the establishment of a nationwide health information technology network that—
(1) improves health care quality, reduces medical errors, increases the efficiency of care, and advances the delivery of appropriate, evidence-based health care services;

(2) lessens the impact of disease and the management of chronic illnesses by increasing the availability and transparency of information related to the health care needs of an individual;

(3) ensures that appropriate information necessary to make medical decisions is available in a usable form at the time and in the location that the medical service involved is provided;

(4) produces greater value for health care expenditures by reducing health care costs that result from inefficiency, medical errors, inappropriate care, and incomplete information;

(5) promotes a more effective marketplace, greater competition, greater systems analysis, increased choice, enhanced quality, and improved outcomes in health care services;

(6) improves the coordination of information and the provision of such services through an effective infrastructure for the secure and authorized exchange and use of health information; and

(7) ensures that health information privacy, security, and confidentiality of individually identifiable health information is protected.

SEC. 842. 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 the consent of a participant to an electronic health record of an individual contained in an IHRT, express consent given by the individual for the use of such record in response to a clear and conspicuous request for such consent or at the individual’s own initiative.

(4) AUTHORIZED EHR DATA USER.—The term ‘‘authorized EHR data user’’ means, with respect to an electronic health record of an IHRT participant contained as part of an IHRT, any entity (other than the participant) that is entitled (in the form of affirmative consent) by the participant to access the electronic health record.

(5) CONFIDENTIALITY.—The term ‘‘confidentiality’’ means, with respect to individually identifiable health information of an individual, the obligation of those who receive such information to respect the privacy of the individual.

(6) ELECTRONIC HEALTH RECORD.—The term ‘‘electronic health record’’ means a longitudinal collection of information concerning a single individual, including medical records and personal health information, that is stored electronically.

(7) HEALTH INFORMATION PRIVACY.—The term ‘‘health information privacy’’ means, with respect to individually identifiable health information of an individual, the right of such individual to control the acquisition, uses, or disclosures of such information.

(8) HEALTH PLAN.—The term ‘‘health plan’’ means a group health plan (as defined in section 302 of the Public Health Service Act (42 U.S.C. 300bb-8)) as well as a plan that offers health insurance coverage in the individual market.

(9) HIPAA PRIVACY REGULATIONS.—The term ‘‘HIPAA privacy regulations’’ means the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

(10) INDIVIDUAL HEALTH RECORD TRUST; ‘‘IHRT’’.—The term ‘‘independent health record trust’’ and ‘‘IHRT’’ mean a legal arrangement under the administration of an IHRT operator that meets the requirements of this subtitle.

(11) IHRT OPERATOR.—The term ‘‘IHRT operator’’ means, with respect to an IHRT, the organization that is responsible for the administration and operation of the IHRT in accordance with this subtitle.

(12) IHRT PARTICIPANT.—The term ‘‘IHRT participant’’ means, with respect to an IHRT, an individual who has a participation agreement in effect with respect to the maintenance of the individual’s electronic health record by the IHRT.

(13) INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The term ‘‘individually identifiable health information’’ means, with respect to individually identifiable health information of an individual, the physical, technological, or administrative safeguards or tools used to protect such information from unauthorized access or disclosure.

SEC. 844. ESTABLISHMENT, CERTIFICATION, AND ADMINISTRATION OF INDEPENDENT HEALTH RECORD TRUSTS.

(a) ESTABLISHMENT.—Not later than one year after the date of the enactment of this Act, the Federal Trade Commission, in consultation with the National Committee on Vital and Health Statistics, shall prescribe standards for the certification, operation, and interoperability of IHRTs to carry out the purposes described in section 842 in accordance with the provisions of this subtitle.

(b) CERTIFICATION.—

(1) CERTIFICATION BY FTC.—The Federal Trade Commission shall provide for the certification by the Commission of IHRTs that meet the criteria established by the IHRTs to carry out the purposes described in section 842 in accordance with the provisions of this subtitle.

(2) DECERTIFICATION.—The Federal Trade Commission shall establish a process for the revocation of certification of an IHRT under this section in the case that the IHRT violates the standards established under subsection (a).

(3) MEMBERSHIP.—

(A) IN GENERAL.—With respect to the electronic health record of an individual, a primary use is a use for purposes of the individual’s self-care or care by health care professionals.

(B) NON LIMITATION ON MEMBERSHIP.—Nothing in this section shall be construed as limiting the authorization for any use that is within the authorized original purpose.

(C) RULES FOR PRIMARY USE OF RECORDS FOR HEALTH CARE PURPOSES.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT standards for access to such record shall provide for the following:

(1) ACCESS BY IHRT PARTICIPANTS TO THEIR ELECTRONIC HEALTH RECORDS.—

(II) OWNERSHIP.—The participant maintains ownership over the entire electronic health record (and all portions of such record) and shall have the right to electronically access and review the contents of the entire record (and any portion of such record) at any time, in accordance with this subparagraph.

(III) ADDITION OF PERSONAL INFORMATION.—The participant may add personal health information to the health record of that participant, except that such participant shall not alter information that is entered into the electronic health record by an authorized EHR data user. Such participant shall have the right to propose an amendment to information that is entered by an authorized EHR data user that is describable by the Federal Trade Commission for purposes of amending such information.

(2) RULES FOR PRIMARY USE OF RECORDS FOR HEALTH CARE PURPOSES.—With respect to the electronic health record of an IHRT participant (or specified parts of such electronic health record) maintained by an IHRT standards for access to such record shall provide for the following:

(1) FIDUCIARY DUTY OF IHRT; PENALTIES FOR VIOLATIONS OF FIDUCIARY DUTY.—

(II) OWNERSHIP.—The participant maintains ownership over the entire electronic health record (and all portions of such record) and shall have the right to electronically access and review the contents of the entire record (and any portion of such record) at any time, in accordance with this subparagraph.

(III) ADDITION OF PERSONAL INFORMATION.—The participant may add personal health information to the health record of that participant, except that such participant shall not alter information that is entered into the electronic health record by an authorized EHR data user. Such participant shall have the right to propose an amendment to information that is entered by an authorized EHR data user that is describable by the Federal Trade Commission for purposes of amending such information.
(iii) Identification of information entered by participant.—Any additions or amendments made by the participant to the health record shall be identified and disclosed within such record as being made by such participant.

(b) Access by entities other than IHRT participant.—

(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) may be made only 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.

(ii) Identification of entity that enters information.—Any information that is added by an authorized EHR data user to the health record shall be identified and disclosed within such record as being made by such user.

(iii) Satisfaction of HIPAA privacy regulations.—In the case of a record of a covered entity (as defined for purposes of HIPAA privacy regulations), with respect to an individual, if such individual is an IHRT participant with an independent health record trust and such entity is an authorized EHR data user, the requirement under the HIPAA privacy regulations for such entity to provide the record to the participant shall be deemed met if such entity, without charge to the IHRT or the participant—

(I) forwards to the trust an appropriately authenticated information set concerning the participant;

(II) may be limited by the participant for purposes of research or other activities only as provided for in such an agreement; and

(iii) recognizes privileged communications between such participant and such IHRT;

(iv) provides adequate protection for the health information of an individual contained in the electronic health record maintained by such trust.

(III) IN GENERAL.—Any information, with respect to the participant, that is sensitive information, as specified by the Federal Trade Commission, shall be deemed met if such information is not provided to any person or entity who has not agreed to use and transfer such record (or portion of the record) in accordance with such agreement.

(2) Treatment of State laws.—

(A) In general.—Except as provided under subparagraph (B) and any regulation, the provisions of a privacy protection agreement entered into between an IHRT and an IHRT participant shall be deemed to preempt any provision of State law (or any State regulation) relating to the privacy and confidentiality of individually identifiable health information or to the security of such health information.

(B) Exception for privileged information.—The provisions of a privacy protection agreement shall not preempt any provision of State law (or any State regulation) that recognizes privileged communications between physicians, health care practitioners, and patients of such physicians or health care practitioners, respectively.

(C) STATE DEFINED.—For purposes of this section, the term "State" has the meaning given such term when used in title XI of the Social Security Act, as provided under section 1101(a) of such Act (42 U.S.C. 1301(a)).

SEC. 847. VOLUNTARY NATURE OF TRUST PARTICIPATION AND INFORMATION SHARING.

(a) In general.—Participation in an independent health record trust, or authorizing access to information from such a trust, is voluntary. No employer, health insurance issuer, group health plan, health care provider, or other person may require, as a condition of employment, issuance of a health insurance policy, coverage under a group health plan, the provision of health care services, payment for such services, or otherwise, that an individual participate in, or authorize access to information from, an independent health record trust.

(b) Enforcement.—The penalties provided for in subsection (a) of section 1177 of the Social Security Act (42 U.S.C. 1320d-6) shall apply to a violation of subsection (a) in the same manner as such penalties apply to a person in violation of subsection (a) of such section.

SEC. 848. FINANCING OF ACTIVITIES.

(a) In general.—Except as provided in subsection (b), an IHRT may generate revenue to pay for the operations of the IHRT through any of the following activities:

(1) charging IHRT participants account fees for use of the trust;

(2) charging authorized EHR data users for accessing electronic health records maintained in the trust;

(3) the sale of information contained in the trust (as provided for in section 846(a)(3)(A)); and

(4) any other activity determined appropriate by the Federal Trade Commission.
(b) Prohibition Against Access Fees for Health Care Providers.—For purposes of providing incentives to health care providers to access information maintained in an IHRT, as authorized by the IHRT participant, or authorized EHR data user, the IHRT may not charge a fee for services specified by the IHRT. Such services shall include the transmittal of information, and amounts of revenue derived under subsection (a) shall be included in an independent electronic health record maintained by the IHRT or permitting such provider to input such information into the record. Such fees shall not be charged for the transmittal of or access to information described in section 9(a)(2)(D)(ii) by appropriate emergency response agencies.

(c) Required Disclosures.—The sources and amounts of revenue derived under subsection (a) for the operations of an IHRT shall be fully disclosed to each IHRT participant of such IHRT and to the public.

(d) Treatment of Income.—For purposes of the Internal Revenue Code of 1986, any revenue described in subsection (a) shall not be included in gross income of any IHRT, IHRT participant, or authorized EHR data user.

SEC. 849. Regulatory Oversight.

(a) In General.—In carrying out this subtitle, the Federal Trade Commission shall promulgate regulations for independent health record trusts.

(b) Establishment of Interagency Steering Committee.—

(1) In General.—The Secretary of Health and Human Services shall establish an Interagency Steering Committee in accordance with this subsection.

(2) Chairperson.—The Secretary of Health and Human Services shall serve as the chairperson of the Interagency Steering Committee.

(3) Membership.—The members of the Interagency Steering Committee shall consist of—

(B) 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), and regulations promulgated under such subsection, and regulations promulgated under this subtitle.

(c) Federal Advisory Committee.—

(1) In General.—The National Committee for Vital and Health Statistics shall serve as an advisory committee for the IHRTs. The membership of such advisory committee shall include a representative from the Federal Trade Commission and the chairperson of the Interagency Steering Committee. Not less than 60 percent of such membership shall consist of representatives of nonfederal entities, at least one of whom shall be a representative from an organization that represents health care consumers.

(2) Duties.—The National Committee for Vital and Health Statistics shall issue periodic reports and review policies concerning IHRTs that include the following factors:

(A) Privacy and security policies.

(B) Economic progress.

(C) Interoperability standards.

(D) Policies promulgated by Federal Trade Commission.—The Federal Trade Commission, in consultation with the National Committee for Vital and Health Statistics and other recognized policies and standards:

(1) provide assistance to encourage the growth of independent health record trusts;

(2) track economic progress as it pertains to independent 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 ensure that information contained in such record may be shared between the trust involved, the participant, and authorized EHR data users by the use of standardized collection and transmission of individual health records (or portions of such records) to authorized EHR data users through a common interface and for the portability of such records among independent health record trusts; and

(5) carry out any other activities determined appropriate by the Federal Trade Commission.

(e) Regulations Promulgated by Federal Trade Commission.—The Federal Trade Commission shall promulgate regulations based on, at a minimum, the following factors:

(1) Requiring that an IHRT participant, who has an electronic health record that is maintained by an IHRT, be notified of a security 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 designated 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 to patients in order to give physicians time to contact the patient.

(4) Recommendations for entities operating IHRTs, including requiring analysis of the potential risks associated with 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 title.

(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 inclusion in the electronic health record trust certification based on—

(A) the potential for conflicts between the interests of such entity and the security of the health record trust; and

(B) the involvement of the entity in any activity that is contrary to the best interests of a patient.

(8) Prevention of the use of revenue sources that are contrary to a patient’s interests.

(9) Public disclosure of audits in a manner similar to financial audits required for publicly traded stock companies.

(10) Requiring notification to a participating entity that the information contained in such record may not be representative of the complete or accurate electronic health record of such record holder.

(f) Compliance Report.—Not later than 1 year after the date of the enactment of this Act, and annually thereafter, the Commission shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Education, Labor, and the Committee on Ways and Means of the House of Representatives, a report on compliance by and progress of independent health record trusts with this subtitle. Such report shall describe the following:

(1) The number of complaints submitted against each IHRT or independent health record trusts, which shall be divided by complaints related to security breaches, and complaints not related to security breaches, and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(2) The number of enforcement actions undertaken by the Commission against independent health record trusts in response to complaints under paragraph (1), which shall include the number of enforcement actions related to security breaches and enforcement actions not related to security breaches and may include other categories as the Interagency Steering Committee established under subsection (b) determines appropriate.

(3) The economic progress of the individual organizations and institutions that received revenue through independent health record trust usage and existing barriers to such usage.

(4) The progress in security auditing as prescribed by the Interagency Steering Committee council under subsection (b).

(5) The other core responsibilities of the Commission as described in subsection (a).

(g) Interagency Memorandum of Understanding.—The Interagency Steering Committee shall ensure, through the execution of an interagency memorandum of understanding, that—

(1) regulations, rulings, and interpretations issued by Federal officials relating to matters over which such officials have responsibility under this subtitle are administered so as to have the same effect at all times; and

(2) the memorandum provides for the coordination of policies related to enforcing the same requirements through such officials in order to have coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

TITLE IX—MISCELLANEOUS


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.


(a) In General.—Beginning not later than 2 years after the date of the 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 Health and Human Services, Tribal Organization, or Urban Indian Organization providers and facilities as the Secretary shall approve for purposes of this section;

(2) pursuant to such procedures as the Secretary of Health and Human Services shall
prescribe for purposes of this section, make payments to such providers and facilities for the provision of such care and services to Indians and individuals described in paragraph (1), and in so doing the Secretary shall specify in such procedures and in such manner so that the Secretary ensures that the aggregate payments made by the Secretary to such providers and facilities do not exceed the aggregate amounts which the Secretary would have paid for such care and services if this section had not been enacted.

(b) In this section, the terms “Indian”, “Indian Health Program”, “Indian Tribe”, “Tribe”, “Urban Indian Organization”, and “Urban Indian” have the meanings given these terms in section 108 of the Indian Health Care Improvement Act.

SEC. 903. TERMINATION OF FEDERAL COORDINATION COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

The Federal Coordinating Council for Comparative Effectiveness Research is hereby terminated and section 806 of the American Recovery and Reinvestment Act of 2009 establishing and funding such Council is here-by 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 health care costs and health toll certain medical conditions will inflict on the baby boomer generation and on other individuals; and

(2) a careful review of certain medical conditions, including heart disease, obesity, diabetes, stroke, cancer, Alzheimers, and other medical conditions the Secretary and Comptroller General determine appropriate.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary and the Comptroller General shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary and the Comptroller General determine appropriate.

(c) TARGETING OF PREVENTION AND WELLNESS INITIATIVES.—The Secretary shall target prevention and wellness efforts conducted under the provisions of this section and amendments made by this Act in order to combat medical conditions identified in the report submitted under subsection (b), including such medical conditions identified as the top 5 medical conditions facing the public which have the greatest impact in terms of morbidity, mortality, and financial cost as of or after the date of enactment of this Act.

SEC. 905. CONSCIENCE PROTECTION.

(a) IN GENERAL.—None of the funds made available in this Act (or an amendment made by this Act) may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide coverage of, or for, provide coverage for, 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 sponsor, a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or program, and any State or local government, if such agency, program, or institution is established or regulated under this Act (or an amendment made by this Act) to subject any institutional or individual health care entity to discrimination; on the basis that such health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(b) DEFINITION.—In this section, the term “health care entity” includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, a plan sponsor, a health insurance issuer, a qualified health plan or issuer offering such a plan, or any other kind of health care facility, organization, or program. (1) above-average rates of Medicare fraud; and

(c) REPORT.—The Secretary and the Comptroller General shall at least annually report to Congress a report describing the recommendation of a government entity when making decisions about the best treatment for an individual patient in an individual circumstance.

SEC. 906. SOLVENCY OF MEDICARE PROGRAM.

Any savings achieved under the Medicare program pursuant to the measures developed and implemented by the Secretary of Health and Human Services under this Act (or an amendment made by this Act) shall be reinvested into the Federal Hospital Insurance Trust Fund, as established under section 1817 of the Social Security Act (42 U.S.C. 1395i), or the Federal Supplementary Medical Insurance Trust Fund, as established under section 1841 of such Act (42 U.S.C. 1395c).

SEC. 907. PROHIBITION ON GOVERNMENT ENTITIES USING COMPARATIVE EFFECTIVENESS RESEARCH FOR CERTAIN PURPOSES.

Comparative effectiveness research and clinical practice guidelines shall not be used by any government entity for payment, coverage, or treatment decisions based on costs. Nothing in the preceding sentence shall limit a physician or other health care provider from using reports and recommendations of a government entity when making decisions about the best treatment for an individual patient in an individual circumstance.

SEC. 908. TO ENSURE PATIENTS RECEIVE DOCTOR RECOMMENDATIONS FOR PREVENTIVE HEALTH SERVICES, INCLUDING MAMMOGRAPHS AND CYSTIC CANCER SCREENING, WITHOUT PAYMENT FROM GOVERNMENT OR INSURANCE COMPANY.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320b-7(f))) or private insurance.

(b) DETERMINATIONS OF BENEFITS COVERAGE.—(1) A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional organizations of relevant medical and health care providers (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiology Oncology, the American College of Obstetricians and Gynecologists, other similar organizations), including guidelines and recommendations relating to the coverage of women’s preventive services (such as mammograms and cervical cancer screenings).

SEC. 909. TO ENSURE PATIENTS RECEIVE DVD RECOMMENDATIONS FOR PREVENTIVE HEALTH SERVICES, INCLUDING MAMMOGRAPHS AND CYSTIC CANCER SCREENING, WITHOUT PAYMENT FROM GOVERNMENT OR INSURANCE COMPANY.

(a) IN GENERAL.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not use any recommendation made by the United States Preventive Services Task Force to deny coverage of an item or service by a health plan or health insurance issuer offering group or individual health insurance coverage or under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320b-7(f))) or private insurance.

(b) DETERMINATIONS OF BENEFITS COVERAGE.—(1) A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, in determining which preventive items and services to provide coverage for under the plan or coverage, consult the medical guidelines and recommendations of relevant professional organizations of relevant medical and health care providers (such as the American Society of Clinical Oncology, the American College of Surgeons, the American College of Radiology Oncology, the American College of Obstetricians and Gynecologists, other similar organizations), including guidelines and recommendations relating to the coverage of women’s preventive services (such as mammograms and cervical cancer screenings).

SEC. 910. ENSURING THAT GOVERNMENT HEALTH CARE PROGRAMS DO NOT HARM, INJURE, OR DENY MEDICALLY NECESSARY CARE.

Notwithstanding any other provision of law—

(1) no individual may be denied health care based on age or life expectancy by any Federal health program; and

(2) no entity of the Federal Government may develop Quality-Adjusted Life Year measures or other similarly designed government program formulas based on an individual’s social utility for limiting access to necessary medical treatment.

SEC. 911. IDENTIFICATION OF FEDERAL GOVERNMENT MEDICAL CARE.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct, and submit to Congress a report describing the results of, a study that—

(1) establishes a list of Federal programs for the coverage of such medical care providers (including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies); and

(2) any restrictions, denials, or rationing relating to the provision of care (including medical procedures, tests (including mammograms and cervical cancer screenings), and prescription drug formularies);

(3) average wait times to see a primary care doctor;

(4) average wait times for medically necessary surgeries and medical procedures; and

(5) the estimated waste, fraud, and abuse (including improper payments) in each program.

(b) DEPARTMENT PROGRAMS.—The programs referred to in subsection (a) are—

(1) Medicare;

(2) Medicaid;

(3) Tricare 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 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 underwriting investigations of health care providers that received improper payments through any Federal public health care program.

(2) SCOPE.—The Secretary shall conduct the demonstration project under this section in States or regions that have—

(A) above-average rates of Medicare fraud; or
(B) any level of Medicaid fraud.

(c) ELIGIBILITY.—To be eligible to receive a contract under subsection (b)(1), a health care professional shall—

(1) be a licensed and practicing medical professional who holds an advanced medical degree from an accredited American university or college and has experience within the health care industry; and

(2) submit to the Secretary such information, at such time, and in such manner, as the Secretary may require.

(d) ACTIVITIES.—Each health care professional awarded a contract under subsection (b)(1) shall assist the Secretary and the Inspector General in conducting random audits of the practices of health care providers that receive reimbursements through any Federal public health care program. Such audits may include—

(1) statistically random visits to the practices of such health care providers;

(2) attempts to purchase pharmaceutical products illegally from such health care providers;

(3) purchasing durable medical equipment from such health care providers;

(4) hospital visits; and

(5) other activities, as the Secretary determines appropriate.

(e) FOLLOW-UP BY THE INSPECTOR GENERAL.—The Inspector General shall follow up on any notable findings of the investigations conducted under subsection (d) in order to report fraudulent practices and refer individual cases to the appropriate State and local authorities.

(f) LIMITATION.—The Secretary shall not contract with a health care professional if, due to physical proximity or a personal, familial, proprietary, or monetary relationship with such health care professional to individuals that such professional would be investigating, a conflict of interest could be inferred.

(g) FUNDING.—To carry out this section, the Secretary and the Inspector General are each authorized to reserve, from amounts appropriated to the Department of Health and Human Services and the Office of the Inspector General of the Department of Health and Human Services, respectively, $500,000 for each of fiscal years 2010 through 2014.

ADJOURNMENT UNTIL 1 P.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 1 p.m. tomorrow.

There upon the Senate, at 5:34 p.m., adjourned until Sunday, December 20, 2009, at 1 p.m.