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[Report No. 111–89]

To provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

IN THE SENATE OF THE UNITED STATES

OCTOBER 19, 2009

Mr. BAUCUS, from the Committee on Finance reported the following original bill; which was read twice and placed on the calendar

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A BILL

To provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''America's Healthy Future Act of 2009''.

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

TITLE I—HEALTH CARE COVERAGE

Subtitle A—Insurance Market Reforms

SEC. 1001. INSURANCE MARKET REFORMS IN THE INDIVIDUAL AND SMALL GROUP MARKETS.

The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following:

"TITLE XXII—HEALTH INSURANCE COVERAGE

"SEC. 2200. ENSURING ESSENTIAL AND AFFORDABLE HEALTH BENEFITS COVERAGE FOR ALL AMERICANS.

''It is the purpose of this title to ensure that all Americans have access to affordable and essential health benefits coverage—

''(1) by requiring that all new health benefits plans offered to individuals and employees in the individual and small group markets be qualified health benefits plans that meet the insurance rating re-

forms and essential health benefits coverage requirements established under parts A and C;

''(2) by establishing State exchanges under part B that provide individuals and employees in the individual and small group markets greater access to qualified health benefits plans and to information concerning these health plans;

''(3) by making health benefits coverage more affordable by establishing premium credits and cost-sharing subsidies under part C for individuals enrolling in a health benefits plan through an exchange; and

''(4) by establishing the CO-OP program under part D to encourage the establishment of nonprofit health care cooperatives.

''PART A—INSURANCE REFORMS

''Subpart 1—Requirements in Individual and Small Group Markets

''SEC. 2201. GENERAL REQUIREMENTS AND DEFINITIONS.

''(a) NEW PLANS MUST BE QUALIFIED HEALTH BENEFITS PLANS.—Except as provided in subpart 3 (relating to preservation of existing coverage), each State shall provide that each health benefits plan which is offered in the individual or small group market within the State shall be a qualified health benefits plan.

''(b) QUALIFIED HEALTH BENEFITS PLAN.—For purposes of this title, a health benefits plan which is offered in the individual or small group market shall be a qualified health benefits plan with respect to a State if—

''(1) the plan has in effect a certification (which may include a seal or other indication of approval) issued or recognized by the State that such plan meets the applicable requirements of—

''(A) this part (relating to requirements for insurance market reforms); and

''(B) part C (relating to requirements to make health insurance affordable); and

''(2) the offeror of the plan—

''(A) is licensed by the State (and in good standing with the State) to offer a health benefits plan in the State; and

''(B) complies with such other requirements as the Secretary or the State may establish pursuant to this title for qualified health benefits plans.

''(c) TERMS RELATING TO HEALTH BENEFITS PLANS.—In this title:

''(1) HEALTH BENEFITS PLAN.—

"(A) IN GENERAL.—The term 'health benefits plan' means health insurance coverage and a group health plan.

"(B) EXCEPTION FOR SELF-INSURED PLANS AND MEWAS.—Except to the extent specifically provided by this title, the term 'health benefits plan' shall not include a group health plan or multiple employer welfare arrangement to the extent the plan is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

"(2) HEALTH INSURANCE COVERAGE AND ISSUER.—The terms 'health insurance coverage' and 'health insurance issuer' have the meanings given such terms by section 9832(b) of the Internal Revenue Code of 1986.

"(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b) of such Code.

"(4) HEALTH BENEFITS PLAN OFFEROR.—The terms 'health benefits plan offeror' and 'offeror' mean in the case of—

"(A) health insurance coverage, the health insurance issuer offering the coverage; and

''(B) a group health plan—

''(i) the plan sponsor; or

''(ii) in the case of a plan maintained jointly by 1 or more employers and 1 or more employee organizations and with respect to which an employer is the primary source of financing, such employer.

''(d) DEFINITIONS RELATING TO MARKETS.—In this title:

''(1) GROUP MARKET.—The term 'group market' means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer.

''(2) INDIVIDUAL MARKET.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(3) LARGE AND SMALL GROUP MARKETS.—The terms 'large group market' and 'small group market' mean the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group

health plan maintained by a large employer (as defined in section 2230(a)(1)) or by a small employer (as defined in section 2230(a)(2)), respectively.

"SEC. 2202. PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

''(a) PROHIBITION.—A health benefits plan shall be treated as a qualified health benefits plan only if the plan does not—

''(1) impose any preexisting condition exclusion with respect to the plan; or

''(2) otherwise impose any limit or condition on the coverage under the plan with respect to an individual or dependent of an individual based on any health status-related factors in relation to the individual or dependent.

''(b) PREEXISTING CONDITION EXCLUSION.—For purposes of this section, the term 'preexisting condition exclusion' means, with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

''(c) HEALTH STATUS-RELATED FACTORS.—For purposes of this section, the term 'health status-related

factors' means health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

"SEC. 2203. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS.

''(a) IN GENERAL.—Except as provided in this section, a health benefits plan shall be treated as a qualified health benefits plan only if the offeror of the plan—

''(1) in the case of a plan offered—

''(A) in the individual market in a State, must accept every individual that applies for enrollment in the plan;

''(B) in the small group market in a State, must accept—

''(i) every small employer in the State that applies for enrollment of its employees under the plan; and

''(ii) every individual who is eligible to enroll in the plan by reason of a relationship to the employer as is determined—

''(I) in accordance with the terms of such plan;

''(II) as provided by the offeror under rules of the offeror that are uniformly applicable to small employers in the small group market within a State; and

''(III) in accordance with all applicable State laws governing the offeror and the small group market; and

''(2) must renew or continue in force coverage under the plan at the option of the individual or small employer, as applicable.

An offeror of a plan shall not be treated as meeting the requirements of this subsection unless the plan also accepts, renews, or continues in force coverage of an individual who is eligible for enrollment in the plan by reason of their relationship to the named insured under the plan.

''(b) SPECIAL RULES FOR GUARANTEED ISSUE.—

''(1) ENROLLMENT.—Each offeror of a health benefits plan shall establish annual and special enrollment periods meeting the requirements of section 2236(d)(2) and may restrict enrollment described in subsection (a)(1) to such enrollment periods.

''(2) CAPACITY LIMITS.—For purposes of applying subsection (a)(1), if, as determined under regulations prescribed by the Secretary, a plan has a ca-

pacity limit, the plan may limit enrollment to that capacity limit but only if the plan selects individuals for enrollment on the basis of the order in which the individuals applied for enrollment and in a manner that does not discriminate in any manner prohibited under section 2202.

''(c) GUARANTEED RENEWABILITY.—For purposes of applying subsection (a)(2)—

''(1) rescissions of coverage shall be treated in the same manner as non-renewals of coverage; and

''(2) the premium rate at the time of renewal shall be determined using only the same categories of rate adjustment factors that were used at issue.

The Secretary may prescribe rules for the application of paragraph (2) during any period during which the reforms under this subpart are being phased in by a State.

''SEC. 2204. PREMIUM RATING RULES.

''(a) IN GENERAL.—A health benefits plan shall be treated as a qualified health benefits plan only if the premium rate charged for any benefit level of the plan may not vary except as provided in this section.

''(b) LIMITS BASED ON SPECIFIC RATIOS.—

''(1) IN GENERAL.—In the case of a health benefits plan offered in a rating area, the premium rate

charged under the plan may vary only as provided in paragraphs (2) and (3).

''(2) BY FAMILY ENROLLMENT.—The premium rate may vary by family enrollment (such as variations within categories and compositions of families) so long as the ratio of the premium for the following types of enrollment to the premium for individual enrollment does not exceed the following ratios:

''(A) Individual, 1 to 1.

''(B) Adult with child, 1.8 to 1.

''(C) Two adults, 2 to 1.

''(D) Family, 3 to 1.

''(3) AGE AND TOBACCO USE.—Within any family enrollment category, the portion of the premium attributable to each individual covered by the health benefits plan in that category may vary as follows:

''(A) LIMITED AGE VARIATION PERMITTED.—By age (within the standard age bands established under subsection (c)) so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 4 to 1.

''(B) TOBACCO USE.—By tobacco use so long as the ratio of the highest such premium

to the lowest such premium does not exceed the ratio of 1.5 to 1.

''(c) STANDARD AGE CATEGORIES.—The Secretary shall establish standard age bands between which premium rates may vary as provided in subsection (b)(3)(A).

''(d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to allow a health benefits plan to vary a premium rate on the basis of health status-related factors, gender, class of business, claims experience, or any other factor not described in subsection (b).

''SEC. 2205. USE OF UNIFORM OUTLINE OF COVERAGE DOCUMENTS.

''A health benefits plan shall provide an outline of the plan's health insurance coverage meeting the standards of uniformity adopted by the Secretary under section 1503 of the America's Healthy Future Act of 2009 to—

''(1) an applicant at the time of application;

''(2) an enrollee at the time of enrollment; and

''(3) a policyholder or certificate holder of the plan at the time the policy is issued or the certificate is delivered.

"Subpart 2—Reforms Relating to Allocation of Risks

"SEC. 2211. RATING AREAS; POOLING OF RISKS; PHASE IN OF RATING RULES IN SMALL GROUP MARKETS.

''(a) RATING AREAS.—

''(1) IN GENERAL.—Each State shall establish 1 or more rating areas within that State for purposes of applying the requirements of this title.

''(2) SECRETARIAL REVIEW.—The Secretary shall review the rating areas established by each State under subsection (a) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State's rating areas are not so adequate, the Secretary may establish rating areas for that State.

''(b) SINGLE RISK POOL.—

''(1) IN GENERAL.—For purposes of applying the insurance reform requirements under subpart 1—

''(A) INDIVIDUAL MARKET.—The offeror of an insured qualified health benefits plan offered in the individual market in an area covered by an exchange shall consider all enrollees in the plan, including individuals who do not purchase such a plan through an exchange, to be members of a single risk pool.

''(B) SMALL GROUP MARKET.—The offeror of a qualified health benefits plan offered in the small group market in an area covered by an exchange shall consider all enrollees in the plan, including individuals who do not purchase such a plan through an exchange, to be members of a single risk pool.

''(2) STATE ELECTION.—A State may elect to combine the individual and small group markets within the State for purposes of applying this subsection.

''(c) PHASE IN OF INSURANCE REFORM RULES IN SMALL GROUP MARKET.—Upon request to, and approval by, the Secretary, each State shall phase in the application to the small group market of the insurance reform requirements under subpart 1 over a consecutive period of years (not greater than 5) beginning July 1, 2013.

''SEC. 2212. RISK ADJUSTMENT.

''(a) IN GENERAL.—Each State shall adopt a risk adjustment model described in subsection (b) to implement procedures for the application of risk adjustment among qualified health benefit plans and grandfathered health benefits plans offered in both the individual and small group market. Such procedures shall apply to such quali-

fied health benefit plans whether or not purchased through an exchange.

''(b) RISK ADJUSTMENT MODELS.—

''(1) IN GENERAL.—The Secretary shall establish 1 or more risk adjustment models for proper adjustments of premium amounts payable among offerors of qualified health benefits plans that take into account (in a manner specified by the Secretary) the differences in the risk characteristics of individuals and employers enrolled under the different plans so as to minimize the impact of adverse selection of enrollees among the plans.

''(2) STATE OPTION.—A State may—

''(A) adopt a risk adjustment model established under paragraph (1); or

''(B) establish its own risk adjustment model for purposes of subsection (a), but only if the State establishes to the satisfaction of the Secretary that such model will produce results substantially similar to the results of risk adjustment models established under paragraph (1) and will not increase costs to the Federal government.

''(3) OPERATION OF RISK ADJUSTMENT SYSTEM.—A State may select an entity certified under

subsection (c) to implement and operate its risk adjustment model under this section.

''(c) CERTIFICATION OF ENTITIES CONDUCTING RISK ADJUSTMENT.—The Secretary shall certify entities which the Secretary determines have the required expertise to implement the risk adjustment models adopted or established under subsection (b). The Secretary may not certify any entity which is a health benefits plan offeror or any entity owned or operated by such an offeror.

''SEC. 2213. ESTABLISHMENT OF TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL MARKETS IN EACH STATE.

''(a) IN GENERAL.—Each State shall, not later than July 1, 2013—

''(1) include in the Model Regulation, Federal standard, or State law or regulation the State adopts and has in effect under section 2225(a)(2) the provisions described in subsection (b); and

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

''(b) MODEL REGULATION.—

''(1) IN GENERAL.—In establishing the Model Regulation under section 2225 to carry out this part, the Secretary shall request the National Asso-

ciation of Insurance Commissioners (the 'NAIC') to include provisions that enable States to establish and maintain a program under which—

"(A) the offerors of health benefits plans that are offered in the individual market are required to make payments to an applicable reinsurance entity for any plan year beginning in the 36-month period beginning July 1, 2013; and

"(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to offerors of health benefits plans described in subparagraph (A) that cover high risk individuals for any plan year beginning in such 36-month period.

If the NAIC does not include such provisions as part of the Model Regulation , the Secretary shall include such provisions in a Federal standard under section 2225(a)(1)(B).

"(2) HIGH-RISK INDIVIDUAL; PAYMENT AMOUNTS.—The following shall be included in the provisions under paragraph (1):

"(A) DETERMINATION OF HIGH-RISK INDIVIDUALS.—The method by which individuals

will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

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

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

''(B) PAYMENT AMOUNT.—

''(i) IN GENERAL.—The formula for determining the amount of payments that will be paid to the offerors of health benefits plans that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—

''(I) to provide a schedule of payments that specifies the amount that

will be paid for each of the conditions identified under subparagraph (A); or

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

"(ii) COORDINATION WITH COST-SHARING AND RISK ADJUSTMENT PAYMENTS.—Such provisions shall provide methods to coordinate the payment system under this section with any cost-sharing requirements of a plan and the risk-adjustment program under section 2212.

"(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.—

"(A) IN GENERAL.—The provisions under paragraph (1) shall include the method for determining the amount each offeror of a health benefits plan participating in the reinsurance program under this section is required to contribute under paragraph (1)(A) for each plan

year beginning in the 36-month period beginning July 1, 2013. The contribution amount for any plan year may be based on the percentage of revenue of each offeror or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

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

''(i) the contribution amount for each offeror proportionally reflects each offeror's fully insured commercial book of business for all major medical products and third party administration fees;

''(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;

''(iii) subject to clause (iv), the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC or the Secretary, whichever is applicable, and without regard to amounts described in clause (ii), equal

$10,000,000,000 for plan years beginning in the 12-month period beginning July 1, 2013, $6,000,000,000 for plan years beginning in the 12-month period beginning July 1, 2014, and $4,000,000,000 for plan years beginning in the 12-month period beginning July 1, 2015; and

''(iv) in addition to the aggregate contribution amounts under clause (iii), each offeror's contribution amount reflects its proportionate share of the $5,000,000,000 amount used to fund the retiree reinsurance program under section 2216.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from offerors on a voluntary basis.

''(4) EXPENDITURE OF FUNDS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the provisions under paragraph (1) shall provide that—

''(i) the contribution amounts collected for any 12-month period may be allocated and used in any of the three 12-month periods for which amounts are col-

lected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

"(ii) amounts remaining unexpended as of June 30, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 24-month period beginning on July 1, 2016.

"(B) TRANSFERS TO SECRETARY FOR RETIREE REINSURANCE.—The provisions under paragraph (1) shall provide that each applicable reinsurance entity shall transfer to the Secretary amounts collected that are allocable to amounts required to be collected under paragraph (3)(B)(iv).

"(c) APPLICABLE REINSURANCE ENTITY.—For purposes of this section—

"(1) IN GENERAL.—The term 'applicable reinsurance entity' means a not-for-profit organization—

"(A) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an exchange for that market within the State when the risk of adverse selection re-

lated to new rating rules and market changes is greatest; and

"(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

"(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

"(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be treated as an organization exempt from taxation under section 501(a) of the Internal Revenue Code of 1986. The preceding sentence shall not apply to the tax imposed by section 511 such Code (relating to tax on unrelated business taxable income of an exempt organization).

"(d) COORDINATION WITH STATE HIGH-RISK POOLS.—The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The

State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

"SEC. 2214. ESTABLISHMENT OF RISK CORRIDORS FOR PLANS IN INDIVIDUAL AND SMALL GROUP MARKETS.

''(a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for plan years beginning during the 36-month period beginning on July 1, 2013, under which a qualified health benefits plan offered in the individual or small group market may elect (before the beginning of such 36-month period) to participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII.

''(b) PAYMENT METHODOLOGY.—

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

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

amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

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

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

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

''(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of

the excess of 92 percent of the target amount over the allowable costs.

''(c) DEFINITIONS.—In this section:

''(1) ALLOWABLE COSTS.—

''(A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

''(B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall be reduced by any risk adjustment and reinsurance payments received under section 2212 and 2213.

''(2) TARGET AMOUNT.—The target amount of a plan for any year is an amount equal to the total premiums (including any premium credits or subsidies under any governmental program) reduced by the administrative costs of the plan.

''SEC. 2215. TEMPORARY HIGH RISK POOLS FOR INDIVIDUALS WITH PREEXISTING CONDITIONS.

''(a) ESTABLISHMENT OF HIGH RISK POOLS.—

''(1) IN GENERAL.—Not later than 1 year after the date of enactment of this title, the Secretary shall establish 1 or more high risk pools that—

''(A) provide to all eligible individuals health insurance coverage (or comparable coverage) that does not impose any preexisting condition exclusion with respect to such coverage for all eligible individuals; and

''(B) provide for health benefits coverage and premium rates described under subsection (b).

''(2) ADMINISTRATION.—The Secretary may carry out this section—

''(A) directly; or

''(B) through agreements, grants, or contracts with States or other persons the Secretary determines appropriate.

''(b) COVERAGE AND PREMIUM RATES.—Except as provided in subsection (c)(2)—

''(1) COVERAGE.—The Secretary shall provide that the health benefits coverage provided to an eligible individual through a high risk pool under this section shall—

''(A) consist of the essential benefits package described in section 2242; and

''(B) provide the bronze level of coverage described in section 2243(b)(1).

''(2) PREMIUM RATES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the premium rate charged to an eligible individual enrolled in a high risk pool shall be equal to the standard premium rate for a health benefits plan providing the essential benefits package and bronze level of coverage described in paragraph (1).

''(B) VARIATION OF PREMIUMS.—The Secretary may vary the premium under subparagraph (A) to the same extent, and in the same manner, as the offeror of a qualified health benefits plan may vary the premium for the plan under section 2204.

''(c) FUNDING; TERMINATION OF AUTHORITY.—

''(1) IN GENERAL.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and administrative costs of) the high risk pool in excess of the premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

''(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that the aggregate amounts available for payment of expenses of the

high risk pool will be less than the amount of the expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit, including reducing benefits, increasing premiums, or establishing waiting lists.

''(3) TERMINATION OF AUTHORITY.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), coverage of eligible individuals under a high risk pool shall terminate as of the end of June 30, 2013.

''(B) TRANSITION TO EXCHANGE.—The Secretary shall develop procedures to provide for the transition of eligible individuals enrolled in health insurance coverage offered through a high risk pool established under this section into qualified health benefits plans offered through an exchange. Such procedures shall ensure that there is no lapse in coverage with respect to the individual and may extend coverage after June 30, 2013, if the Secretary determines necessary to avoid such a lapse.

''(d) ELIGIBLE INDIVIDUAL.—In this section, the term 'eligible individual' means an individual who demonstrates to the satisfaction of the Secretary that the individual—

''(1) has been denied health insurance coverage by reason of a preexisting condition (as defined in section 2202(b));

''(2) has been uninsured for a continuous period of at least 6 months before the date of application for enrollment in a high risk pool;

''(3) is not eligible for essential health benefits coverage (as defined in section 5000A(f)); and

''(4) is an individual who is, and who is reasonably expected to be for the entire period of coverage, a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien lawfully present in the United States.

''SEC. 2216. REINSURANCE FOR RETIREES COVERED BY EMPLOYER-BASED PLANS.

''(a) ADMINISTRATION.—

''(1) IN GENERAL.—Not later than 90 days after the date of enactment of this section, the Secretary shall establish a temporary reinsurance program to provide reimbursement to participating employment-based plans for a portion of the cost of providing health benefits to retirees during the period beginning on the date on which such program is established and ending on the date on which the

Secretary estimates that applications for payments under this section will have been made that equal the funds made available under this section (reduced by any administrative costs of the program).

''(2) REFERENCE.—In this section:

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

''(B) EMPLOYMENT-BASED PLAN.—The term 'employment-based plan' means a group health benefits plan that—

''(i) is—

''(I) maintained by one or more current or former employers (including without limitation any State or local government or political subdivision thereof), an employee organization, a voluntary employees' beneficiary association, or a committee or board of individuals appointed to administer such plan; or

"(II) a multiemployer plan (as defined in section 3(37) of the Employee Retirement Income Security Act of 1974); and

"(ii) provides health benefits to retirees.

"(C) RETIREES.—The term 'retirees' means individuals who are age 55 and older but are not eligible for coverage under title XVIII of the Social Security Act, and who are not active employees of an employer maintaining, or currently contributing to, the employment-based plan or of any employer that has made substantial contributions to fund such plan.

"(b) PARTICIPATION.—

"(1) EMPLOYMENT-BASED PLAN ELIGIBILITY.—A participating employment-based plan is an employment-based plan that—

"(A) meets the requirements of paragraph (2) with respect to benefits provided under the plan; and

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

''(2) PLAN REQUIREMENTS.—An employment-based plan meets the requirements of this paragraph if the plan—

''(A) provides benefits appropriate for individuals between the ages described in subsection (a)(2)(C) and that are certified as so appropriate by the Secretary;

''(B) implements programs and procedures to generate cost-savings with respect to participants with chronic and high-cost conditions; and

''(C) provides documentation of the actual cost of medical claims involved and for which reimbursement is sought under this section.

''(c) PAYMENTS.—

''(1) SUBMISSION OF CLAIMS.—

''(A) IN GENERAL.—A participating employment-based plan shall submit claims for reimbursement to the Secretary which shall contain documentation of the actual costs of the items and services for which each claim is being submitted.

''(B) BASIS FOR CLAIMS.—Claims submitted under paragraph (1) shall be based on the actual amount expended by the partici-

pating employment-based plan involved within the plan year for the appropriate employment-based health benefits provided to a retiree or the spouse, surviving spouse, or dependent of such retiree. In determining the amount of a claim for purposes of this subsection, the participating employment-based plan shall take into account any negotiated price concessions (such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations) obtained by such plan with respect to such health benefit. For purposes of determining the amount of any such claim, the costs paid by the retiree or the retiree's spouse, surviving spouse, or dependent in the form of deductibles, co-payments, or co-insurance shall be included in the amounts paid by the participating employment-based plan.

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

''(3) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan under paragraph (1) with respect to any individual shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for all urban consumers (rounded to the nearest multiple of $1,000) for the year involved.

''(4) USE OF PAYMENTS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs for plan participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a mechanism to monitor the appropriate use of such payments by such entities.

''(5) PAYMENTS NOT TREATED AS INCOME.—Payments received under this subsection shall not be included in determining the gross income of an enti-

ty described in subsection (a)(2)(B)(i) that is maintaining or currently contributing to a participating employment-based plan.

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

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

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

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

''(e) AVAILABLE FUNDS.—

''(1) IN GENERAL.—The Secretary of the Treasury shall establish a separate account within the Treasury of the United States for deposit of amounts transferred to the Secretary of Health and Human Services under section 2213(b)(4)(B).

''(2) APPROPRIATIONS.—Amounts in the account are hereby appropriated for use by the Sec-

retary in carrying out the program under this section.

''(3) LIMITATIONS.—The Secretary has the authority to stop taking applications for participation in the program if applications will exceed amounts in the account.

"Subpart 3—Preservation of Right to Maintain Existing Coverage

"SEC. 2221. GRANDFATHERED HEALTH BENEFITS PLANS.

''(a) IN GENERAL.—In the case of a grandfathered health benefits plan—

''(1) nothing in this title shall be construed to require that an individual terminate coverage under the plan if such individual was enrolled in the plan as of the day before the effective date of this title;

''(2) except as provided in subsection (b), the requirements of this part shall not apply to the plan; and

''(3) the plan shall not be treated as a qualified health benefits plan for purposes of this title.

''(b) APPLICATION OF RATING RULES IN SMALL GROUP MARKET.—Each State shall phase in the application of the insurance reform requirements under subpart 1 to grandfathered health benefits plans offered in the small group market within the State over a consecutive

period of years (not greater than 5) beginning July 1, 2013.

''(c) GRANDFATHERED HEALTH BENEFITS PLAN.—In this title:

''(1) IN GENERAL.—The term 'grandfathered health benefits plan' means any of the following that was offered and was in force and effect on the effective date of this title:

''(A) Health insurance coverage in the individual market.

''(B) A group health plan.

''(2) LIMITED NEW ENROLLMENT.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), a health benefits plan shall cease to be a grandfathered health benefits plan if it enrolls individuals who were not enrolled in the plan as of the day before the date described in paragraph (1).

''(B) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—Family members of an individual enrolled in a health benefits plan as of the day before the date described in paragraph (1) may enroll in the plan on or after such date.

''(C) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan of an employer that provides coverage as of the day before the date described in paragraph (1) may provide for the enrolling of new employees (and their families) in such plan.

''(3) SPECIAL RULE FOR CATASTROPHIC PLANS.—If health insurance coverage offered and in force in the individual market as of the day before the effective of this title is actuarially equivalent to a catastrophic plan described in section 2243(c), such coverage shall be treated as a grandfathered health benefits plan for purposes of this section.

''Subpart 4—Continued Role of States

''SEC. 2225. CONTINUED STATE ENFORCEMENT OF INSURANCE REGULATIONS.

''(a) IN GENERAL.—

''(1) MODEL REGULATION.—

''(A) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners (in this section referred to as the 'NAIC') to, not later than 12 months after the date of enactment of this title, develop and promulgate a Model Regulation that implements the requirements set forth in this title

for health benefit plans offered within a State. In developing and promulgating the Model Regulation, the NAIC shall consult with its members, health insurance issuers, consumer organizations, and such other individuals as the NAIC selects in a manner designed to ensure balanced representation among interested parties.

''(B) SECRETARIAL ACTION.—The Secretary shall include the Model Regulation established under paragraph (1) in the regulations prescribed by the Secretary to implement the requirements described in subparagraph (A). If the NAIC does not promulgate the Model Regulation within the 12-month period under subparagraph (A), the Secretary shall establish a Federal standard implementing such requirements.

''(2) STATE ACTION.—Each State that elects to apply the requirements set forth in this title to health benefit plans offered within the State shall, not later than July 1, 2013, adopt and have in effect—

''(A) the Model Regulation or Federal standard established under paragraph (1), whichever is applicable; or

''(B) a State law or regulation that the Secretary determines implements the requirements for health benefit plans offered within the State.

''(3) FAILURE TO IMPLEMENT PROVISIONS.—

''(A) IN GENERAL.—If—

''(i) a State does not elect to apply the requirements set forth in this title to health benefit plans offered within the State; or

''(ii) the Secretary determines that an electing State has failed to adopt or substantially enforce the Model Regulation, Federal standard, or State law or regulations described in paragraph (2), whichever is applicable, with respect to health benefits plan offerors in the State,

the Secretary shall implement and enforce such requirements insofar as they relate to the issuance, sale, renewal, and offering of health benefits plans in such State until such time as the Secretary determines the State has adopted and is substantially enforcing the requirements.

''(B) ENFORCEMENT AUTHORITY.—The provisions of section 2722(b) of the Public

Health Services Act shall apply to the enforcement under subparagraph (A) of the provisions of this part (without regard to any limitation on the application of those provisions to group health plans).

''(4) RATINGS REFORMS MUST APPLY UNIFORMLY TO ALL OFFERORS.—The Model Regulation, Federal standard, or State law and regulation implemented by a State under this subsection shall require that any standard or requirement adopted pursuant to this title (including any standard or requirement described in subsection (c) that offers more protection to consumers than the protection offered by any standard or requirement set forth in this title) shall be applied uniformly to all offerors of all health benefits plans in the individual or small group market, whichever is applicable.

''(b) STATE EXCHANGES.—

''(1) EXCHANGES FOR QUALIFIED PLANS.—

''(A) IN GENERAL.—Subject to paragraph (2), not later than July 1, 2013, an electing State under subsection (a)(2) shall establish and have in operation 1 or more exchanges (including SHOP exchanges) meeting the requirements of part B with respect to the offering of

qualified health benefits plans through the exchange.

"(B) FAILURE TO ESTABLISH.—If—

"(i) a State is not an electing State under subsection (a)(2); or

"(ii) an electing State does not establish the exchanges described in subparagraph (A) within 24 months after the date of enactment of this title (or the Secretary determines at the end of the 24-month period that the exchanges will not be operational by July 1, 2013),

the Secretary shall enter into a contract with a nongovernmental entity to establish and operate the exchanges within the State.

"(2) INTERIM EXCHANGES.—Each electing State under subsection (a)(2) shall as soon as practicable establish the exchanges described in section 2235(e) for use by residents of the State during the period beginning January 1, 2010, and ending June 30, 2013. In the case of a State that is not an electing State under subsection (a)(2), or if the Secretary determines that the exchanges in an electing State will not be operational within a reasonable period of time after the date of enactment of this title, the

Secretary shall enter into a contract with a non-governmental entity to establish and operate the exchanges within the State during such period.

''(c) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH BENEFITS PLANS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), this title shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement relating to health benefits plan offerors in connection with a health benefits plan that offers more protection to consumers than the protection offered by any standard or requirement set forth in this title. The standards or requirements referred to in the preceding sentence shall include standards or requirements relating to—

''(A) consumer protections, including claims grievance procedures, external review of claims determinations, oversight of insurance agent practices and training, and insurance market conduct;

''(B) premium rating reviews;

''(C) solvency and reserve requirements relating to the licensure of health insurance issuers operating in the State; and

"(D) the assessment of State-based premium taxes on health insurance issuers.

"(2) SPECIAL RULE FOR RATING REQUIREMENTS.—For purposes of paragraph (1), in the case of the ratings requirements under section 2204, a State law shall not be treated as offering more protection to consumers than the protection offered by such requirements if the State law imposes ratios that are greater than the ratios specified in section 2204(b).

"(3) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

"(d) AUTOMATIC ENROLLMENT.—A State may institute a program to provide that offerors of qualified health benefit plans, small employers, and exchanges offering qualified health benefits plans in the individual and small group market within the State may automatically enroll individuals and employees in, or continue enrollment of individuals in, qualified health benefit plans where appropriate to ensure coverage of the individuals. Any automatic enrollment program shall include adequate notice

and the opportunity for an individual or employee to opt out of any coverage the individual or employee were automatically enrolled in.

''(e) CLAIMS REVIEW PROCESS.—Each State shall—

''(1) require each offeror of a qualified health benefits plans offered through an exchange—

''(A) to provide an internal claims appeal process;

''(B) to provide notice in clear language and in the enrollee's primary language of available internal and external appeals processes and the availability of the ombudsman established under section 2229(a) to assist them with the appeals processes; and

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

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

''(3) ensure enrollees can seek judicial review through available Federal or State procedures.

''(f) APPLICABLE STATE AUTHORITY.—In this title, the term 'applicable State authority' means the State insurance commissioner or official or officials designated by the State to enforce the requirements of this title for the State involved.

"SEC. 2226. WAIVER OF HEALTH INSURANCE REFORM REQUIREMENTS.

''(a) APPLICATION.—A State may apply to the Secretary for the waiver of all or any requirements under this title and section 5000A of the Internal Revenue Code of 1986 with respect to health insurance coverage within that State for plan years beginning on or after July 1, 2015. Such application shall—

''(1) be filed at such time and in such manner as the Secretary may require; and

''(2) contain such information as the Secretary may require, including—

''(A) a comprehensive description of the State legislation or program for implementing a plan meeting the requirements for a waiver under this section; and

''(B) a 10-year budget plan for such plan that is budget neutral for the Federal government.

''(b) GRANTING OF WAIVERS.—The Secretary may grant a request for a waiver under this section if the Secretary determines that—

''(1) the State plan to provide health care coverage to its residents provides coverage that is at least as comprehensive as the coverage required under a qualified health benefits plan offered through exchanges established under this title; and

''(2) the State plan to provide health care coverage to its residents will lower the growth in health care spending, will improve delivery system performance, will provide affordable choices for its citizens, will expand protection against excessive out-of-pocket spending, will provide coverage to the same number of uninsured as the provisions of this title will provide, and will not increase the Federal deficit.

''(c) SCOPE OF WAIVER.—

''(1) IN GENERAL.—The Secretary shall determine the scope of a waiver granted to a State under this section, including which Federal laws and requirements will not apply to the State under the waiver.

''(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

''(d) DETERMINATIONS BY SECRETARY.—

''(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under this section not later than 180 days after the receipt of an application from a State under subsection (a).

''(2) EFFECT OF DETERMINATION.—

''(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under this section, the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

''(B) DENIAL OF WAIVER.—If the Secretary determines a waiver should not be granted under this section, the Secretary shall notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefor.

''SEC. 2227. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

''(a) HEALTH CARE CHOICE COMPACTS.—

''(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to, no later than July 1, 2012, develop model rules for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

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

''(B) the offeror of any qualified health benefits plan to which the compact applies—

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

''(ii) would be required to be licensed in each State in which it offers the plan under the compact or to submit to the jurisdiction of each such State with regard to

the standards described in clause (i) (including allowing access to records as if the insurer were licensed in the State); and

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

If the NAIC does not promulgate the model rules by July 1, 2012, the Secretary shall, not later than July 1, 2013, establish a Federal standard implementing such rules.

''(2) STATE AUTHORITY.—A State may not enter into an agreement under this subsection unless the State enacts a law after the date of the enactment of this title that specifically authorizes the State to enter into such agreements.

''(3) EFFECTIVE DATE.—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2015.

''(b) AUTHORITY FOR NATIONWIDE PLANS.—

''(1) IN GENERAL.—Notwithstanding section 2225(c)(1), and except as provided in paragraph (2), if an offeror of a qualified health benefits plan in the individual or small group market meets the requirements of this subsection—

''(A) the offeror of the plan may offer the qualified health benefits plan in more than 1 State; and

''(B) any State law mandating benefit coverage by a health benefits plan shall not apply to the qualified health benefits plan.

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

''(3) PLAN REQUIREMENTS.—An offeror meets the requirements of this subsection with respect to a qualified health benefits plan if—

''(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraph (3);

''(B) the offeror is licensed in each State in which it offers the plan and is subject in such State to the standards and requirements described in the last sentence of section 2225(c)(1);

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

"(D) the offeror determines the premiums for the plan in any State on the basis of the ratings rules in effect in that State for the ratings areas in which it is offered.

"(4) APPLICABLE REGULATIONS.—

"(A) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to, no later than 2012, develop model rules for the offering of a qualified health benefits plans on a national basis. Such rules shall establish standards for—

"(i) the implementation of benefit categories, taking into account how each benefit is offered in a majority of States; and

"(ii) harmonization between applicable State authorities of State insurance regulations relating to filing of forms and the filing of premium rates.

If the NAIC does not promulgate the model rules by December 31, 2012, the Secretary shall, not later than December 31, 2013, establish a Federal standard implementing such rules.

''(B) STATE ACTION.—Each State (other than a State described in paragraph (2)) shall include the provisions described in subparagraph (A) in the Model Regulation, Federal standard, or State law or regulation the State adopts and has in effect under section 2225(a)(2).

''SEC. 2228. STATE FLEXIBILITY TO ESTABLISH BASIC HEALTH PROGRAMS FOR LOW-INCOME INDIVIDUALS NOT ELIGIBLE FOR MEDICAID.

''(a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a basic health program meeting the requirements of this section under which a State may enter into contracts to offer 1 or more standard health plans providing at least an essential benefits package described in section 2242 to eligible individuals in lieu of offering such individuals coverage through an exchange established under part B.

''(2) CERTIFICATIONS AS TO BENEFIT COVERAGE AND COSTS.—Such program shall provide that a State may not establish a basic health program under this section unless the State establishes to the satisfaction of the Secretary, and the Secretary certifies, that—

''(A) in the case of an eligible individual enrolled in a standard health plan offered through the program, the State provides—

''(i) that the amount of the monthly premium an eligible individual is required to pay for coverage under the standard health plan for the individual and the individual's dependents does not exceed the amount of the monthly premium that the eligible individual would have been required to pay if the individual had enrolled in the applicable second lowest cost silver plan (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) offered to the individual through an exchange; and

''(ii) that the cost-sharing an eligible individual is required to pay under the standard health plan does not exceed—

"(I) the cost-sharing required under a platinum plan in the case of an eligible individual with household income not in excess of 150 percent of the poverty line for the size of the family involved; and

"(II) the cost-sharing required under a gold plan in the case of an eligible individual; and

"(B) the benefits provided under the standard health plans offered through the program cover at least benefits required under an essential benefits package described in section 2242.

For purposes of subparagraph (A)(i), the amount of the monthly premium an individual is required to pay under either the standard health plan or the applicable second lowest cost silver plan shall be determined after reduction for any premium credits and premium subsidies allowable with respect to either plan.

"(b) STANDARD HEALTH PLAN.—In this section, the term 'standard heath plan' means a health benefits plan that the State contracts with under this section—

''(1) under which the only individuals eligible to enroll are eligible individuals;

''(2) that provides at least an essential benefits package described in section 2242; and

''(3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

''(c) CONTRACTING PROCESS.—

''(1) IN GENERAL.—A State basic health program shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to those required by an essential benefits package described in section 2242.

''(2) SPECIFIC ITEMS TO BE CONSIDERED.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

''(A) INNOVATION.—Negotiation with offerors of a standard health plan for the inclusion of innovative features in the plan, including—

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

"(ii) incentives for use of preventive services; and

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

"(B) HEALTH AND RESOURCE DIFFERENCES.—Consideration of, and the making of suitable allowances for, differences in health care needs of enrollees and differences in local availability of, and access to, health care providers. Nothing in this subparagraph shall be construed as allowing discrimination on the basis of pre-existing condition or other health status-related factors.

"(C) MANAGED CARE.—Contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market.

''(D) PERFORMANCE MEASURES.—Establishing specific performance measures and standards for offerors of standard health plans that focus on quality of care and improved health outcomes, requiring such plan to report to the State with respect to the measures and standards, and making the performance and quality information available to enrollees in a useful form.

''(3) ENHANCED AVAILABILITY.—

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

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

''(4) COORDINATION WITH OTHER STATE PROGRAMS.—A State shall, to the maximum extent feasible, seek to coordinate the administration of, and provision of benefits under, its program under this section with the State medicaid program under title

XIX, the State child health plan under title XXI, and other State-administered health programs to maximize the efficiency of such programs and to improve the continuity of care.

''(d) TRANSFER OF FUNDS TO STATES.—

''(1) IN GENERAL.—If the Secretary determines that a State electing the application of this section meets the requirements of the program established under subsection (a), the Secretary shall transfer to the State for each fiscal year for which 1 or more standard health plans are operating within the State the amount determined under paragraph (3).

''(2) USE OF FUNDS.—A State shall establish a trust for the deposit of the amounts received under paragraph (1) and amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State. Amounts in the trust fund, and expenditures of such amounts, shall not be included in determining the amount of any non-Federal funds for purposes of meeting any matching or expenditure requirement of any federally-funded program.

''(3) AMOUNT OF PAYMENT.—

''(A) SECRETARIAL DETERMINATION.—

"(i) IN GENERAL.—The amount determined under this paragraph for any fiscal year is the amount the Secretary determines is equal to 85 percent of the credits under section 36B of the Internal Revenue Code of 1986, and the cost-sharing subsidies under section 2247, that would have been provided for the fiscal year to eligible individuals enrolled in standard health plans in the State if such eligible individuals were allowed to enroll in qualified health benefits plans through an exchange established under part B.

"(ii) SPECIFIC REQUIREMENTS.—The Secretary shall make the determination under clause (i) on a per enrollee basis and shall take into account all relevant factors necessary to determine the value of the credits and subsidies that would have been provided to eligible individuals described in clause (i).

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

''(4) APPLICATION OF ABORTION COVERAGE REQUIREMENTS.—The rules of section 2245 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified basic health benefits plans.

''(e) ELIGIBLE INDIVIDUAL.—

''(1) IN GENERAL.—In this section, the term 'eligible individual' means, with respect to any State, an individual—

''(A) who a resident of the State who is not eligible to enroll in the State's medicaid program under title XIX for benefits that at a minimum consist of the essential benefits package described in section 2242;

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

''(C) who is not eligible for essential health benefits coverage (as defined in section 5000A(f)) or is eligible for an employer-sponsored plan that is not affordable coverage (as determined under section 5000A(e)(2)); and

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

Such term shall not include any individual who is not eligible under section 2232(c) to be covered by a qualified health benefits plan offered through an exchange.

''(2) ELIGIBLE INDIVIDUALS MAY NOT USE EXCHANGE.—An eligible individual shall not be treated as a qualified individual under section 2223 eligible for enrollment in a qualified health benefits plan offered through an exchange established under part B.

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

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

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

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

''(g) STANDARD HEALTH PLAN OFFERORS.—A State may provide that persons eligible to offer standard health plans under a basic health program established under this section may include a licensed health maintenance organization, a licensed health insurance insurer, or

a network of health care providers established to offer services under the program.

''(h) DEFINITIONS.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

"Subpart 5—Other Definitions and Rules

"SEC. 2230. OTHER DEFINITIONS AND RULES.

''(a) EMPLOYERS.—In this title:

''(1) LARGE EMPLOYER.—The term 'large employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

''(2) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. Unless an employer elects otherwise, if an employer is treated as a small employer for any plan year to

which this title applies, then such employer shall continue to be treated as a small employer for any subsequent plan year even if the number of employees exceeds the number in effect under this subparagraph.

''(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2015, a State may elect to apply this subsection by substituting '51 employees' for '101 employees' in paragraph (1) and by substituting '50 employees' for '100 employees' in paragraph (2).

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

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small or large employer shall be based on the average number of

employees that it is reasonably expected such employer will employ on business days in the current calendar year.

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

''(b) TERMS RELATING TO PLANS.—In this title:

''(1) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(2) PLAN YEAR.—The term 'plan year' means—

''(A) with respect to a group health plan, a plan year as specified under such plan; or

''(B) with respect to another health benefits plan, the calendar year, the 12-month period beginning on July 1 of each year, or such other 12-month period as may be specified by the Secretary.''.

Subtitle B—Exchanges and Consumer Assistance

SEC. 1101. ESTABLISHMENT OF QUALIFIED HEALTH BENEFITS PLAN EXCHANGES.

(a) IN GENERAL.—Title XXII of the Social Security Act, as added by section 1001, is amended by adding at the end the following:

"PART B—EXCHANGE AND CONSUMER ASSISTANCE

"Subpart 1—Individuals and Small Employers Offered Affordable Choices

"SEC. 2231. RIGHTS AND RESPONSIBILITIES REGARDING CHOICE OF COVERAGE THROUGH EXCHANGE.

''(a) RIGHT TO ENROLL THROUGH AN EXCHANGE.—

''(1) QUALIFIED INDIVIDUALS.—Each qualified individual shall have the choice to enroll or to not enroll in a qualified health benefits plan offered through an exchange that is established under this title, that covers the State in which the individual resides, and that covers qualified health benefits plans in the individual market.

''(2) QUALIFIED SMALL EMPLOYERS.—

''(A) IN GENERAL.—In the case of a qualified small employer—

''(i) such employer may elect to offer to its employees qualified health benefits plans offered through an exchange that is established under this title, that covers the State in which the employees resides, and that covers qualified health benefits plans in the small group market; and

''(ii) each employee of such employer shall have the choice to enroll or to not enroll in a qualified health benefits plan offered through such exchange.

If a qualified small employer elects to limit the qualified health benefits plans or levels of coverage under part C that employees may enroll in through such exchange, employees may only choose to enroll in those plans or plans in those levels.

''(B) SELF-INSURED PLANS.—If a qualified small employer offers its employees coverage under a self-insured health benefits plan, the employer may not offer its employees qualified health benefits plans through an exchange.

''(3) MEMBERS OF CONGRESS AND CONGRESSIONAL STAFF REQUIRED TO PARTICIPATE IN EXCHANGE.—

"(A) IN GENERAL.—Notwithstanding chapter 89 of title 5, United States Code, or any provision of this title—

"(i) each Member of Congress and Congressional employee shall be treated as a qualified individual entitled to the right under this paragraph to enroll in a qualified health benefits plan in the individual market offered through an exchange in the State in which the Member or employee resides; and

"(ii) any employer contribution under such chapter on behalf of the Member or employee may be paid only to the offeror of a qualified health benefits plan in which the Member or employee enrolled in through such exchange and not to the offeror of a plan offered through the Federal employees health benefit program under such chapter.

"(B) PAYMENTS BY FEDERAL GOVERNMENT.—The Secretary, in consultation with the Director of the Office of Personnel Management, shall establish procedures under which—

''(i) the employer contributions on behalf of a Member or Congressional employee are actuarially adjusted for age; and

''(ii) the employer contributions may be made directly to an exchange for payment to an offeror.

''(C) CONGRESSIONAL EMPLOYEE.—In this paragraph, the term 'Congressional employee' means an employee whose pay is disbursed by the Secretary of the Senate or the Clerk of the House of Representatives.

''(b) RESPONSIBILITY OF OFFERORS OF QUALIFIED HEALTH BENEFITS PLANS.—

''(1) ALL PLANS MUST BE OFFERED THROUGH AN EXCHANGE.—An offeror of a qualified health benefits plan in a State—

''(A) shall offer the plan through the exchange established by the State for the market in which the plan is being offered; and

''(B) may offer such plan outside of an exchange.

''(2) OFFERORS MUST OFFER PLANS IN SILVER AND GOLD PLANS.—An offeror of a qualified health benefits plan in the individual or small group market within a State—

''(A) shall offer within that market at least one qualified health benefits plan in the silver coverage level and at least one such plan in the gold coverage level; and

''(B) may offer 1 or more qualified health benefits plan in the bronze and platinum coverage levels, a catastrophic plan described in section 2243(c), or a child-only plan described in section 2243(d).

''(c) RESPONSIBILITY OF EXCHANGES.—

''(1) IN GENERAL.—Each exchange offering plans in the individual or small group market within a State shall offer all qualified health benefits plans in the State that are licensed by the State to be offered in that market.

''(2) OFFERING OF STAND-ALONE DENTAL BENEFITS.—

''(A) IN GENERAL.—Each exchange within a State shall allow an offeror of a health benefits plan that only provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the exchange (either separately or in conjunction with a qualified health benefits plan) if the plan pro-

vides pediatric dental benefits meeting the requirements of 2242(b)(11) for individuals who have not attained the age of 21.

"(B) ELIGIBILITY FOR CREDIT AND SUBSIDY.—If an individual enrolls in both a qualified health benefits plan and a plan described in subparagraph (A) for any plan year, the portion of the premium for the plan described in subparagraph (A) that (under regulations prescribed by the Secretary) is properly allocable to individuals covered by the plan who have not attained the age of 21 before the beginning of the plan year shall be treated as a premium payable for a qualified health benefits plan for purposes of determining the amount of the premium credit under section 36B of such Code and cost-sharing subsidies under section 2237 with respect to the plan year.

"(d) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State is required to allow agents or brokers—

"(1) to enroll individuals in any qualified health benefits plans in the individual or small group market as soon as the plan is offered through an exchange in the State; and

''(2) to assist individuals in applying for premium credits and cost-sharing subsidies for plans sold through an exchange.

"SEC. 2232. QUALIFIED INDIVIDUALS AND SMALL EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.

''(a) QUALIFIED INDIVIDUALS.—In this title:

''(1) IN GENERAL.—The term 'qualified individual' means, with respect to an exchange, an individual who—

''(A) is seeking to enroll in a qualified health benefits plan in the individual market offered through the exchange; and

''(B) resides in the State that established the exchange.

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

''(b) QUALIFIED SMALL EMPLOYER.—In this title, the term 'qualified small employer' means an employer that is a small employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health benefits plans offered through an exchange estab-

lished under this subtitle that offers qualified health benefits plans in the small group market.

''(c) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be for the entire plan year for which enrollment is sought, a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien lawfully present in the United States—

''(1) the individual shall not be treated as a qualified individual and may not be covered under a qualified health benefits plan in the individual market that is offered through an exchange; and

''(2) if the individual is an employee of a qualified small employer offering employees the opportunity to enroll in a qualified health benefits plan in the small group market through an exchange (or an individual bearing a relationship to such an employee that entitles such individual to coverage under such plan), the individual may not be covered under such plan.

''Subpart 2—Establishment of Exchanges

''SEC. 2235. ESTABLISHMENT OF EXCHANGES BY STATES.

''(a) IN GENERAL.—Each State shall, not later than July 1, 2013, establish —

''(1) an exchange for the State that is designed to facilitate the enrollment of qualified individuals in qualified health benefits plans offered in the individual market in the State; and

''(2) a Small Business Health Options Program (in this title referred to as a 'SHOP exchange') that is designed to assist qualified small employers in facilitating the enrollment of their employees in qualified health benefits plans offered in either the individual or the small group market in the State.

''(b) STATE FLEXIBILITY.—

''(1) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one exchange in the State for providing both exchange and SHOP exchange services to both qualified individuals and qualified small employers, but only if the exchange has separate resources to assist individuals and employers.

''(2) REGIONAL EXCHANGES.—An exchange or SHOP exchange may operate in more than 1 State if—

''(A) each of the States agrees to the operation of the exchange in that State; and

''(B) the Secretary approves of the operation of the exchange in all such States.

''(3) AUTHORITY TO CONTRACT FOR EXCHANGE SERVICES.—

''(A) CONTRACT WITH SUB-EXCHANGE.—Subject to such conditions and restrictions as the Secretary, in consultation with the Secretary of the Treasury, may prescribe under sections 2238 and 2248—

''(i) IN GENERAL.—A State may elect to authorize an exchange established by the State under this title to contract with an eligible entity to carry out 1 or more responsibilities of the exchange, including marketing and sale of qualified health benefits plans offered by the exchange, enrollment activities, broker relations, customer service, customer education, premium billing and collection, member advocacy with qualified health benefits plans, maintaining call center support, and performing the duties of the exchange under section 2238 in determining eligibility to participate in the exchange and to receive any credit or subsidy. An eligible entity may charge an additional fee to be used to pay the adminis-

trative and operational expenses of the entity.

''(ii) ELIGIBLE ENTITY.—In this subparagraph, the term 'eligible entity' means a person—

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

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

''(III) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 as a member of the same controlled group of corporations (or under common control with) a health insurance issuer.

''(B) DELEGATION TO STATE MEDICAID AGENCY.—A State may elect to authorize an exchange established by the State under this title to enter into an agreement with the State medicaid agency under title XIX to carry out the responsibilities of the exchange under this

section in establishing the eligibility of individuals to participate in the exchange and to receive the premium credit under section 36B of the Internal Revenue Code of 1986 and the cost-sharing subsidy under section 2247. An exchange may enter into an agreement under this subparagraph only if the agreement meets requirements promulgated by the Secretary (after consultation with the Secretary of the Treasury) ensuring that the agreement lowers overall administrative costs and reduces the likelihood of eligibility errors and disruptions in coverage.

''(c) ESTABLISHMENT OF BROKER RATE SCHEDULES.—Each State shall provide for the establishment of rate schedules for broker commissions paid by health benefits plans offered through an exchange.

''(d) OFFERING OF PLANS IN LARGE GROUP MARKET.—Beginning in 2017, each State may allow offerors of health benefits plans in the large group market in the State to offer the plans through an exchange. Nothing in this subsection shall be construed as requiring an offeror to offer such plans through an exchange.

''(e) INTERIM EXCHANGES BEFORE QUALIFIED PLANS.—

''(1) IN GENERAL.—Each State shall, as soon as practicable after the date of enactment of this Act, establish an exchange through which enrollment in eligible health insurance coverage is offered for coverage during the period beginning January 1, 2010, and ending June 30, 2013. Each State may use the database established under paragraph (2)(C)(ii) in the operation of the exchange.

''(2) ELIGIBLE HEALTH INSURANCE COVERAGE.—In this subsection:

''(A) IN GENERAL.—The term 'eligible health insurance coverage' means, with respect to any State, any health insurance coverage meeting the requirements of section 2244 which is offered—

''(i) by an issuer who is licensed to offer such coverage in that State; and

''(ii) in the individual or small group markets within the State.

''(B) EXCEPTION FOR MINI-MEDICAL PLANS.—Such term shall not include any health insurance coverage which, as determined under regulations prescribed by the Secretary, offers limited benefits or has a low annual limitation on the amount of benefits provided.

''(C) ADMINISTRATION.—

''(i) IN GENERAL.—The Secretary shall provide technical assistance to each State in establishing exchanges under this subsection.

''(ii) DATABASE OF PLAN OFFERINGS.—The Secretary, either directly or by grant or contract with a private entity, shall establish and maintain a database of health insurance coverage in the individual and small group markets. The Secretary shall ensure that individuals and small employers are able to access the information in the database that is specific to the State in which the individuals and employees reside.

''SEC. 2236. FUNCTIONS PERFORMED BY SECRETARY, STATES, AND EXCHANGES.

''(a) AGREEMENTS TO PERFORM FUNCTIONS.—The Secretary shall enter into an agreement with each State (in this section referred to as the 'agreement') setting forth which of the functions described in this section with respect to an exchange shall be performed by the Secretary, the State, or the exchange.

''(b) CERTIFICATION OF PLANS.—The agreement shall provide for the State to establish procedures for the certification, recertification, and decertification of a health benefits plan as a qualified health benefits plan that meets the requirements of this title for offering the plan through exchanges within the State.

''(c) OUTREACH AND ELIGIBILITY.—The agreement shall provide for the conduct of the following activities:

''(1) OUTREACH.—

''(A) IN GENERAL.—The establishment and carrying out of a plan to conduct outreach activities to inform and educate individuals and employers about the exchange, the annual open enrollment periods described in subsection (d)(2), and options for qualified health benefits plans offered through the exchange.

''(B) CALL CENTERS.—The establishment and maintenance of call centers to provide information to, and answer questions from, individuals seeking to enroll in qualified health benefit plans through an exchange, including providing multilingual assistance and mailing of relevant information to individuals based on their inquiry and zip code.

"(C) INTERNET PORTALS.—The development of a model template for an Internet portal to be used to direct qualified individuals and qualified small employers to qualified health benefits plans, to assist individuals and employers in determining whether they are eligible to participate in an exchange or eligible for a premium credit or cost-sharing subsidy, and to present standardized information regarding qualified health benefits plans offered through an exchange to enable easier consumer choice. Such template shall include with respect to each qualified health benefits plan offered through the exchange in each rating area access to the uniform outline of coverage the plan is required to provide under section 2205 and to a copy of the plan's policy.

"(D) RATING SYSTEM.—The establishment of a rating system that would rate qualified health benefits plans offered through an exchange on the basis of the relative quality and price of plans in the same benefit level. The exchange shall include the quality rating in the information provided to individuals and employ-

ers through the Internet portal established under subparagraph (C).

''(2) ELIGIBILITY.—Subject to section 2238, the making of timely determinations as to whether—

''(A) individuals or employers are qualified individuals or qualified small employers eligible to participate in the exchange; and

''(B) an individual is disqualified from participation in the exchange or from receiving any premium credit or cost-sharing subsidy because the individual is not, or is not reasonably expected to be for the entire plan year for which enrollment is sought, a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien lawfully present in the United States.

''(d) ENROLLMENT.—The agreement shall provide for the establishment and carrying out of an enrollment process which—

''(1) provides for enrollment in person, by mail, by telephone, or electronically, including—

''(A) through enrollment in local hospitals and schools, State motor vehicle offices, local Social Security offices, locations operated by Indian tribes and tribal organizations, and any

other accessible locations specified by the exchange; and

''(B) through use of the call center and Web portal established under subsection (c)(1);

''(2) provides for—

''(A) an initial open enrollment period from March 1, 2013, through May 31, 2013;

''(B) annual open enrollment periods from March 1 through May 31 of subsequent calendar years;

''(C) special enrollment periods specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under part D of title XVIII; and

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

''(3) subject to section 2239—

''(A) establishes a uniform enrollment form that qualified individuals and qualified small businesses may use (either electronically or on paper) in enrolling in qualified health benefits plans offered through an exchange, and that takes into account criteria that the National

Association of Insurance Commissioners develops and submits to the Secretary; and

''(B) informs individuals of eligibility requirements for the medicaid program under title XIX, the CHIP program under title XXI, or any applicable State or local public program and refers individuals to such programs if a determination is made that the individuals are so eligible;

''(4) establishes standardized marketing requirements that are based on the standards used for Medicare Advantage plans and ensures that marketing practices with respect to qualified health benefits plans offered through the exchange meet the requirements; and

''(5) provides for a standardized format for presenting health benefits plan options in the exchange, including use of the uniform outline of coverage established under section 1503 of the America's Healthy Future Act of 2009.

''(e) ELIGIBILITY FOR CREDIT AND SUBSIDY.—The agreement shall provide for the establishment and use of a calculator to determine the actual cost of coverage after application of any premium credit or cost-sharing subsidy and the carrying out of responsibilities under section 2248

with respect to the advance determination and payment of such credits or subsidies.

''(f) CERTIFICATION OF EXEMPTION FROM INDIVIDUAL RESPONSIBILITY EXCISE TAX .—Subject to section 2238, the agreement shall establish procedures for—

''(1) granting a certification attesting that, for purposes of the individual responsibility excise tax under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the tax imposed by such section because—

''(A) there is no affordable qualified health benefits plan available through the exchange, or the individual's employer, covering the individual; or

''(B) the individual meets the requirements for any other such exemption from the individual responsibility requirement or tax; and

''(2) transferring to the Secretary of the Treasury or the Secretary's delegate a list of the individuals who are so exempt.

The Secretary shall establish the period for which any certification under this subsection is in effect.

"SEC. 2237. DUTIES OF THE SECRETARY TO FACILITATE EXCHANGES.

''(a) CREDIT AND SUBSIDY DETERMINATIONS.—The Secretary and the Secretary of the Treasury shall carry out the responsibilities under section 2248 (relating to advance determination and payment of premium credit and cost-sharing subsidies) that are delegated specifically to the Secretary and the Secretary of the Treasury.

''(b) SHOP EXCHANGE ASSISTANCE.—The Secretary shall designate an office within the Department of Health and Human Services to provide technical assistance to States to facilitate the participation of qualified small businesses in SHOP exchanges.

''(c) FUNDING OF START-UP COSTS.—

''(1) IN GENERAL.—The Secretary shall pay to each State the amount the Secretary reasonably estimates to be the unreimbursed start-up costs for any exchange or SHOP exchange established within a State. The Secretary shall make separate payments for the start-up costs of the interim and permanent exchanges.

''(2) OPERATIONAL COSTS.—No payments shall be made under this subsection for any operational costs of an exchange after the initial start-up is completed but an exchange may assess each quali-

fied health benefits plan offered through the exchange its proportional share of such costs.

"SEC. 2238. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM CREDITS AND COST-SHARING SUBSIDIES, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

''(a) IN GENERAL.—The Secretary shall establish a program meeting the requirements of this section for determining—

''(1) whether an individual who is to be covered by a qualified health benefits plan offered through an exchange, or who is claiming a premium credit or cost-sharing subsidy, meets the requirements of sections 2236(c)(2)(B) and 2247(e) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien lawfully present in the United States;

''(2) in the case of an individual claiming a premium credit or cost-sharing subsidy under section 36B of such Code or section 2247—

''(A) whether the individual meets the income and coverage requirements of such sections; and

''(B) the amount of the credit or subsidy;

''(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C), 4980H(c)(2), and 5000A(e)(2); and

''(4) whether to grant a certification under section 2237(f) attesting that, for purposes of the individual responsibility excise tax under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the tax imposed by such section.

''(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

''(1) IN GENERAL.—An applicant for enrollment in a qualified health benefits plan offered through an exchange shall provide—

''(A) the name, address, and date of birth of each individual who is to be covered by the plan (in this subsection referred to as an 'enrollee'); and

"(B) the information required by any of the following paragraphs that is applicable to an enrollee.

"(2) CITIZENSHIP OR IMMIGRATION STATUS.—The following information shall be provided with respect to every enrollee:

"(A) In the case of an enrollee whose eligibility is based on an attestation of citizenship of the enrollee, the enrollee's social security number.

"(B) In the case of an individual whose eligibility is based on an attestation of the enrollee's immigration status, the enrollee's social security number (if applicable) and such identifying information with respect to the enrollee's immigration status as the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

"(3) ELIGIBILITY AND AMOUNT OF CREDIT OR SUBSIDY.—In the case of an enrollee with respect to whom a premium credit or cost-sharing subsidy under section 36B of such Code or section 2247 is being claimed, the following information:

"(A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described

in section 6103(l)(21) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.

''(B) CHANGES IN CIRCUMSTANCES.—The information described in section 2248(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant reductions in income.

''(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium credit under section 36B of such Code or cost-sharing subsidy under section 2247, is being established on the basis that the enrollee's (or related individual's) employer is not treated under section 36B(c)(2)(C) of such Code as providing essential benefits coverage or affordable essential benefits coverage, the following information:

''(A) The name, address, and employer identification number (if available) of the employer.

"(B) Whether the enrollee or individual is a full-time employee and whether the employer provides such essential benefits coverage.

"(C) If the employer provides such essential benefits coverage, the lowest cost option for the enrollee's or individual's enrollment status and the enrollee's or individual's required contribution (as defined in section 5000A(e)(2) of such Code) under the employer-sponsored plan.

"(D) If an enrollee claims an employer's essential benefits coverage is unaffordable, the information described in paragraph (3).

"(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY REQUIREMENTS.—In the case of an individual who is seeking an exemption certificate under section 2237(f) from any requirement or tax imposed by section 5000A, the following information:

"(A) In the case of an individual seeking exemption based on the individual's status as a member of an exempt religious sect or division, as a member of a health care sharing ministry, as an Indian, or as an individual eligible for a hardship exemption, such information as the Secretary shall prescribe.

"(B) In the case of an individual seeking exemption based on the lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line, the information described in paragraphs (3) and (4), as applicable.

"(c) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—

"(1) INFORMATION TRANSFERRED TO SECRETARY.—An exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).

"(2) CITIZENSHIP OR IMMIGRATION STATUS.—

"(A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:

"(i) The name, date of birth, and social security number of each individual for whom such information was provided under subsection (b)(2).

"(ii) The attestation of an individual that the individual is a citizen.

"(B) SECRETARY OF HOMELAND SECURITY.—

"(i) IN GENERAL.—In the case of an individual—

"(I) who attests that the individual is an alien lawfully admitted to the United States for permanent residence or an alien lawfully present in the United States; or

"(II) who attests that the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;

the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.

''(ii) INFORMATION.—The information described in clause (ii) is the following:

''(I) The name, date of birth, and any identifying information with respect to the individual's immigration status provided under subsection (b)(2).

''(II) The attestation that the individual is an alien lawfully admitted to the United States for permanent residence or an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.

''(3) ELIGIBILITY FOR CREDIT AND SUBSIDY.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of the Treasury for verification of household income and family size for purposes of eligibility.

''(4) METHOD.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social

Security, shall provide that verifications and determinations under this subsection shall be done—

''(A) through use of an on-line system or otherwise for the electronic submission of, and response to, the information submitted under this subsection with respect to an applicant; or

''(B) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.

''(d) VERIFICATION BY SECRETARY.—In the case of information provided under subsection (b) that is not subject to verification under subsection (c), the Secretary shall verify the accuracy of such information in such manner as the Secretary determines appropriate, including delegating responsibility for verification to the exchange.

''(e) ACTIONS RELATING TO VERIFICATION.—

''(1) IN GENERAL.—Each person to whom the Secretary provided information under subsection (c) shall report to the Secretary under the method established under subsection (c)(4) the results of its verification and the Secretary shall notify the ex-

change of such results. Each person to whom the Secretary provided information under subsection (d) shall report to the Secretary in such manner as the Secretary determines appropriate.

''(2) VERIFICATION.—

''(A) ELIGIBILITY FOR ENROLLMENT AND SUBSIDIES.—If information provided by an applicant under paragraphs (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d)—

''(i) the individual's eligibility to enroll through the exchange and to apply for premium credits and cost-sharing subsidies shall be satisfied; and

''(ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 2248(c) of the amount of any advance payment to be made.

''(B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsection (b)(5) is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 2236(f).

"(3) INCONSISTENCIES.—If the information provided by an applicant is inconsistent with information in the records maintained by persons under subsection (c) or is not verified under subsection (d), the Secretary shall notify the exchange and the exchange shall take the following actions:

"(A) REASONABLE EFFORT.—The exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the applicant to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may identify.

"(B) NOTICE AND OPPORTUNITY TO CORRECT.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the exchange shall—

"(i) notify the applicant of such fact;

"(ii) provide the applicant with a reasonable period from the date on which the notice required under clause (i) is received by the applicant to either present satisfactory documentary evidence or resolve the

inconsistency with the person verifying the information under subsection (c).

''(4) SPECIFIC ACTIONS.—

''(A) CITIZENSHIP OR IMMIGRATION STATUS.—If an inconsistency involving citizenship or immigration status with respect to any enrollee is unresolved under this subsection, the exchange shall notify the applicant that the enrollee is not eligible to participate in the exchange.

''(B) ELIGIBILITY OR AMOUNT OF CREDIT OR SUBSIDY.—If an inconsistency involving the eligibility for, or amount of, any credit or subsidy is unresolved under this subsection, the exchange shall notify the applicant of the amount (if any) of the credit or subsidy.

''(C) EMPLOYER AFFORDABILITY.—If the Secretary notifies an exchange that an enrollee is eligible for a premium credit under section 36B of such Code or cost-sharing subsidy under section 2247 because the enrollee's (or related individual's) employer does not provide essential benefits coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage,

the exchange shall notify the employer of such fact and that the employer may be liable for the tax imposed by section 4980H with respect to an employee.

''(D) EXEMPTION.—In any case where the inconsistency involving, or inability to verify, information provided under subsection (b)(5) is not resolved, the exchange shall notify an applicant that no certification of exemption from any requirement or tax under section 5000A will be issued.

''(E) APPEALS PROCESS.—The exchange shall also notify each person receiving notice under this paragraph of the appeals processes established under subsection (f).

''(f) APPEALS AND REDETERMINATIONS.—

''(1) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers—

''(A) hears and makes decisions with respect to appeals of any determination under subsection (c); and

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

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

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

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

Such process shall be in addition to any rights of appeal the employer may have under subtitle F of the Internal Revenue Code of 1986.

"(g) CONFIDENTIALITY OF APPLICANT INFORMATION.—Any person who receives information provided by an applicant under subsection (b), or receives information from a Federal agency under subsection (c), (d), or (e) shall—

"(1) use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the exchange, including verifying the eligibility of an individual to enroll through an exchange or to claim a premium credit or cost-sharing subsidy or the amount of the credit or subsidy; and

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

"(h) PENALTIES.—

"(1) FALSE OR FRAUDULENT INFORMATION.—

"(A) CIVIL PENALTY.—If—

"(i) any person fails to provides correct information under subsection (b); and

"(ii) such failure is attributable to negligence or disregard of any rules or regulations of the Secretary,

such person shall be subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000 with

respect to any failures involving an application for a plan year. For purposes of this subparagraph, the terms 'negligence' and 'disregard' shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

''(B) CRIMINAL PENALTY.—Any person who knowingly and willfully provides false or fraudulent information under subsection (b) shall be guilty of a felony, and upon conviction thereof, shall be fined not more than $250,000, imprisoned for not more than 5 years, or both.

''(2) IMPROPER USE OR DISCLOSURE OF INFORMATION.—Any person who knowingly and willfully uses or discloses information in violation of subsection (g) shall be guilty of a felony, and upon conviction thereof, shall be fined not more than $25,000, imprisoned for not more than 5 years, or both.

''SEC. 2239. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

''(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under

which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs.

''(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

''(1) REQUIREMENTS RELATING TO FORMS.—

''(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

''(i) may be used to apply for all applicable State health subsidy programs within the State;

''(ii) may be filed online, in person, by mail, or by telephone;

''(iii) may be filed with an exchange or with State officials operating one of the other applicable State health subsidy programs; and

''(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

''(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

''(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

''(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

''(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

''(1) DEVELOPMENT OF SECURE INTERFACES.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b)) that allows a determination of eligibility for all such programs based on a single application. Such interface shall be compatible with the exchange method established for data verification under section 2238(c)(4).

''(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

''(A) provides access to data described in paragraph (3);

''(B) applies only to individuals who—

''(i) receive assistance from an applicable State health subsidy program; or

''(ii) apply for such assistance—

''(I) by filing a form described in subsection (b); or

"(II) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

"(C) consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1946 or that are otherwise applicable to such programs.

"(3) DETERMINATION OF ELIGIBILITY.—

"(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

"(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

"(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(i), and 1942(a), obtained through such arrangement.

''(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

''(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

''(d) ADMINISTRATIVE AUTHORITY.—

''(1) AGREEMENTS.—Subject to section 2238 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model agreements, and enter

into agreements, for the sharing of data under this section.

''(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

''(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

''(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

''(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term 'applicable State health subsidy program' means—

''(1) the program under this title for the enrollment in qualified health benefits plans offered through an exchange, including the premium credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing subsidies under section 2237;

''(2) a State medicaid program under title XIX;

''(3) a State children's health insurance program (CHIP) under title XXI; and

''(4) a State program under section 2228 establishing qualified basic health plans.''.

(b) STUDY OF ADMINISTRATION OF EMPLOYER RESPONSIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, in consultation with the Secretary of the Treasury, conduct a study of the procedures that are necessary to ensure that in the administration of part B of subtitle A of title XXII of the Social Security Act (as added by this section) and section 4980H of the Internal Revenue Code of 1986 (as added by section 1306) that the following rights are protected:

(A) The rights of employees to preserve their right to confidentiality of their taxpayer return information and their right to enroll in a qualified basic health benefits plan through an exchange if an employer does not provide affordable coverage.

(B) The rights of employers to adequate due process and access to information necessary to accurately determine any tax imposed on employers.

(2) REPORT.—Not later than July 1, 2012, the Secretary of Health and Human Services shall report the results of the study conducted under paragraph (1), including any recommendations for legislative changes, to the Committees on Finance and Health, Education, Labor and Pensions of the Senate and the Committees of Education and Labor and Ways and Means of the House of Representatives.

SEC. 1102. ENCOURAGING MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of methods that can be employed by qualified health benefits plans offered through an exchange to encourage increased meaningful use of electronic health records by health care providers, including—

(1) payment systems established by qualified health benefit plans that provide higher rates of reimbursement for health care providers that engage in meaningful use of electronic health records; and

(2) promotion of low-cost electronic health record software packages that are available for use by health care providers, including software packages that are available to health care providers through the Veterans Administration.

(b) REPORT.—

(1) IN GENERAL.—Not later than 24 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate, including recommendations regarding the feasibility and effectiveness of payment systems established by qualified health benefit plans offered through an exchange to provide for higher rates of reimbursement for health care providers that engage in meaningful use of electronic health records.

(2) DISSEMINATION TO EXCHANGES.—Not later than 12 month after submitting the report under paragraph (1), the Secretary shall provide such report to any regional exchange or exchange established within a State.

Subtitle C—Making Coverage Affordable

PART I—ESSENTIAL BENEFITS COVERAGE

SEC. 1201. PROVISIONS TO ENSURE COVERAGE OF ESSENTIAL BENEFITS.

Title XXII of the Social Security Act (as added by section 1001 and amended by section 1101) is amended by adding at the end the following:

"PART C—MAKING COVERAGE AFFORDABLE

"Subpart 1—Essential Benefits Coverage

"SEC. 2241. REQUIREMENTS FOR QUALIFIED HEALTH BENEFITS PLAN.

''A health benefits plan shall be treated as a qualified health benefits plan for purposes of this title only if—

''(1) the plan provides an essential benefits package described in section 2242;

''(2) subject to section 2243(c), the plan provides either the bronze, silver, gold, or platinum level of coverage described in section 2243; and

''(3) the offeror of the plan charges the same premium rate for the plan without regard to whether the plan is purchased through an exchange or whether the plan is purchased directly from the offeror or through an agent.

"SEC. 2242. ESSENTIAL BENEFITS PACKAGE DEFINED.

''(a) IN GENERAL.—In this division, the term 'essential benefits package' means, with respect to any health benefits plan, coverage that—

''(1) provides payment for the items and services described in subsection (b) in accordance with generally accepted standards of medical or other appropriate clinical or professional practice;

''(2) limits cost-sharing for such covered health care items and services in accordance with subsection (c);

''(3) meets the requirements with respect to specific items and services described in subsection (d); and

''(4) does not impose any annual or lifetime limit on the coverage of such covered health care items and services.

''(b) MINIMUM SERVICES TO BE COVERED.—Subject to subsection (e), the items and services described in this subsection are the following:

''(1) Hospitalization.

''(2) Outpatient hospital and outpatient clinic services, including emergency department services.

''(3) Professional services of physicians and other health professionals.

''(4) Medical and surgical care.

''(5) Such services, equipment, and supplies incident to the services of a physician's or a health professional's delivery of care in institutional settings, physician offices, patients' homes or place of residence, or other settings, as appropriate.

''(6) Prescription drugs.

''(7) Rehabilitative and habilitative services.

''(8) Mental health and substance use disorder services, including behavioral health treatment.

''(9) Preventive services, including those services recommended with a grade of A or B by the United States Preventive Services Task Force and those vaccines recommended for use by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention).

''(10) Maternity benefits.

''(11) Well baby and well child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

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

''(1) NO COST-SHARING FOR PREVENTIVE SERVICES.—There shall be no cost-sharing under an es-

sential benefits package for preventive items and services described in subsection (b)(9).

''(2) ANNUAL LIMITATION ON COST-SHARING.—

''(A) 2013.—The cost-sharing incurred under an essential benefits package with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2013 shall not exceed the dollar amounts in effect under section 223(c)(2)(A) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2013.

''(B) 2014 AND LATER.—In the case of any plan year beginning in a calendar year after 2013, the limitation under this paragraph shall—

''(i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (7) for the calendar year; and

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

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

''(3) ANNUAL LIMITATION ON DEDUCTIBLES FOR EMPLOYER-SPONSORED PLANS.—

''(A) IN GENERAL.—In the case of a health benefits plan offered in the small group market, the deductible under an essential benefits package shall not exceed—

''(i) $2,000 in the case of a plan covering a single individual; and

''(ii) $4,000 in the case of any other plan.

The amounts under clauses (i) and (ii) may be increased by the maximum amount of reimbursement which is reasonably available to a participant under a flexible spending arrangement described in section 106(c)(2) of the Internal Revenue Code of 1986 (determined without regard to any salary reduction arrangement).

''(B) INDEXING OF LIMITS.—In the case of any plan year beginning in a calendar year after 2013—

"(i) the dollar amount under subparagraph (A)(i) shall be increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (7) for the calendar year; and

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

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

"(C) LIMITATIONS.—

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

"(ii) CATASTROPHIC PLAN.—This paragraph shall not apply to a catastrophic plan described in section 2243(c).

"(4) PARITY WITHIN CATEGORIES.—In the case of items and services described in paragraphs (1), (2), (3), and (5) of subsection (b), the cost-sharing incurred under an essential benefits package shall be the same for treatment of conditions within each such category of covered services.

"(5) SPECIAL RULE FOR VALUE-BASED DESIGN.—

"(A) IN GENERAL.—Paragraphs (1) and (4) shall not apply in the case of a health benefits plan for which a value-based design is used.

"(B) VALUE-BASED DESIGN.—For purposes of subparagraph (A), a value-based design is a methodology under which—

"(i) clinically beneficial preventive screenings, lifestyle interventions, medications, immunizations, diagnostic tests and procedures, and treatments are identified; and

"(ii) cost-sharing for items and services described in clause (i) is reduced or eliminated to reflect the high value and effectiveness of the items and services.

"(6) COST-SHARING.—In this title, the term 'cost-sharing' includes deductibles, coinsurance, co-

payments, and similar charges but does not include premiums or any network payment differential for covered services or spending for non-covered services.

''(7) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (2)(B)(i) and (3)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2012 (as determined by the Secretary).

''(d) SPECIFIC ITEMS AND SERVICES.—

''(1) PRESCRIPTION DRUGS.—An essential benefits package shall at least meet the class and coverage requirements of part D of title XVIII of this Act with respect to prescription drugs.

''(2) MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES.—An essential benefits package shall at least meet the minimum standards required by Federal or State law for coverage of mental health and substance use disorder services, including ensuring that any financial requirements and treat-

ment limitations applicable to such services comply with the requirements of section 9812(a) of the Internal Revenue Code of 1986 in the same manner as such requirements apply to a group health plan.

''(3) TOBACCO CESSATION PROGRAMS.—If a health benefits plan varies its premium on the basis of tobacco use, an essential benefits package shall include coverage for tobacco cessation programs, including counseling and pharmacotherapy (involving either prescription or nonprescription drugs).

''(4) OTHER ITEMS AND SERVICES.—An essential benefits package shall include coverage of day surgery and related anaesthesia, diagnostic images and screening (including x-rays), and radiation and chemotherapy.

''(5) PEDIATRIC DENTAL BENEFITS.—If a health benefits plan described in section 2231(c)(2) (relating to stand-alone dental benefits plans) is offered through an exchange, another health benefits plan offered through such exchange shall not fail to be treated as a qualified health benefits plan solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under subsection (b)(11).

''(6) SPECIAL RULES FOR EMERGENCY DEPARTMENT SERVICES.—A health benefits plan shall not be treated as meeting the requirements of subsection (b)(2) to provide coverage for emergency department services unless the plan provides that—

''(A) coverage for such services will be provided without regard to any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services; and

''(B) if such services are provided out-of-network, any cost-sharing required by the plan does not exceed the cost-sharing that would be required if such services were provided in-network.

''(e) SPECIFICATION AND ANNUAL UPDATE.—

''(1) IN GENERAL.—Not later than July 1, 2012, the Secretary shall—

''(A) define the benefit categories established under subsection (b) for qualified health benefits plans offered in the individual market within a State; and

"(B) specify the covered treatments, items, and services within each of such categories.

The Secretary shall establish such benefits coverage on the basis of the most recent medical evidence and information with respect to scientific advancement.

"(2) ANNUAL UPDATES.—The Secretary shall annually update the benefits coverage determined under paragraph (1). The Secretary may address any gaps in access to coverage or changes in the evidence base by modifying or adding any category of benefits and covered treatments, items, and services.

"(3) LIMITATION.—The Secretary shall ensure that the scope of the benefits coverage under this subsection is not more extensive than the scope of the benefits provided under a typical employer plan, as determined by the Secretary and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services.

"(4) FLEXIBILITY IN PLAN DESIGN.—The Secretary shall allow flexibility in plan design to the extent such flexibility does not result in adverse selection.

"(f) EXCHANGE REQUIREMENT.—Each State shall ensure that at least 1 plan offered in each exchange established in the State shall offer qualified health benefits

plans that are at least actuarially equivalent to the standard option Blue Cross Blue Shield plan offered under the Federal Employees Health Benefits Program chapter 89 of title 5, United States Code.

''(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—If any item or service covered by a qualified health benefits plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) for such item or service.

''SEC. 2243. LEVELS OF COVERAGE.

''(a) IN GENERAL.—Except as provided in subsections (c) and (d), a health benefits plan shall provide a bronze, silver, gold, or platinum level of coverage.

''(b) LEVELS OF COVERAGE DEFINED.—In this title, a health benefits plan providing an essential benefits package shall be assigned to 1 of the following levels of coverage:

''(1) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 65 percent of the full actuarial value of the

benefits provided under the essential benefits package.

''(2) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the essential benefits package.

''(3) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the essential benefits package.

''(4) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the essential benefits package.

''(c) CATASTROPHIC PLAN FOR YOUNG INDIVIDUALS.—

''(1) IN GENERAL.—A health benefits plan not providing a bronze, silver, gold, or platinum level of coverage shall be treated as meeting the requirements of this section with respect to any plan year if—

''(A) except as provided in paragraph (3), the only individuals who are eligible to enroll in the plan are individuals who have not attained the age of 26 before the beginning of the plan year; and

''(B) the plan provides an essential benefits package meeting the requirements of section 2242, except that, subject to paragraph (2), the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect under section 2242(c)(2) for the plan year.

''(2) PREVENTIVE SERVICES.—A health benefits plan shall not be treated as described in paragraph (1) unless the plan requires no cost-sharing with respect to preventive services described in section 2242(b)(9).

''(3) INDIVIDUALS WITHOUT AFFORDABLE COVERAGE.—If an individual has a certification in effect for any plan year under section 2236(f) that the individual is exempt from the requirement under section 5000A of the Internal Revenue Code of 1986 by reason of section 5000A(e)(2), such individual shall

be eligible to enroll for the plan year in a plan described in paragraph (1).

''(d) CHILD-ONLY PLANS.—If an offeror offers a qualified health benefits plan in any level of coverage specified under this section, the offeror may also offer that plan in that level as a plan in which the only enrollees are individuals who, as of the beginning of a plan year—

''(1) have not attained the age of 21; or

''(2) have attained the age of 21 but are the dependent of another person.

''(e) ALLOWABLE VARIANCE.—A State may allow a de minimus variation in the actuarial valuations used in determining the level of coverage of a plan to account for differences in actuarial estimates.

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

''SEC. 2244. APPLICATION OF CERTAIN RULES TO PLANS IN GROUP MARKETS.

''(a) ANNUAL AND LIFETIME LIMITS.—In the case of a health benefits plan offered in the large or small group market in a State, the State shall prohibit the plan for plan years beginning after 2009 from imposing unrea-

sonable annual or lifetime limits (within the meaning of section 223 of the Internal Revenue Code of 1986) on enrollees in the plan. This subsection shall not apply to a grandfathered health benefits plan or to a qualified health benefits plan in the small group market.

''(b) ADDITIONAL LARGE GROUP REQUIREMENTS.—In the case of a health benefits plan offered in the large group market in a State, the State shall require such plan for plan years beginning after June 30, 2013—

''(1) to meet the requirements of section 2243(c)(2) (relating to annual limits on cost-sharing); and

''(2) to provide preventive items and services described in section 2243(b)(9) and except as provided in section 2243(c)(5), to require no cost-sharing for such items and services.

''(c) AUTO ENROLLMENT.—Each State shall require any large employer that has more than 200 employees and that offers employees enrollment in 1 or more health benefits plans to automatically enroll new full-time employees in one of the plans and to continue the enrollment of current employees in a health benefits plan offered through the employer. Any automatic enrollment program shall include adequate notice and the opportunity for an employee

to opt out of any coverage the individual was automatically enrolled in.

"SEC. 2245. SPECIAL RULES RELATING TO COVERAGE OF ABORTION SERVICES.

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

"(1) IN GENERAL.—Notwithstanding any other provision of this subpart and subject to paragraph (3)—

"(A) nothing in this subpart shall be construed to require a health benefits plan to provide coverage of services described in paragraph (2)(A) or (2)(B) as part of its essential benefits package for any plan year; and

"(B) the offeror of a health benefits plan shall determine whether or not the plan provides coverage of services described in paragraph (2)(A) or (2)(B) as part of such package for the plan year.

"(2) ABORTION SERVICES.—

"(A) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this subparagraph 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.

''(B) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this subparagraph 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.

''(3) ASSURED AVAILABILITY OF VARIED COVERAGE THROUGH EXCHANGES.—

''(A) IN GENERAL.—The Secretary shall assure that with respect to qualified health benefits plans offered in any exchange established pursuant to this title—

''(i) there is at least one such plan that provides coverage of services described in subparagraphs (A) and (B) of paragraph (2); and

''(ii) there is at least one such plan that does not provide coverage of services described in paragraph (2)(A).

''(B) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) a plan shall be treated as described in subparagraph (A)(ii) if the plan does not provide coverage of services described in either paragraph (2)(A) or (2)(B); and

''(ii) if a State has one exchange covering both the individual and small group markets, the Secretary shall meet the requirements of subparagraph (A) separately with respect to each such market.

''(b) PROHIBITION OF USE OF FEDERAL FUNDS.—

''(1) IN GENERAL.—If a qualified health benefits plan provides coverage of services described in subsection (a)(2)(A), the offeror of the plan shall not use any amount attributable to any of the following for purposes of paying for such services:

''(A) The credit under section 36B(b) of the Internal Revenue Code of 1986 (and the amount of the advance payment of the credit under section 2248 of the Social Security Act).

''(B) Any cost-sharing subsidy under section 2247.

''(2) SEGREGATION OF FUNDS.—In the case of a plan to which paragraph (1) applies, the offeror of the plan shall, out of amounts not described in paragraph (1), segregate an amount equal to the actuarial amounts determined under paragraph (3) for all enrollees from the amounts described in paragraph (1).

''(3) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

''(A) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health benefits plan of the services described in subsection (a)(2)(A).

''(B) CONSIDERATIONS.—In making such estimate, the Secretary—

''(i) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

''(ii) shall estimate such costs as if such coverage were included for the entire population covered; and

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

''(c) NO DISCRIMINATION ON THE BASIS OF PROVISION OF ABORTION.—A qualified health benefits plan may not discriminate against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay for, provide coverage of, or refer for abortions.''.

SEC. 1202. APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.

(a) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(b) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

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

(A) conscience protection;

(B) willingness or refusal to provide abortion; and

(C) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(c) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this section shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

SEC. 1203. APPLICATION OF EMERGENCY SERVICES LAWS.

Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Social Security Act (popularly known as ''EMTALA'').

PART II—PREMIUM CREDITS, COST-SHARING SUBSIDIES, AND SMALL BUSINESS CREDITS

Subpart A—Premium Credits and Cost-sharing Subsidies

SEC. 1205. REFUNDABLE CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH BENEFITS PLAN.

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

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

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

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

''(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

''(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the excess (if any) of—

''(A) the lesser of—

''(i) the monthly premiums for such month for 1 or more qualified health benefits plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an exchange established by the State under subpart B of title XXII of the Social Security Act, or

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

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

''(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

''(A) APPLICABLE PERCENTAGE.—

''(i) IN GENERAL.—The applicable percentage with respect to any taxpayer for any taxable year is equal to 2 percent, increased by the number of percentage points (not greater than 10) which bears the same ratio to 10 percentage points as—

''(I) the taxpayer's household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, bears to

''(II) an amount equal to 200 percent of the poverty line for a family of the size involved.

''(ii) INDEXING.—In the case of taxable years beginning in any calendar year after 2013, the Secretary shall adjust the initial and final applicable percentages for the calendar year to reflect the excess of the rate of premium growth between the preceding calendar year and 2012 over the rate of income growth for such period.

''(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest

cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan in the individual market which—

"(i) is offered through the same exchange through which the qualified health benefits plans taken into account under paragraph (2)(A)(i) were offered, and

"(ii) in the case of—

"(I) an applicable taxpayer whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households), provides self-only coverage, and

"(II) any other applicable taxpayer, provides family coverage.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse.

"(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applica-

ble second lowest cost silver plan is the monthly premium which would have been charged for the plan if each individual covered under a qualified health benefits plan taken into account under paragraph (2)(A)(i) were covered by the plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2204 of the Social Security Act.

''(4) REDUCTION TO ELIMINATE FEDERAL BUDGET DEFICIT.—The premium assistance credit amount (determined without regard to this paragraph) with respect to a month in a plan year for which a reduction is required in such amount under section 1209 of the America's Healthy Future Act of 2009 shall be reduced by the percentage specified in such section.

''(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH BENEFITS PLAN.—For purposes of this section—

''(1) APPLICABLE TAXPAYER.—

''(A) IN GENERAL.—The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for

the taxable year exceeds 100 percent (133 percent in the case of taxable years beginning in 2013) but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

''(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—In the case of any taxable year beginning after December 31, 2013, if—

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

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

the taxpayer shall be treated as an applicable taxpayer.

''(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the

taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

"(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(2) COVERAGE MONTH.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—

"(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health benefits plan described in subsection (b)(2)(A)(i), and

"(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of

the credit under subsection (a) under section 2248 of the Social Security Act).

''(B) EXCEPTION FOR ESSENTIAL HEALTH BENEFITS COVERAGE.—

''(i) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for essential health benefits coverage other than eligibility for coverage under a qualified health benefits plan in the individual market offered through an exchange.

''(ii) ESSENTIAL HEALTH BENEFITS COVERAGE.—The term 'essential health benefits coverage' has the meaning given such term by section 5000A.

''(C) SPECIAL RULE FOR EMPLOYER-SPONSORED ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

''(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for essential health benefits coverage if such coverage—

"(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) or a grandfathered health benefits plan maintained by the employee's employer, and

"(II) the employee's required contribution (within the meaning of section 5000A(e)(2)) with respect to the plan exceeds 10 percent of the applicable taxpayer's household income.

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

"(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for essential health benefits coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) or a grandfathered health benefits plan maintained by the employee's employer and the plan's share of the total allowed costs of benefits provided

under the plan is less than 65 percent of such costs.

''(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health benefits plan.

''(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2013, clause (i)(II) shall be applied by substituting for 10 percent a percentage equal to the sum of—

''(I) 10 percent, plus

''(II) 10 percent multiplied by the premium adjustment percentage (as defined in section 2242(c)(7) of the Social Security Act) for the calendar year.

''(D) SPECIAL RULE FOR MEDICAID INDIVIDUALS.—An individual shall not be treated as eligible for essential health benefits coverage if under title XIX of the Social Security Act the

individual may elect to enroll in the medicaid program or in a qualified health benefits plan in the individual market through an exchange and elects to enroll in such plan even if under the medicaid program the individual receives coverage for items and services or cost-sharing which is provided under the medicaid program but not under such plan.

''(3) DEFINITIONS.—For purposes of this paragraph—

''(A) QUALIFIED HEALTH BENEFITS PLAN.—The term 'qualified health benefits plan' has the meaning given such term by section 2201(b) of the Social Security Act.

''(B) GRANDFATHERED HEALTH BENEFITS PLAN.—The term 'grandfathered health benefits plan' has the meaning given such term by section 2221 of the Social Security Act.

''(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to al-

lowance of deduction for personal exemptions) for the taxable year.

''(2) HOUSEHOLD INCOME.—

''(A) IN GENERAL.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—

''(i) the modified gross income of the taxpayer, plus

''(ii) the aggregate modified gross incomes of all other individuals taken into account in determining the taxpayer's family size under paragraph (1).

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

''(i) decreased by the amount of any deduction allowable under paragraphs (1), (3), or (4) of section 62(a),

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

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

''(3) POVERTY LINE.—

''(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(B) POVERTY LINE USED.—In the case of any qualified health benefits plan offered through an exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

''(e) RULES FOR UNDOCUMENTED ALIENS.—

''(1) IN GENERAL.—If any individual for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year is an undocumented alien—

''(A) no credit shall be allowed under subsection (a) with respect to any portion of any premium taken into account under clause (i) or (ii) of subsection (b)(2)(A) which is attributable to the individual, and

''(B) the individual shall not be taken into account in determining the family size involved

but the individual's modified gross income shall be taken into account in determining household income.

''(2) UNDOCUMENTED ALIEN.—For purposes of this section—

''(A) The term 'undocumented alien' means an individual who is not, or who is reasonably not expected to be for the entire taxable year, a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien lawfully present in the United States.

''(B) IDENTIFICATION REQUIREMENT.—An individual shall be treated as an undocumented alien unless the information required under section 2238(b)(2) of the Social Security Act has been provided with respect to such individual.

''(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

''(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 2248 of the Social Security Act.

''(2) EXCESS ADVANCE PAYMENTS.—

"(A) IN GENERAL.—If the advance payments to a taxpayer under section 2248 of the Social Security Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

"(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 300 PERCENT OF POVERTY LINE.—In the case of an applicable taxpayer whose household income is less than 300 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 ($250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

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

"(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 2248 of the Social Security Act,

''(2) requirements for information required to be included on a return of tax with respect to the modified gross income of individuals other than the taxpayer, and

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

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health benefits plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.''.

(c) TREATMENT OF FAILURE TO PROVIDE DOCUMENTATION AS MATHEMATICAL ERROR.—Section 6213(g)(2) of the Internal Revenue Code of 1986 is amended by striking ''and'' at the end of subparagraph (M), by striking the period at the end of subparagraph (N) and inserting '', and'', and by inserting after subparagraph (N) the following new subparagraph:

"(O) the omission of identifying information described in section 2238(b)(1) of the Social Security Act and required under section 36B(e)(2)(B).".

(d) STUDY.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage. The Secretary shall report the results of such study to the appropriate committees of Congress, including any recommendations for legislative changes.

(e) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting "36B," after "36A,".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Rev-

enue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

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

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 1206. COST-SHARING SUBSIDIES AND ADVANCE PAYMENTS OF PREMIUM CREDITS AND COST-SHARING SUBSIDIES.

Title XXII of the Social Security Act (as added by section 1001 and amended by sections 1101 and 1201) is amended by adding at the end the following:

''Subpart 2—Premium Credits and Cost-sharing Subsidies

''SEC. 2246. PREMIUM CREDITS.

''For refundable tax credit providing premium assistance for individuals with income less than 400 percent of the Federal poverty line, see section 36B of the Internal Revenue Code of 1986 (as added by section 1205 of the America's Healthy Future Act of 2009).

''SEC. 2247. COST-SHARING SUBSIDIES FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH BENEFIT PLANS.

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

to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of the Internal Revenue Code of 1986—

''(1) the Secretary shall notify the offeror of the plan of the eligible insured's eligibility for a reduction in cost-sharing under this section; and

''(2) the offeror shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

''(b) ELIGIBLE INSURED.—In this section, the term 'eligible insured' means an individual—

''(1) who enrolls in a qualified health benefits plan in the silver level of coverage in the individual market offered through an exchange under part B; and

''(2) whose household income exceeds 100 percent (133 percent in the case of taxable years beginning in 2013) but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986 for any taxable year beginning after December 31, 2013, the individual shall be treated as having household income equal to 100 percent of such poverty line for purposes of applying this section.

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

''(1) REDUCTION IN OUT-OF-POCKET LIMIT.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 2242(c)(2) in the case of—

''(A) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

''(B) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

''(C) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

The reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above 80 percent (90 percent in the case of an eligible insured described in subparagraph (A)) of such costs

''(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSUREDS.—The Secretary shall establish procedures under which the offeror of a qualified health benefits plan to which this section applies shall further reduce cost-sharing under the plan in a manner sufficient to—

''(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

''(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

''(3) REDUCTION TO ELIMINATE FEDERAL BUDGET DEFICIT.—The reduction in cost-sharing under this section (determined without regard to this paragraph) with respect to a plan year for which a reduction is required in such amount under

section 1209 of the America's Healthy Future Act of 2009 shall be reduced by the percentage specified in such section.

''(4) METHODS FOR PROVIDING SUBSIDY.—

''(A) IN GENERAL.—An offeror of a qualified health benefits plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the offeror equal to the value of the reductions.

''(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of subsidies under this section. Any such system shall take into account the value of the subsidies and make appropriate risk adjustments to such payments.

''(d) SPECIAL RULES FOR INDIANS.—

''(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health benefits plan in the individual market through an exchange is an Indian (as defined in section 4 of the Indian Health Care Improvement Act) whose household income is not more than 300 per-

cent of the poverty line for a family of the size involved, then, for purposes of this section—

"(A) such individual shall be treated as an eligible insured; and

"(B) the offeror of the plan shall eliminate any cost-sharing under the plan.

"(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health benefits plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

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

"(B) the offeror of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

"(3) PAYMENT.—The Secretary shall pay to the offeror of a qualified health benefits plan the amount necessary to reflect the increase in actuarial

value of the plan required by reason of this subsection.

''(e) RULES FOR UNDOCUMENTED ALIENS.—

''(1) IN GENERAL.—In the case of an individual who is undocumented alien—

''(A) no cost-sharing reduction under this subsection shall apply with respect to any item or service provided to the individual; and

''(B) the individual shall not be taken into account in determining the family size involved but the individual's modified gross income shall be taken into account in determining household income.

''(2) IDENTIFICATION REQUIREMENT.—An individual shall be treated as an undocumented alien unless the information required under section 2238(b)(2) of the Social Security Act has been provided with respect to such individual.

''(f) DEFINITIONS AND SPECIAL RULES.—In this section:

''(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

''(2) LIMITATIONS ON SUBSIDY.—No subsidy shall be allowed under this section with respect to coverage for any month if such month would not be treated as a coverage month under section 36B(c)(2) of such Code.

"SEC. 2248. ADVANCE DETERMINATION AND PAYMENT OF PREMIUM CREDITS AND COST-SHARING SUBSIDIES.

''(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall establish a program under which—

''(1) upon request of an exchange, advance determinations are made under section 2238 with respect to the income eligibility of individuals enrolling in a qualified health benefits plan in the individual market through the exchange for the credit allowable under section 36B of the Internal Revenue Code of 1986 and the cost-sharing subsidy under section 2247;

''(2) the Secretary notifies the exchange and the Secretary of the Treasury of the advance determinations; and

''(3) the Secretary of the Treasury makes advance payments of such credit or subsidy to the offerors of the qualified health benefits plans in

order to reduce the premiums payable by individuals eligible for such credit.

''(b) ADVANCE DETERMINATIONS.—

''(1) IN GENERAL.—The Secretary shall provide under the program established under subsection (a) that advance determination of eligibility with respect to any individual shall be made—

''(A) during the annual open enrollment period applicable to the individual (or such other enrollment period as may be specified by the Secretary); and

''(B) on the basis of the individual's household income for the second taxable year preceding the taxable year in which enrollment through such enrollment period first takes effect.

''(2) CHANGES IN CIRCUMSTANCES.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1)(B) in cases where information included with an application form demonstrates substantial changes in income, changes in family size or other household circumstances, change in filing status, the filing of an application

for unemployment benefits, or other significant changes affecting eligibility, including—

"(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual's estimate of such income for the taxable year; and

"(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

"(c) PAYMENT OF PREMIUM CREDITS.—

"(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the exchange through which the individual is enrolling of the advance determination under section 2238.

"(2) PREMIUM CREDIT.—

"(A) IN GENERAL.—The Secretary of the Treasury shall make the advance payment under this section of any credit allowed under section 36B of the Internal Revenue Code of 1986 to the offeror of a qualified health bene-

fits plan on a monthly basis (or such other periodic basis as the Secretary may provide).

''(B) OFFEROR RESPONSIBILITIES.—An offeror of a qualified health benefits plan receiving an advance payment with respect to an individual enrolled in the plan shall—

''(i) reduce the premium charged the insured for any period by the amount of the advance payment for the period;

''(ii) notify the exchange and the Secretary of such reduction; and

''(iii) in the case of any nonpayment of premiums by the insured—

''(I) notify the Secretary of such nonpayment; and

''(II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.

''(d) COORDINATION WITH VERIFICATION OF LAWFUL PRESENCE.—No advance payment shall be made under this section unless there has been a verification under section 2238 of the individual's citizenship or nationality or lawful presence in the United States.''.

SEC. 1207. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—

(1) TAXPAYER RETURN INFORMATION.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

''(21) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.—

''(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services return information of any taxpayer whose income is relevant in determining any credit under section 36B or any cost-sharing subsidy under section 2247 of the Social Security Act or eligibility for participation in a State medicaid program under title XIX of such Act, a State's children's health insurance program under title XXI of such Act, or a basic health program under section 2228 of such Act. Such return information shall be limited to—

"(i) taxpayer identity information with respect to such taxpayer,

"(ii) the filing status of such taxpayer,

"(iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer's spouse),

"(iv) the modified gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii),

"(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or subsidy (and the amount thereof), and

"(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

"(B) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services may disclose to an exchange established under title XXII of the So-

cial Security Act or its contractors, or to a State agency administering a State program described in subparagraph (A) or its contractors, any inconsistency between the information provided by the exchange or State agency to the Secretary and the information provided to the Secretary under subparagraph (A).

''(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) or (B) may be used by officers, employees, and contractors of the Department of Health and Human Services, an exchange, or a State agency only for the purposes of, and to the extent necessary in—

''(i) establishing eligibility for participation in the exchange, and verifying the appropriate amount of, any credit or subsidy described in subparagraph (A),

''(ii) determining eligibility for participation in the State programs described in subparagraph (A).''.

(2) SOCIAL SECURITY NUMBERS.—Section 205(c)(2)(C) of the Social Security Act is amended by adding at the end the following new clause:

''(x) The Secretary of Health and Human Services, and the exchanges established under title XXII, are authorized to collect and use the names and social security account numbers of individuals as required to administer the provisions of, and the amendments made by, America's Healthy Future Act of 2009.''.

(b) CONFIDENTIALITY AND DISCLOSURE.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting '', or any entity described in subsection (l)(21),'' after ''or (20)'' in the matter preceding subparagraph (A),

(2) by inserting ''or any entity described in subsection (l)(21),'' after ''or (o)(1)(A)'' in subparagraph (F)(ii), and

(3) by inserting ''or any entity described in subsection (l)(21),'' after ''or (20)'' both places it appears in the matter after subparagraph (F).

(d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (20)'' and inserting ''(20), or (21)''.

SEC. 1208. PREMIUM CREDIT AND SUBSIDY REFUNDS AND PAYMENTS DISREGARDED FOR FEDERAL AND FEDERALLY-ASSISTED PROGRAMS.

For purposes of determining the eligibility of any individual for benefits or assistance, or the amount or extent of benefits or assistance, under any Federal program or under any State or local program financed in whole or in part with Federal funds—

(1) any credit or refund allowed or made to any individual by reason of section 36B of the Internal Revenue Code of 1986 (as added by section 1205) shall not be taken into account as income and shall not be taken into account as resources for the month of receipt and the following 2 months; and

(2) any cost-sharing subsidy payment or advance payment of the credit allowed under such section 36B that is made under section 2247 or 2248 of the Social Security Act (as added by section 1206) shall be treated as made to the qualified health benefits plan in which an individual is enrolled and not to that individual.

SEC. 1209. FAIL-SAFE MECHANISM TO PREVENT INCREASE IN FEDERAL BUDGET DEFICIT.

(a) ESTIMATE AND CERTIFICATION OF EFFECT OF ACT ON BUDGET DEFICIT.—

(1) IN GENERAL.—The President shall include in the submission under section 1105 of title 31, United States Code, of the budget of the United States Government for fiscal year 2013 and each fiscal year thereafter an estimate of the budgetary effects for the fiscal year of the provisions of (and the amendments made by) this Act, based on the information available as of the date of such submission.

(2) CERTIFICATION.—The President shall include with the estimate under paragraph (1) for any fiscal year a certification as to whether the sum of the decreases in revenues and increases in outlays for the fiscal year by reason of the provisions of (and the amendments made by) this Act exceed (or do not exceed) the sum of the increases in revenues and decreases in outlays for the fiscal year by reason of the provisions and amendments.

(b) EFFECT OF DEFICIT.—If the President certifies an excess under subsection (a)(2) for any fiscal year—

(1) the President shall include with the certification the percentage by which the credits allowable under section 36B of the Internal Revenue Code of

1986 and the cost-sharing subsidies under section 2247 of the Social Security Act must be reduced for plan years beginning during such fiscal year such that there is an aggregate decrease in the amount of such credits and subsidies equal to the amount of such excess; and

(2) the President shall instruct the Secretary of Health and Human Services and the Secretary of the Treasury to reduce such credits and subsidies for such plan years by such percentage for purposes of applying section 36B(b)(4) of such Code and section 2247(c)(3) of such Act.

Subpart B—Credit for Small Employers

SEC. 1221. CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL BUSINESSES.

(a) IN GENERAL.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by inserting after section 45Q the following:

"SEC. 45R. EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.

"(a) GENERAL RULE.—For purposes of section 38, in the case of an eligible small employer, the small employer health insurance credit determined under this sec-

tion for any taxable year in the credit period is the amount determined under subsection (b).

''(b) HEALTH INSURANCE CREDIT AMOUNT.—Subject to subsection (c), the amount determined under this subsection with respect to any eligible small employer is equal to 50 percent (35 percent in the case of a tax-exempt eligible small employer) of the lesser of—

''(1) the aggregate amount of nonelective contributions the employer made on behalf of its employees during the taxable year under the arrangement described in subsection (d)(4) for premiums for qualified health benefits plans offered by the employer to its employees through an exchange, or

''(2) the aggregate amount of nonelective contributions which the employer would have made during the taxable year under the arrangement if each employee taken into account under paragraph (1) had enrolled in a qualified health benefits plan which had a premium equal to the average premium (as determined by the Secretary of Health and Human Services) for the small group market in the exchange through which the employee is eligible for coverage.

In the case of a taxable year beginning in 2013, the credit determined under this section shall be determined only

with respect to premiums for coverage after June 30, 2013.

''(c) LIMITATIONS ON CREDIT.—

''(1) PHASEOUT OF CREDIT AMOUNT BASED ON NUMBER OF EMPLOYEES AND AVERAGE WAGES.—The amount of the credit determined under subsection (b) without regard to this subsection shall be reduced (but not below zero) by the sum of the following amounts:

''(A) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

''(B) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (d)(3)(B) and the denominator of which is $20,000.

''(2) STATE FAILURE TO ADOPT INSURANCE RATING REFORMS.—No credit shall be determined under this section with respect to contributions by the employer for any qualified health benefits plans purchased through an exchange for any month of coverage before the first month the State estab-

lishing the exchange has in effect the insurance rating reforms described in subtitle A of title XXII of the Social Security Act.

''(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

''(1) IN GENERAL.—The term 'eligible small employer' means, with respect to any taxable year, an employer—

''(A) which has no more than 25 full-time equivalent employees for the taxable year,

''(B) the average annual wages of which do not exceed an amount equal to the amount in effect under paragraph (3)(B) for the taxable year plus $20,000, and

''(C) which has in effect an arrangement described in paragraph (4).

''(2) FULL-TIME EQUIVALENT EMPLOYEES.—

''(A) IN GENERAL.—The term 'full-time equivalent employees' means a number of employees equal to the number determined by dividing—

''(i) the total number of hours for which wages were paid by the employer to employees during the taxable year, by

''(ii) 2,080.

Such number shall be rounded to the next lowest whole number if not otherwise a whole number.

''(B) EXCESS HOURS NOT COUNTED.—If an employee works in excess of 2,080 hours during any taxable year, such excess shall not be taken into account under subparagraph (A).

''(C) SPECIAL RULES.—The Secretary shall prescribe such regulations, rules, and guidance as may be necessary to apply this paragraph to employees who are not compensated on an hourly basis.

''(3) AVERAGE ANNUAL WAGES.—

''(A) IN GENERAL.—The average annual wages of an eligible small employer for any taxable year is the amount determined by dividing—

''(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

''(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lowest multiple of $1,000 if not otherwise such a multiple.

''(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B)—

''(i) 2010.—The dollar amount in effect under this paragraph for taxable years beginning in 2010 is $20,000.

''(ii) SUBSEQUENT YEARS.—In the case of a taxable year beginning in a calendar year after 2010, the dollar amount in effect under this paragraph shall be equal to $20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2009' for 'calendar year 1992' in subparagraph (B) thereof.

''(4) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a nonelective contribution on behalf of each employee who enrolls in a qualified health benefits plan offered to employees by the employer through an exchange in an amount equal to a uniform percentage (not less

than 50 percent) of the premium cost of the qualified health benefits plan.

''(5) SEASONAL WORKER HOURS AND WAGES NOT COUNTED.—For purposes of this subsection—

''(A) IN GENERAL.—The number of hours worked by, and wages paid to, a seasonal worker of an employer shall not be taken into account in determining the full-time equivalent employees and average annual wages of the employer.

''(B) DEFINITION OF SEASONAL WORKER.—The term 'seasonal worker' means an individual who performs labor or services on a seasonal basis where, ordinarily, the employment pertains to or is of the kind exclusively performed at certain seasons or periods of the year and which, from its nature, may not be continuous or carried on throughout the year.

''(e) OTHER RULES AND DEFINITIONS.—For purposes of this section—

''(1) EMPLOYEE.—

''(A) CERTAIN EMPLOYEES EXCLUDED.—The term 'employee' shall not include—

''(i) an employee within the meaning of section 401(c)(1),

"(ii) any 2-percent shareholder (as defined in section 1372(b)) of an eligible small business which is an S corporation,

"(iii) any 5-percent owner (as defined in section 416(i)(1)(B)(i)) of an eligible small business, or

"(iv) any individual who bears any of the relationships described in subparagraphs (A) through (G) of section 152(d)(2) to, or is a dependent described in section 152(d)(2)(H) of, an individual described in clause (i), (ii), or (iii).

"(B) LEASED EMPLOYEES.—The term 'employee' shall include a leased employee within the meaning of section 414(n).

"(2) CREDIT PERIOD.—The term 'credit period' means, with respect to any eligible small employer, the 2-consecutive-taxable year period beginning with the 1st taxable year in which the employer (or any predecessor) offers 1 or more qualified health benefits plans to its employees through an exchange. If no credit is allowed to an employer (or predecessor) under this section by reason of subsection (c)(2) (relating to failure by States to adopt insurance rating reforms), the credit period with respect to the em-

ployer shall not begin until the 1st taxable year following the taxable year in which the State has in effect the insurance rating reforms described in such subsection.

''(3) NONELECTIVE CONTRIBUTION.—The term 'nonelective contribution' means an employer contribution other than an employer contribution pursuant to a salary reduction arrangement.

''(4) WAGES.—The term 'wages' has the meaning given such term by section 3121(a) (determined without regard to any dollar limitation contained in such section).

''(5) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

''(A) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

''(B) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

''(f) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

''(1) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subpart C (and not allowable under this subpart) the lesser of— —

''(A) the amount of the credit determined under this section with respect to such employer, or

''(B) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

''(2) TAX-EXEMPT ELIGIBLE SMALL EMPLOYER.—For purposes of this section, the term 'tax-exempt eligible small employer' means an eligible small employer which is any organization described in section 501(c) which is exempt from taxation under section 501(a).

''(3) PAYROLL TAXES.—For purposes of this subsection—

''(A) IN GENERAL.—The term 'payroll taxes' means—

''(i) amounts required to be withheld from the employees of the tax-exempt eligible small employer under section 3401(a),

"(ii) amounts required to be withheld from such employees under section 3101(b), and

"(iii) amounts of the taxes imposed on the tax-exempt eligible small employer under section 3111(b).

"(B) SPECIAL RULE.—A rule similar to the rule of section 24(d)(2)(C) shall apply for purposes of subparagraph (A).

"(g) APPLICATION OF SECTION FOR CALENDAR YEARS 2011 AND 2012.—In the case of any taxable year beginning in 2011 or 2012, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

"(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2012, no credit period shall be treated as beginning with a taxable year beginning before 2013.

"(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

"(A) by substituting '35 percent (25 percent in the case of a tax-exempt eligible small employer)' for '50 percent (35 percent in the case of a tax-exempt eligible small employer)',

"(B) by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)) of an employee, and

"(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for the small group market in the State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

"(3) STATE RATING REFORM LIMITATION.—The limitation of paragraph (2) of subsection (c) shall not apply.

"(4) CONTRIBUTION ARRANGEMENT.—An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an exchange.

''(h) INSURANCE DEFINITIONS.—Any term used in this section which is also used in title XXII of the Social Security Act shall have the meaning given such term by such title.

''(i) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under paragraphs (1) and (2) of subsection (c) through the use of multiple entities.''.

(b) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ''plus'' at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting '', plus'', and by inserting after paragraph (35) the following:

''(36) the small employer health insurance credit determined under section 45R.''.

(c) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) is amended by redesignating clauses (vi), (vii), and (viii) as clauses (vii),

(viii), and (ix), respectively, and by inserting after clause (v) the following new clause:

"(vi) the credit determined under section 45R,".

(d) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed), as amended by section 1205(b), is amended by adding at the end the following new subsection:

"(h) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health benefits plans (as defined in section 2201(b) of the Social Security Act) paid by an employer which is equal to the amount of the credit determined under section 45R(a).".

(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking "and" at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ", and", and by adding at the end the following new paragraph:

''(14) the small employer health insurance credit determined under section 45R(a).''.

(e) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

''Sec. 45R. Employee health insurance expenses of small employers.''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.

Subtitle D—Shared Responsibility

PART I—INDIVIDUAL RESPONSIBILITY

SEC. 1301. EXCISE TAX ON INDIVIDUALS WITHOUT ESSENTIAL HEALTH BENEFITS COVERAGE.

(a) IN GENERAL.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

''CHAPTER 48—MAINTENANCE OF ESSENTIAL HEALTH BENEFITS COVERAGE

''Sec. 5000A. Failure to maintain essential health benefits coverage.

"SEC. 5000A. FAILURE TO MAINTAIN ESSENTIAL HEALTH BENEFITS COVERAGE.

"(a) REQUIREMENT TO MAINTAIN ESSENTIAL HEALTH BENEFITS COVERAGE.—If an individual is an applicable individual for any month beginning after June 30, 2013, the individual is required to be covered by essential health benefits coverage for such month.

"(b) IMPOSITION OF TAX.—

"(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (d), there is hereby imposed a tax with respect to the individual in the amount determined under subsection (c).

"(2) INCLUSION WITH INCOME TAX RETURN.—Any tax imposed by this section with respect to any month shall be included with a taxpayer's return of tax imposed by chapter 1 for the taxable year which includes such month.

"(3) LIABILITY FOR TAX.—If an individual with respect to whom tax is imposed by this section for any month—

"(A) is a dependent (as defined in section 152) of another taxpayer for the other tax-

payer's taxable year including such month, such other taxpayer shall be liable for such tax, or

"(B) files a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such tax.

"(c) AMOUNT OF TAX.—

"(1) IN GENERAL.—The tax determined under this subsection for any month with respect to any individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year.

"(2) DOLLAR LIMITATION.—The amount of the tax imposed by this section on any taxpayer for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to twice the applicable dollar amount for the calendar year with or within which the taxable year ends.

"(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the applicable dollar amount is $750.

''(B) PHASE IN.—The applicable dollar amount is $200 for 2014, $400 for 2015, and $600 for 2016.

''(C) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2017, the applicable dollar amount shall be equal to $750, increased by an amount equal to—

''(i) $750, multiplied by

''(ii) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2016' for 'calendar year 1992' in subparagraph (B) thereof.

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

''(4) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

''(A) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(B) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—

"(i) the modified gross income of the taxpayer, plus

"(ii) the aggregate modified gross incomes of all other individuals taken into account in determining the taxpayer's family size under paragraph (1).

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

"(i) decreased by the amount of any deduction allowable under paragraphs (1), (3), or (4) of section 62(a),

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

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

"(D) POVERTY LINE.—

"(i) IN GENERAL.—The term 'poverty line' has the meaning given that term in

section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

''(ii) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the such calendar year.

''(d) APPLICABLE INDIVIDUAL.—For purposes of this section—

''(1) IN GENERAL.—The term 'applicable individual' means, with respect to any month, any individual who has attained the age of 18 before the beginning of the month other than an individual described in paragraph (2) or (3).

''(2) RELIGIOUS EXEMPTIONS.—

''(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 2236(f) of the Social Security Act which certifies that such individual is a member of a recognized religious sect or division thereof described in section 1402(g)(1) and an adherent of established te-

nets or teachings of such sect or division as described in such section.

''(B) HEALTH CARE SHARING MINISTRY.—

''(i) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.

''(ii) HEALTH CARE SHARING MINISTRY.—The term 'health care sharing ministry' means an organization—

''(I) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),

''(II) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,

''(III) members of which retain membership even after they develop a medical condition,

''(IV) which (or a predecessor of which) has been in existence at all

times since December 31, 1999, and medical expenses of its members have been shared during the entire period of its existence, and

"(V) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

"(3) UNDOCUMENTED ALIENS.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States, an alien lawfully admitted to the United States for permanent residence, or an alien lawfully present in the United States.

"(e) EXEMPTIONS FROM TAX.—No tax shall be imposed under subsection (a) with respect to—

"(1) MONTHS DURING SHORT COVERAGE GAPS.—Any month the last day of which occurred during a period in which the applicable individual was not covered by essential health benefits coverage for a period of less than 3 months.

''(2) INDIVIDUALS WHO CANNOT AFFORD COVERAGE.—

''(A) IN GENERAL.—Any applicable individual if the applicable individual's required contribution for a calendar year exceeds 8 percent of such individual's household income for the second taxable year preceding the taxable year described in subsection (b)(2). For purposes of applying this subparagraph, the taxpayer's household income shall be increased by any exclusion from gross income for any portion of the required contribution made through a salary reduction arrangement.

''(B) REQUIRED CONTRIBUTION.—For purposes of this paragraph, the term 'required contribution' means—

''(i) in the case of an individual eligible to purchase health insurance coverage through an employer other than through an exchange, the portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for health insurance coverage which is the low-

est cost coverage offered through the employer, or

''(ii) in the case of any individual not described in clause (i), the annual premium for the lowest cost bronze plan available in the individual market through the exchange in the State in which the individual resides (without regard to whether the individual is eligible to purchase a qualified health benefits plan through the exchange), reduced by the amount of the credit allowable under section 36B for the taxable year (determined as if the individual was covered by a qualified health benefits plan offered through the exchange for the entire taxable year).

''(C) SPECIAL RULE FOR INDIVIDUALS ELIGIBLE FOR COVERAGE THROUGH EMPLOYEE.—If an applicable individual is eligible for coverage through an employer by reason of a relationship to an employee, the determination under subparagraph (B)(i) shall be made by reference to the affordability of the coverage to the employee.

"(D) INDEXING.—In the case of plan years beginning in any calendar year after 2013, subparagraph (A) shall be applied by substituting for '8 percent' the percentage the Secretary of Health and Human Services determines reflects the excess of the rate of premium growth between the preceding calendar year and 2012 over the rate of income growth for such period.

"(3) TAXPAYERS WITH INCOME UNDER 100 PERCENT OF POVERTY LINE.—Any applicable individual who has a household income for the for the second taxable year preceding the taxable year described in subsection (b)(2) which is less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

"(4) NATIVE AMERICANS.—Any applicable individual who is an Indian as defined in section 4 of the Indian Health Care Improvement Act.

"(5) HARDSHIPS.—Any applicable individual who is determined by the Secretary to have suffered a hardship with respect to the capability to obtain coverage under a qualified health benefits plan.

"(f) ESSENTIAL HEALTH BENEFITS COVERAGE.—For purposes of this section—

"(1) IN GENERAL.—The term 'essential health benefits coverage' means any of the following:

"(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

"(B) GRANDFATHERED HEALTH BENEFITS PLAN.—Coverage under a grandfathered health benefits plan (as defined in section 2221(c) of the Social Security Act).

"(C) EMPLOYER-SPONSORED PLAN.—Coverage under an eligible employer-sponsored plan.

"(D) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

"(E) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act.

"(F) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

"(G) VA.—Coverage under the veteran's health care program under chapter 17 of title

38, United States Code, but only if the coverage for the individual involved is determined by the Secretary of Health and Human Services in coordination with the Secretary to be not less than a level specified by the Secretary of Health and Human Services, based on the individual's priority for services as provided under section 1705(a) of such title.

''(H) FEDERAL EMPLOYEES COVERAGE.—Coverage under the Federal employees health benefits program under chapter 89 of title 5, United States Code.

''(I) OTHER COVERAGE.—Such other health benefits coverage, such as a State health benefits risk pool or coverage while incarcerated, as the Secretary of Health and Human Services, in coordination with the Secretary, recognizes for purposes of this subsection.

''(2) ELIGIBLE EMPLOYER-SPONSORED PLAN.—The term 'eligible employer-sponsored plan' means, with respect to any employee, a health benefits plan (other than a grandfathered health benefits plan) offered by an employer to the employee, but only if—

''(A) in the case of a small employer, the plan is a qualified health benefits plan, and

''(B) in the case of a large employer plan, the plan meets the requirements of section 2244 of the Social Security Act.

''(3) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title XXII of the Social Security Act shall have the same meaning as when used in such title.

''(g) MODIFICATIONS OF SUBTITLE F.—Notwithstanding any other provision of law—

''(1) WAIVER OF CRIMINAL AND CIVIL PENALTIES AND INTEREST.—In the case of any failure by a taxpayer to timely pay any tax imposed by this section—

''(A) such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure, and

''(B) no penalty, addition to tax, or interest shall be imposed with respect to such failure or such tax.

''(2) LIMITED COLLECTION ACTIONS PERMITTED.—In the case of the assessment of any tax imposed by this section, the Secretary shall not take any action with respect to the collection of such tax other than—

"(A) giving notice and demand for such tax under section 6303,

"(B) crediting under section 6402(a) the amount of any overpayment of the taxpayer against such tax, and

"(C) offsetting any payment owed by any Federal agency to the taxpayer against such tax under the Treasury offset program.".

(b) CLERICAL AMENDMENT.—The table of chapters for subtitle D of the Internal Revenue Code of 1986 is amended by inserting after the item relating to chapter 47 the following new item:

"CHAPTER 48—MAINTENANCE OF ESSENTIAL HEALTH BENEFITS COVERAGE".

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—The Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such

Code on maintaining and expanding the health insurance coverage of individuals,

(ii) the availability of affordable health benefits plans, and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—Not later than February 1, 2014, the Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) CONGRESSIONAL CONSIDERATION OF RECOMMENDATIONS.—

(A) COMMITTEE CONSIDERATION OF PROPOSAL; DISCHARGE; CONTINGENCY FOR INTRODUCTION.—Not later than April 1, 2014, the appropriate committees of Congress shall report legislation implementing the recommendations contained in the report described in paragraph (1)(B). If, with respect to the House involved, any such committee has not reported such legis-

lation by such date, such committees shall be deemed to be discharged from further consideration of the proposal and any member of the House of Representatives or the Senate, respectively, may introduce legislation implementing the recommendations contained in the proposal and such legislation shall be placed on the appropriate calendar of the House involved.

(B) EXPEDITED PROCEDURE.—

(i) CONSIDERATION.—If legislation is reported out of committee or legislation is introduced under subparagraph (A), not later than 15 calendar days after the date on which a committee has been or could have been discharged from consideration of such legislation or such legislation is introduced, the Speaker of the House of Representatives, or the Speaker's designee, or the majority leader of the Senate, or the leader's designee, shall move to proceed to the consideration of the legislation. It shall also be in order for any member of the Senate or the House of Representatives, respectively, to move to proceed to the consideration of the legislation at any time

after the conclusion of such 15-day period. All points of order against the legislation (and against consideration of the legislation) with the exception of points of order under the Congressional Budget Act of 1974 are waived. A motion to proceed to the consideration of the legislation is privileged in the Senate and highly privileged in the House of Representatives and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the legislation, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to proceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the Senate or the House of Representatives, as the case may be, shall immediately proceed to consideration of the legislation in accordance with the Standing Rules of the Senate or the House of Representatives, as the case may be, without intervening motion, order, or other business, and the resolution shall remain the unfinished business

of the Senate or the House of Representatives, as the case may be, until disposed of.

(ii) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the legislation that was introduced in such House, such House receives from the other House legislation as passed by such other House—

(I) the legislation of the other House shall not be referred to a committee and shall immediately displace the legislation that was reported or introduced in the House in receipt of the legislation of the other House; and

(II) the legislation of the other House shall immediately be considered by the receiving House under the same procedures applicable to legislation reported by or discharged from a committee or introduced under subparagraph (A).

Upon disposition of legislation that is received by one House from the other House, it shall no longer be in order to consider

the legislation that was reported or introduced in the receiving House.

(iii) SENATE LIMITS ON DEBATE.—In the Senate, consideration of the legislation and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between those favoring and those opposing the legislation. A motion further to limit debate on the legislation is in order and is not debatable. Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal. All time used for consideration of the legislation, including time used for quorum calls and voting, shall be counted against the total 30 hours of consideration.

(iv) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the legislation that results in a disagreement between the two Houses of Congress with respect to the legislation, conferees shall be appointed and a conference

convened. Not later than 15 days after the date on which conferees are appointed (excluding periods in which one or both Houses are in recess), the conferees shall file a report with the Senate and the House of Representatives resolving the differences between the Houses on the legislation. Notwithstanding any other rule of the Senate or the House of Representatives, it shall be in order to immediately consider a report of a committee of conference on the legislation filed in accordance with this subsection. Debate in the Senate and the House of Representatives on the conference report shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report.

(C) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This paragraph is enacted by Congress—

(i) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of legislation under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(ii) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

(3) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term ''appropriate committees of Congress'' means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Com-

mittee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2012.

SEC. 1302. REPORTING OF HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986 is amended by inserting after subpart C the following new subpart:

"Subpart D—Information Regarding Health Insurance Coverage

"Sec. 6055. Reporting of health insurance coverage.

"SEC. 6055. REPORTING OF HEALTH INSURANCE COVERAGE.

"(a) IN GENERAL.—Every person who provides essential health benefits coverage to an individual during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

"(b) FORM AND MANNER OF RETURN.—

"(1) IN GENERAL.—A return is described in this subsection if such return—

"(A) is in such form as the Secretary may prescribe, and

"(B) contains—

''(i) the name, address and TIN of the primary insured and the name of each other individual obtaining coverage under the policy,

''(ii) the dates during which such individual was covered under essential health benefits coverage during the calendar year,

''(iii) the amount (if any) of any advance payment under section 2248 of the Social Security Act of any cost-sharing subsidy under section 2247 of such Act or of any premium credit under section 36B with respect to such coverage, and

''(iv) such other information as the Secretary may require.

''(2) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If essential health benefits coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

''(A) the name, address, and employer identification number of the employer maintaining the plan,

''(B) the portion of the premium (if any) required to be paid by the employer, and

''(C) if the health insurance coverage is a qualified health benefits plan in the small group market offered through an exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employee health insurance expenses of small employers).

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

''(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(B) the information required to be shown on the return with respect to such individual.

''(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the

year following the calendar year for which the return under subsection (a) was required to be made.

''(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

''(e) ESSENTIAL HEALTH BENEFITS COVERAGE.—For purposes of this section, the term 'essential health benefits coverage' has the meaning given such term by section 5000A(f).''.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking ''or'' at the end of clause (xxii), by striking ''and'' at the end of clause (xxiii) and inserting ''or'', and by inserting after clause (xxiii) the following new clause:

''(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and''.

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking ''or'' at the end of sub-

paragraph (EE), by striking the period at the end of subparagraph (FF) and inserting ", or" and by inserting after subparagraph (FF) the following new subparagraph:

"(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).".

(c) CONFORMING AMENDMENT.—The table of subparts for part III of subchapter A of chapter 61 of such Code is amended by inserting after the item relating to subpart C the following new item:

"SUBPART D—INFORMATION REGARDING HEALTH INSURANCE COVERAGE".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after 2012.

PART II—EMPLOYER RESPONSIBILITY

SEC. 1306. EMPLOYER SHARED RESPONSIBILITY REQUIREMENT.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"SEC. 4980H. EMPLOYER RESPONSIBILITY TO PROVIDE HEALTH COVERAGE.

"(a) IMPOSITION OF EXCISE TAX.—If—

"(1) an applicable large employer fails to meet the health insurance coverage requirements of sub-

section (c) with respect to its full-time employees, and

''(2) any such full-time employee of the employer is enrolled for any month during the period of such failure in a qualified health benefits plan with respect to which an applicable premium credit or cost-sharing subsidy is allowed or paid with respect to the employee,

there is hereby imposed on such failure with respect to each such employee for each such month a tax in the amount determined under subsection (b).

''(b) AMOUNT OF TAX.—

''(1) IN GENERAL.—The tax determined under this subsection with respect to a failure involving an employee for any month described in subsection (a)(2) shall be equal to 1/12 of the dollar amount which the Secretary of Health and Human Services determines (on the basis of the most recent data available) is equal to the sum of the average annual credit allowed under section 36B and the average annual cost-sharing subsidy under section 2247 of the Social Security Act for taxable years beginning in the calendar year preceding the calendar year in which such month occurs. In the case of a month occurring during 2013, the Secretary shall determine

the average annual credit and subsidy on the basis of the aggregate amount of credits and subsidies (expressed as an annual amount) for which applicants were determined eligible during the initial open enrollment period under section 2237(d)(2)(A) of the Social Security Act.

''(2) OVERALL LIMITATION.—

''(A) IN GENERAL.—The aggregate amount of tax determined under paragraph (1) with respect to all employees of an applicable large employer for any month shall not exceed 1/12 of the product of—

''(i) $400, and

''(ii) the average number of full-time employees of the employer on business days during the calendar year preceding the calendar year in which such month occurs (determined in the same manner as under subsection (d)(1)).

''(B) INDEXING.—In the case of any calendar year after 2013, the $400 amount under subparagraph (A)(i) shall be increased by an amount equal to the product of—

''(i) $400, and

"(ii) the premium adjustment percentage (as defined in section 2242(c)(7) of the Social Security Act) for the calendar year.

If the amount of any increase under this subparagraph is not a multiple of $10, such increase shall be rounded to the next lowest multiple of $10.

"(c) HEALTH INSURANCE COVERAGE REQUIREMENTS.—For purposes of this section—

"(1) IN GENERAL.—An applicable large employer meets the health insurance coverage requirements of this subsection if the employer—

"(A) in the case of an employer in the small group market in a State, offers to its full-time employees (and their dependents) the opportunity to enroll in a qualified health benefits plan or a grandfathered health benefits plan, and

"(B) in the case of an employer in the large group market in a State, offers to its full-time employees (and their dependents) the opportunity to enroll in a group health plan meeting the requirements of section 2244 of the So-

cial Security Act or a grandfathered health benefits plan.

''(2) EXCEPTION WHERE COVERAGE IS UNAFFORDABLE OR FAILS TO PROVIDE MINIMUM VALUE.—An employer shall not be treated as meeting the requirements of this subsection with respect to any employee if—

''(A) the employee is eligible for the credit allowable under section 36B because the employee's required contribution under the plan described in paragraph (1) is determined to be unaffordable under section 36B(c)(2)(C), or

''(B) in the case of a plan (other than a qualified health benefits plan) offered under paragraph (1), the plan's share of the total allowed costs of benefits provided under the plan is less than 65 percent of such costs.

''(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

''(1) APPLICABLE LARGE EMPLOYER.—

''(A) IN GENERAL.—The term 'applicable large employer' means, with respect to a calendar year, an employer who employed an average of at least 50 employees on business days during the preceding calendar year.

"(B) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

"(i) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(ii) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is an applicable large employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

"(iii) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

''(2) APPLICABLE PREMIUM CREDIT AND COST-SHARING SUBSIDY.—The term 'applicable premium credit and cost-sharing subsidy' means—

''(A) any premium credit allowed under section 36B (and any advance payment of the credit under section 2248 of the Social Security Act), and

''(B) any cost-sharing subsidy payment under section 2247 of such Act.

''(3) FULL-TIME EMPLOYEE.—

''(A) IN GENERAL.—The term 'full-time employee' means an employee who is employed on average at least 30 hours per week.

''(B) SPECIAL RULES.—The Secretary shall prescribe such regulations, rules, and guidance as may be necessary to apply this paragraph to employees who are not compensated on an hourly basis.

''(4) OTHER DEFINITIONS.—Any term used in this section which is also used in title XXII of the Social Security Act shall have the same meaning as when used in such title.

''(5) TAX NONDEDUCTIBLE.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

''(e) TIME FOR PAYMENT OF TAX.—The Secretary may provide for the payment of the tax imposed by this section on an annual, monthly, or other periodic basis as the Secretary may prescribe.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding at the end the following new item:

''Sec. 4980H. Employer responsibility to provide health coverage.''.

(c) STUDY AND REPORT OF EFFECT OF TAX ON WORKERS' WAGES.—

(1) IN GENERAL.—The Secretary of Labor shall conduct a study to determine whether employees' wages are reduced by reason of the application of the tax imposed under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The Secretary shall make such determination on the basis of the National Compensation Survey published by the Bureau of Labor Statistics.

(2) REPORT.—The Secretary shall report the results of the study under paragraph (1) to the Committee on Ways and Means of the House of Representatives and to the Committee on Finance of the Senate.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after June 30, 2013.

SEC. 1307. REPORTING OF EMPLOYER HEALTH INSURANCE COVERAGE.

(a) IN GENERAL.—Subpart D of part III of subchapter A of chapter 61 of the Internal Revenue Code of 1986, as added by section 1302, is amended by inserting after section 6055 the following new section:

"SEC. 6056. LARGE EMPLOYERS REQUIRED TO REPORT ON HEALTH INSURANCE COVERAGE.

''(a) IN GENERAL.—Every applicable large employer required to meet the requirements of section 4980H(c) with respect to its full-time employees during a calendar year shall, at such time as the Secretary may prescribe, make a return described in subsection (b).

''(b) FORM AND MANNER OF RETURN.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains—

''(A) the name, date, and employer identification number of the employer,

''(B) a certification as to whether the employer offers to its full-time employees (and

their dependents) the opportunity to enroll in a health benefits plan or a grandfathered health benefits plan described in section 4980H(c) and applicable to the employer,

''(C) if the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll—

''(i) the months during the calendar year for which coverage was available, and

''(ii) the monthly premium for the lowest cost option in each of the enrollment categories under each health benefits plan offered to employees,

''(D) the name, address, and TIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such health benefits plans and,

''(E) such other information as the Secretary may require.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

''(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to

each full-time employee whose name is required to be set forth in such return under subsection (b)(2)(D) a written statement showing—

"(A) the name and address of the person required to make such return and the phone number of the information contact for such person, and

"(B) the information required to be shown on the return with respect to such individual.

"(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

"(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

"(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

"(2) in the case of an applicable large employer offering a health benefits plan of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required

under this section with the return and statement required to be provided by the issuer under section 6055.

''(e) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of any applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

''(f) DEFINITIONS.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H.''.

(b) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d)(1) of the Internal Revenue Code of 1986 (relating to definitions), as amended by section 1302, is amended by striking ''or'' at the end of clause (xxiii), by striking ''and'' at the end of clause (xxiv) and inserting ''or'', and by inserting after clause (xxiv) the following new clause:

''(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and''.

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking ''or'' at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG) and inserting '', or'' and by inserting after subparagraph (GG) the following new subparagraph:

''(HH) section 6056(c) (relating to statements relating to large employers required to report on health insurance coverage).''.

(c) CONFORMING AMENDMENT.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1302, is amended by adding at the end the following new item:

''Sec. 6056. Large employers required to report on health insurance coverage.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to periods beginning after June 30, 2013.

Subtitle E—Federal Program for Health Care Cooperatives

SEC. 1401. ESTABLISHMENT OF FEDERAL PROGRAM FOR HEALTH CARE COOPERATIVES.

(a) IN GENERAL.—Title XXII of the Social Security Act (as added by section 1001 and amended by sections 1101 and 1201) is amended by adding at the end the following:

"PART D—FEDERAL PROGRAM FOR HEALTH CARE COOPERATIVES

"SEC. 2251. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NONPROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

''(a) ESTABLISHMENT OF PROGRAM.—

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

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

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

''(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the awarding to persons applying to become qualified nonprofit health insurance issuers of—

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

''(B) grants to provide assistance to such person in meeting any solvency requirements of

States in which the person seeks to be licensed to issue qualified health benefits plans.

''(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—

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

''(i) take into account the recommendations of the advisory board established under paragraph (3);

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

''(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that nothing in this clause shall prohibit the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

''(B) STATES WITHOUT ISSUERS IN PROGRAM.—If no health insurance issuer applies to

be a qualified nonprofit health insurance issuer within a State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

''(C) AGREEMENT.—

''(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet)—

''(I) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

''(II) any requirements contained in the agreement for such person to receive such loan or grant.

''(ii) RESTRICTIONS ON USE OF FEDERAL FUNDS.—The agreement shall include a requirement that no portion of the

funds made available by any loan or grant under this section may be used—

"(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

"(II) for marketing.

Nothing in this clause shall be construed to allow a person to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

"(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time of when the person first knows (or reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

"(I) 110 percent of the aggregate amount of loans and grants received under this section; plus

"(II) interest on the aggregate amount of loans and grants received

under this section for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer's tax-exempt status under section 501(c)(29) of such Code.

''(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than January 1, 2012, award the loans and grants under the CO-OP program and begin the distribution of amounts awarded under such loans and grants.

''(3) ADVISORY BOARD.—

''(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2).

''(B) RULES RELATING TO APPOINTMENTS.—

''(i) STANDARDS.—Any individual appointed under subparagraph (A) shall meet ethics and conflict of interest standards

protecting against insurance industry involvement and interference.

''(ii) ORIGINAL APPOINTMENTS.—The original appointment of board members under subparagraph (A)(ii) shall be made no later than 3 months after the date of enactment of this title.

''(C) VACANCY.—Any vacancy on the advisory board shall be filled in the same manner as the original appointment.

''(D) PAY AND REIMBURSEMENT.—

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

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

''(E) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall

apply to the advisory board, except that section 14 of such Act shall not apply.

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

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

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

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

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

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

''(2) CERTAIN ORGANIZATIONS PROHIBITED.—An organization shall not be treated as a qualified nonprofit health insurance issuer if—

''(A) the organization or a related entity (or any predecessor of either) was a health insurance issuer on July 16, 2009; or

''(B) the organization is sponsored by a State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision.

''(3) GOVERNANCE REQUIREMENTS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless—

''(A) the governance of the organization is subject to a majority vote of its members;

''(B) its governing documents incorporate ethics and conflict of interest standards protecting against insurance industry involvement and interference; and

''(C) as provided in regulations promulgated by the Secretary, the organization is required to operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

''(4) PROFITS INURE TO BENEFIT OF MEMBERS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless any profits made by the organization are required to

be used to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members.

''(5) COMPLIANCE WITH STATE INSURANCE LAWS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements that other offerors of qualified health benefits are required to meet in any State where the issuer offers a qualified health benefits plan, including solvency and licensure requirements, rules on payments to providers, and compliance with network adequacy rules, rate and form filing rules, and any applicable State premium assessments.

''(6) COORDINATION WITH STATE INSURANCE REFORMS.—An organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization does not offer a health benefits plan in a State until that State has in effect the Model Regulation, Federal standard, or State law described in section 2225(a)(2).

''(d) ESTABLISHMENT OF PRIVATE PURCHASING COUNCIL.—

''(1) IN GENERAL.—Qualified nonprofit health insurance issuers participating in the CO-OP pro-

gram under this section may establish a private purchasing council to enter into collective purchasing arrangements for items and services that increase administrative and other cost efficiencies, including claims administration, administrative services, health information technology, and actuarial services.

''(2) COUNCIL MAY NOT SET PAYMENT RATES.—The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

''(3) CONTINUED APPLICATION OF ANTITRUST LAWS.—

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

''(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term 'antitrust laws' has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the

Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

''(e) LIMITATION ON PARTICIPATION.—No representative of any Federal, State, or local government (or of any political subdivision or instrumentality thereof), and no representative of a person described in subsection (c)(2)(A), may serve on the board of directors of a qualified nonprofit health insurance issuer or with a private purchasing council established under subsection (d).

''(f) LIMITATIONS ON SECRETARY.—

''(1) IN GENERAL.—The Secretary shall not—

''(A) participate in any negotiations between 1 or more qualified nonprofit health insurance issuers (or a private purchasing council established under subsection (d)) and any health care facilities or providers, including any drug manufacturer, pharmacy, or hospital; and

''(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuers.

''(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing

health benefits through qualified nonprofit health insurance issuers.

''(g) STATE.—For purposes of this section, the term 'State' means each of the 50 States and the District of Columbia.

''(h) APPROPRIATIONS.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.''.

(b) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following:

''(29) CO-OP HEALTH INSURANCE ISSUERS.—

''(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 2251 of the Social Security Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

''(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

''(i) the organization has given notice to the Secretary, in such manner as the Secretary may by regulations prescribe, that it is applying for recognition of its status under this paragraph,

''(ii) except as provided in section 2251(c)(4) of the Social Security Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

''(iii) no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

''(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.''.

(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns by

exempt organizations) is amended by redesignating subsection (m) as subsection (n) and by inserting after subsection (l) the following:

''(m) ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

''(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health benefits plans.

''(2) The amount of reserves on hand.''.

(3) APPLICATION OF TAX ON EXCESS BENEFIT TRANSACTIONS.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by striking ''paragraph (3) or (4)'' and inserting ''paragraph (3), (4), or (29)''.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an anal-

ysis of new offerors of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year (beginning with 2014), report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in the health insurance market.

Subtitle F—Transparency and Accountability

SEC. 1501. PROVISIONS ENSURING TRANSPARENCY AND ACCOUNTABILITY.

(a) IN GENERAL.—Title XXII of the Social Security Act, as added by subtitle A, is amended by adding at the end of subpart 4 of part A the following new section:

"SEC. 2229. REQUIREMENTS RELATING TO TRANSPARENCY AND ACCOUNTABILITY.

''(a) OMBUDSMEN.—Each State shall establish an ombudsmen program to address complaints related to health benefits plans issued within the State. Such program shall—

''(1) require each offeror of a health benefits plan within a State to provide an internal claims appeal process meeting the requirements of section 2226(e); and

''(2) authorize an individual covered by such a health benefits plan to have access to the services of an ombudsman—

''(A) if such an internal appeal lasts more than 3 months or involves a life threatening issue; or

''(B) to resolve problems with obtaining premium credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 2247.

''(b) HEALTH INSURANCE CONSUMER ASSISTANCE GRANTS.—

''(1) IN GENERAL.—Each State shall establish a program to provide grants to eligible entities to develop, support, and evaluate consumer assistance programs related to navigating options for health benefits plan coverage and selecting the appropriate health benefits plan coverage. Such program shall include a fair and open application process and shall attempt to ensure regional and geographic equity.

''(2) DATA COLLECTION.—As a condition of receiving a grant under paragraph (1), an organization shall be required to collect and report data to the Secretary on the types of problems and inquiries encountered by consumers served by the consumer assistance programs.

''(3) FUNDING.—

''(A) INITIAL FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the fiscal year 2014 to carry out this subsection. Such amount shall remain available without fiscal year limitation.

''(B) AUTHORIZATION FOR SUBSEQUENT YEARS.—There are authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in subparagraph (A) such sums as may be necessary to carry out this subsection.

''(4) ELIGIBLE ENTITIES.—In this section, the term 'eligible entity' means any public, private, or not-for-profit consumer assistance organizations. Such term includes—

''(A) any commercial fishing organization, any ranching or farming organization, or any

other organization capable of conducting community-based health care outreach and enrollment assistance for workers who are hard to reach or employed in rural areas; and

''(B) any Small Business Development Center that is capable of assisting small businesses in getting access to health benefits plans.''.

(b) CONFORMING AMENDMENT.—The table of sections for subpart 4 of part A of title XXII of the Social Security Act, as added by subtitle A, is amended by adding at the end the following new item:

''Sec. 2229. Requirements relating to transparency and accountability.''.

SEC. 1502. REPORTING ON UTILIZATION OF PREMIUM DOLLARS AND STANDARD HOSPITAL CHARGES.

(a) UTILIZATION OF PREMIUM DOLLARS.—

(1) IN GENERAL.—Each offeror of a health benefits plan offering health insurance coverage within the United States shall, with respect to each plan year beginning after December 31, 2009, report to the Secretary of Health and Human Services the percentage of the premiums collected for such coverage that are used to pay for items other than medical care.

(2) SECRETARIAL AUTHORITY.—An offeror shall make the report under paragraph (1) at such

time and in such manner as the Secretary of Health and Human Services may prescribe by regulations.

(b) STANDARD HOSPITAL CHARGES.—Each hospital operating within the United States shall for each calendar year after 2009 establish (and update) a list of the hospital's standard charges for items and services provided by the hospital, including for each diagnosis-related group established under section 1886(d)(4) of the Social Security Act (42 U.S.C. 1395ww).

SEC. 1503. DEVELOPMENT AND UTILIZATION OF UNIFORM OUTLINE OF COVERAGE DOCUMENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall request the National Association of Insurance Commissioners (referred to, in this section as the ''NAIC'') to develop, and submit to the Secretary not later than 12 months after the date of enactment of this Act, standards for use by health insurance issuers in compiling and providing to enrollees an outline of coverage that accurately describes the coverage under the applicable health insurance plan. In developing such standards, the NAIC shall consult with a working group composed of representatives of consumer advocacy organizations, issuers of health insurance plans, and other qualified individuals.

(b) REQUIREMENTS.—The standards for the outline of coverage developed under subsection (a) shall provide for the following:

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

(2) LANGUAGE.—The standards shall ensure that the language used is presented in a manner determined to be understandable by the average health plan enrollee.

(3) CONTENTS.—The standards shall ensure that the outline of coverage includes—

(A) the uniform definitions of standard insurance terms developed under section 1504;

(B) a description of the coverage, including dollar amounts for coverage of—

(i) daily hospital room and board;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) physician services;

(vi) prevention and wellness services;

(vii) prescription drugs; and

(viii) other benefits, as identified by the NAIC;

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

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

(E) the renewability and continuation of coverage provisions;

(F) a statement that the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions; and

(G) a contact number for the consumer to call with additional questions and a web link where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

For individual policies issued prior to January 1, 2014, the health insurance issuer will be deemed compliant with the web link requirement if the issuer makes a copy of the actual policy available upon request.

(c) REGULATIONS.—

(1) SUBMISSION.—If, not later than 12 months after the date of enactment of this Act, the NAIC submits to the Secretary of Health and Human Service the standards provided for under subsection (a), the Secretary shall, not later than 60 days after the date on which such standards are submitted, promulgate regulations to apply such standards to entities described in subsection (d)(3).

(2) FAILURE TO SUBMIT.—If the NAIC fails to submit to the Secretary the standards under subsection (a) within the 12-month period provided for in paragraph (1), the Secretary shall, not later than 90 days after the expiration of such 12-month period, promulgate regulations providing for the application of Federal standards for outlines of coverage to entities described in subsection (d)(3).

(d) REQUIREMENT TO PROVIDE.—

(1) IN GENERAL.—Not later than 24 months after the date of enactment of this Act, each entity described in paragraph (3) shall deliver an outline of coverage pursuant to the standards promulgated by the Secretary under subsection (c) to—

(A) an applicant at the time of application;

(B) an enrollee at the time of enrollment; or

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

(2) COMPLIANCE.—An entity described in paragraph (3) is deemed in compliance with this section if the outline of coverage is provided in paper or electronic form.

(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

(A) a health insurance issuer (including a group health plan) offering health insurance coverage within the United States (including carriers under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code); and

(B) the Secretary with respect to coverage under the Medicare, Medicaid, and CHIP programs under titles XVIII, XIX, and XXI of the Social Security Act (42 U.S.C. 1395, 1396, 1397aa et seq.).

(e) PREEMPTION.—The standards promulgated under subsection (c) shall preempt any related State standards that require an outline of coverage.

(f) FAILURE TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the infor-

mation required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

(g) DEFINITIONS.—For purposes of this section, any term used in this section that is also used in title XXII of the Social Security Act shall have the same meaning as when used in such title.

SEC. 1504. DEVELOPMENT OF STANDARD DEFINITIONS, PERSONAL SCENARIOS, AND ANNUAL PERSONALIZED STATEMENTS.

(a) DEFINING INSURANCE TERMS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall, by regulations, provide for the development of standards for the definitions of terms used in health insurance coverage, including insurance-related terms (including the insurance-related terms described in paragraph (2)) and medical terms (including the medical terms described in paragraph (3)).

(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network co-payments, UCR (usual,

customary and reasonable) fees, excluded services, grievance and appeals, and such other terms as the Secretary determines are important to define so that consumers may compare health insurance coverage and understand the terms of their coverage.

(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, hospital outpatient care, emergency room care, physician services, prescription drug coverage, durable medical equipment, home health care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by insurance health insurance and understand the extent of those medical benefits (or exceptions to those benefits).

(b) COVERAGE FACTS LABELS FOR PATIENT CLAIMS SCENARIOS.—The Secretary of Health and Human Services shall, by regulations, develop standards for coverage facts labels based on patient claims scenarios described in the regulations, which include information on estimated out-of-pocket cost-sharing and significant exclusions or benefit limits for such scenarios.

(c) PERSONALIZED STATEMENT.—The Secretary of Health and Human Services shall, by regulations, develop standards for an annual personalized statement that summarizes use of health care services and payment of claims with respect to an enrollee (and covered dependents) under health insurance coverage in the preceding year.

Subtitle G—Role of Public Programs

PART I—MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS

SEC. 1601. MEDICAID COVERAGE FOR THE LOWEST INCOME POPULATIONS.

(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—

(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) by striking ''or'' at the end of subclause (VI);

(B) by adding ''or'' at the end of subclause (VII); and

(C) by inserting after subclause (VII) the following:

''(VIII) beginning January 1, 2014, who are under 65 years of age,

not pregnant, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, subject to subsection (k);''.

(2) COVERAGE OF, AT A MINIMUM, ESSENTIAL BENEFITS; INDIVIDUALS WITH INCOME EXCEEDING 100, BUT LESS THAN 133 PERCENT OF THE POVERTY LINE MAY ELECT SUBSIDIZED EXCHANGE COVERAGE INSTEAD OF MEDICAID.—Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (j) the following:

''(k)(1) The medical assistance provided to an individual described in subclause (VIII) of subsection (a)(10)(A)(i) shall consist of benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2). Such medical assistance shall be provided subject to the requirements of section 1937, without regard to whether a State otherwise has elected the option to provide medical assistance through coverage under that section, unless an individual described in subclause (VIII) of subsection (a)(10)(A)(i)

is also an individual for whom, under subparagraph (B) of section 1937(a)(2), the State may not require enrollment in benchmark coverage described in subsection (b)(1) of section 1937 or benchmark equivalent coverage described in subsection (b)(2) of that section, or the individual is a non-pregnant, non-elderly adult whose income exceeds 100, but does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved, who has elected under section 1943(c) to enroll in a qualified health benefits plan through an exchange established by the State under section 2235.''.

(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(A) in subsection (b), in the first sentence, by inserting ''subsection (y) and'' before ''section 1933(d)''; and

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

''(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—

''(1) AMOUNT OF INCREASE.—

''(A) INITIAL EXPANSION PERIOD.—

"(i) IN GENERAL.—During the period that begins on January 1, 2014, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraphs (C) and (D) and section 1902(gg)(5), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by the applicable percentage point increase specified in clause (ii) for the quarter and the State.

"(ii) APPLICABLE PERCENTAGE POINT INCREASE.—

"(I) IN GENERAL.—For purposes of clause (i), the applicable percentage point increase for a quarter is the following:

"For any fiscal year quarter occurring in the calendar year:	If the State is an expansion State, the applicable percentage point increase is:	If the State is not an expansion State, the applicable percentage point increase is:
2014	27.3	37.3
2015	28.3	36.3
2016	29.3	35.3
2017	30.3	34.3
2018	31.3	33.3

"(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is an expansion State if, on the date of the enactment of the America's Healthy Future Act of 2009, the State offers health benefits coverage to parents and nonpregnant, childless adults whose income is at least 100 percent of the poverty line, that is not dependent on access to employer coverage or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) purchased through a health savings account (as defined under section 223(d) of such Code), or alternative benefits under a

demonstration program authorized under section 1938. A State that offers health benefits coverage to only parents or only nonpregnant childless adults described in the preceding sentence shall not be considered to be an expansion State.

''(B) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (C), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be increased by 32.3 percentage points.

''(C) LIMITATION.—The Federal medical assistance percentage determined for a State under subparagraph (A) or (B) shall in no case be more than 95 percent.

''(D) HIGH-NEED STATES.—Notwithstanding subparagraph (A), in the case of a high-need State, during the period that begins

on January 1, 2014, and ends on December 31, 2018, the Federal medical assistance percentage determined for each fiscal year quarter occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall be equal to 100 percent. For purposes of the preceding sentence, the term 'high-need State' means a State that is one of the 50 States or the District of Columbia, on the date of the enactment of the America's Healthy Future Act of 2009, has a total Medicaid enrollment under the State plan under this title and under any waiver of the plan that is below the national average for Medicaid enrollment as a percentage of State population, and for August 2009, has a seasonally-adjusted unemployment rate that is at least 12 percent, as determined by the Bureau of Labor Statistics of the Department of Labor.

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

''(A) NEWLY ELIGIBLE.—The term 'newly eligible' means, with respect to an individual described in subclause (VIII) of section

1902(a)(10)(A)(i), an individual who is not under 19 years of age (or such higher age as the State may have elected under section 1902(l)(1)(D)) and who, on the date of enactment of the America's Healthy Future Act of 2009, is not eligible under the State plan or under a waiver of the plan for full benefits or for benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2) that has an aggregate actuarial value that is at least actuarially equivalent to benchmark coverage described in subparagraph (A), (B), or (C) of section 1937(b)(1), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

''(B) FULL BENEFITS.—The term 'full benefits' means, with respect to an individual, medical assistance for all services covered under the State plan under this title that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent,

to the medical assistance available for an individual described in section 1902(a)(10)(A)(i).''.

(4) STATE OPTION TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN REQUIRED TO HAVE COVERAGE FOR PARENTS TO BE ELIGIBLE.—Subsection (k) of section 1902 of the Social Security Act (as added by paragraph (2)), is amended by inserting after paragraph (1) the following:

''(2) A State may elect through a State plan amendment to provide medical assistance to individuals described in subclause (VIII) of subsection (a)(10)(A)(i) beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014. A State may elect to phase-in the extension of eligibility for medical assistance to such individuals based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

''(3) If the State has elected the option to provide for a period of presumptive eligibility under section 1920 or 1920A, the State may elect to provide for a period of presumptive eligibility for medical assistance (not to exceed 60 days) for individuals described in subclause (VIII)

of subsection (a)(10)(A)(i) in the same manner as the State provides for such a period under that section, subject to such guidance as the Secretary shall establish.

''(4) If an individual described in subclause (VIII) of subsection (a)(10)(A)(i) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected under section 1902(l)(1)(D)) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes an individual treated as a caretaker relative for purposes of carrying out section 1931 and a noncustodial parent.''.

(5) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G), by striking ''and (XIV)'' and inserting ''(XIV)'' and by inserting ''and (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1)'' before the semicolon.

(B) Section 1902(l)(2)(C) of such Act (42 U.S.C. 1396a(l)(2)(C)) is amended by striking ''100'' and inserting ''133''.

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xii);

(ii) by inserting ''or'' at the end of clause (xiii); and

(iii) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(a)(10)(A)(i)(VIII),''.

(D) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(i)(VIII),'' after ''1902(a)(10)(A)(i)(VII),''.

(E) Section 1937(a)(1)(B) of such Act (42 U.S.C. 1396u–7(a)(1)(B)) is amended by inserting ''subclause (VIII) of section 1902(a)(10)(A)(i) or under'' after ''eligible under''.

(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (72);

(B) by striking the period at the end of paragraph (73) and inserting ''; and''; and

(C) by inserting after paragraph (73) the following new paragraph:

''(74) provide for maintenance of effort under the State plan or under any waiver of the plan in accordance with subsection (gg).''; and

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

''(gg) MAINTENANCE OF EFFORT.—

''(1) GENERAL REQUIREMENT TO MAINTAIN ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to the succeeding paragraphs of this subsection, during the period that begins on the date of enactment of the America's Healthy Future Act of 2009 and ends on the date on which the Secretary determines that an exchange established by the State under section 2235 is fully operational, as a condition for receiving any Federal

payments under section 1903(a) for calendar quarters occurring during such period, a State shall not have in effect eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under the plan or waiver that are in effect on the date of enactment of the America's Healthy Future Act of 2009.

''(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR ADULTS WITH INCOME AT OR BELOW 133 PERCENT OF POVERTY UNTIL JANUARY 1, 2014.—The requirement under paragraph (1) shall continue to apply to a State through December 31, 2013, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of adults whose income does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)).

''(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—The requirement under paragraph (1) shall continue to

apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19 years of age (or such higher age as the State may have elected under section 1902(l)(1)(D)).

''(4) NONAPPLICATION.—During the period that begins on January 1, 2011, and ends on December 31, 2013, the requirement under paragraph (1) shall not apply to a State with respect to nonpregnant, nondisabled adults who are eligible for medical assistance under the State plan or under a waiver of the plan at the option of the State and whose income exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved if, on or after December 31, 2010, the State certifies to the Secretary that, with respect to the State fiscal year during which the certification is made, the State has a budget deficit, or with respect to the succeeding State fiscal year, the State is projected to have a budget deficit. Upon submission of such a certification to the Secretary, the requirement under paragraph (1) shall

not apply to the State with respect to any remaining portion of the period described in the preceding sentence.

''(5) ADDITIONAL FEDERAL FINANCIAL PARTICIPATION.—

''(A) IN GENERAL.—During the period that begins on October 1, 2013, and ends on September 30, 2019, notwithstanding section 1905(b), the Federal medical assistance percentage otherwise determined for a State under such section with respect to a fiscal year for amounts expended for medical assistance for individuals who are not newly eligible (as defined in section 1905(y)(2)(A)) individuals described in subclause (VIII) of section 1902(a)(10)(A)(i), shall—

''(i) in the case of a State that is one of the 50 States or the District of Columbia, be increased by 0.15 percentage point; and

''(ii) in the case of any other State, be increased by 0.075 percentage point.

''(B) SCOPE OF APPLICATION.—The increase in the Federal medical assistance percentage for a State under subparagraph (A)

shall apply only for purposes of this title and shall not apply with respect to—

"(i) disproportionate share hospital payments described in section 1923;

"(ii) payments under title IV;

"(iii) payments under title XXI; and

"(iv) payments under this title that are based on the enhanced FMAP described in section 2105(b).

"(6) DETERMINATION OF COMPLIANCE.—

"(A) STATES SHALL APPLY MODIFIED GROSS INCOME.—A State's determination of income in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the America's Healthy Future Act of 2009 for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAIVERED POPULATIONS INTO COVERAGE UNDER THE STATE PLAN.—With respect to any

period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures under the State plan under this title or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the America's Healthy Future Act of 2009, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan amendment with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (VIII) of section 1902(a)(10)(A)(i), shall not be considered to have in effect eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the America's Healthy Future Act of 2009 for purposes of determining

compliance with the requirements of paragraph (1), (2), or (3).''.

(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST ESSENTIAL BENEFITS.—Section 1937(b) of such Act (42 U.S.C. 1396u–7(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6),'' before ''each'';

(2) in paragraph (2)—

(A) in the mater preceding subparagraph (A), by inserting ''subject to paragraphs (5) and (6)'' after ''subsection (a)(1),'';

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (v) and (vi), respectively; and

(ii) by inserting after clause (iii), the following:

''(IV) Coverage of prescription drugs.''; and

(C) in subparagraph (C)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii) and (iv) as clauses (i) and (ii), respectively; and

(3) by adding at the end the following new paragraphs:

''(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential benefits described in section 2242 (as defined and specified annually by the Secretary in accordance with subsection (e) of that section).

''(6) MENTAL HEALTH SERVICES PARITY.—

''(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.

''(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described

in section 1905(a)(4)(B) and covered under the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with section 1902(a)(43), shall be deemed to satisfy the requirements of subparagraph (A).''.

(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking ''and'' at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting ''; and''; and

(C) by inserting after paragraph (74) the following new paragraph:

''(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

''(A) the total number of newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on Sep-

tember 30 of the preceding calendar year, disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require; and

''(B) a description of the outreach and enrollment processes used by the State during such fiscal year.''.

(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a national and State-by-State basis, and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WITH INCOME THAT EXCEEDS 133 PERCENT OF THE POVERTY LINE.—

(1) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)—

(i) in subclause (XVIII), by striking ''or'' at the end;

(ii) in subclause (XIX), by adding ''or'' at the end; and

(iii) by adding at the end the following new subclause:

''(XX) beginning January 1, 2014, who are under 65 years of age and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh);'' and

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

''(hh)(1) A State may elect to phase-in the extension of eligibility for medical assistance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on income, so long as the State does not extend such eligibility to individuals described in such subclause with higher income before making individuals described in such subclause with lower income eligible for medical assistance.

''(2) If the State has elected the option to provide for a period of presumptive eligibility under section 1920 or 1920A, the State may elect to provide for a period of presumptive eligibility for medical assistance (not to exceed 60 days) for individuals described in subclause (XX) of subsection (a)(10)(A)(ii) in the same manner as the State provides for such a period under that section, subject to such guidance as the Secretary shall establish.

''(3) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or such higher age as the State may have elected under section 1902(l)(1)(D)) who is eligible for medical assistance under the State plan or under a waiver of such plan, the individual may not be enrolled under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term 'parent' includes

an individual treated as a caretaker relative for purposes of carrying out section 1931 and a noncustodial parent.''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by subsection (a)(5)(C), is amended in the matter preceding paragraph (1)—

(i) by striking ''or'' at the end of clause (xiii);

(ii) by inserting ''or'' at the end of clause (xiv); and

(iii) by inserting after clause (xiv) the following:

''(xv) individuals described in section 1902(a)(10)(A)(ii)(XX),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ''1902(a)(10)(A)(ii)(XX),'' after ''1902(a)(10)(A)(ii)(XIX),''.

SEC. 1602. INCOME ELIGIBILITY FOR NONELDERLY DETERMINED USING MODIFIED GROSS INCOME.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

"(14) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

"(A) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), the modified gross income of an individual or family, as determined for purposes of allowing a premium credit assistance amount for the purchase of a qualified health benefits plan under section 36B of the Internal Revenue Code of 1986, shall be used for purposes of determining income eligibility for medical assistance under the State plan and under any waiver of such plan, and for any other purpose applicable under the plan or waiver for which a determination of income is required, including imposition of premiums and cost-sharing.

"(B) NO INCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State in determining the modified gross income of an individual or family under the State plan or under a waiver of the plan.

"(C) NO ASSETS TEST.—A State shall not apply any assets or resources test for purposes

of determining the eligibility for medical assistance under the State plan or under a waiver of the plan of an individual or family.

''(D) EXCEPTIONS.—

''(i) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER AID OR ASSISTANCE, ELDERLY INDIVIDUALS, MEDICALLY NEEDY INDIVIDUALS, INDIVIDUALS ELIGIBLE FOR MEDICARE COST-SHARING, AND OPTIONAL TARGETED LOW-INCOME CHILDREN.—Subparagraphs (A), (B), and (C) shall not apply to the determination of eligibility under the State plan or under a waiver for medical assistance for the following:

''(I) Individuals who are eligible for medical assistance under the State plan or under a waiver of the plan on a basis that does not require a determination of income by the State agency administering the State plan or waiver, including as a result of eligibility for, or receipt of, other Federal or State aid or assistance, individuals who are eligible on the basis of receiving (or being treated as if receiving)

supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State.

''(II) Individuals who have attained age 65 or who are title II disability beneficiaries (as defined in section 1148(k)(3)).

''(III) Individuals described in subsection (a)(10)(C).

''(IV) Individuals described in any clause of subsection (a)(10)(E).

''(V) Optional targeted low-income children described in section 1905(u)(2)(B).

''(ii) EXPRESS LANE AGENCY FINDINGS.—In the case of a State that elects the Express Lane option under paragraph (13), notwithstanding subparagraphs (A), (B), and (C), the State may rely on a finding made by an Express Lane agency in accordance with that paragraph relating to the income of an individual for purposes of

determining the individual's eligibility for medical assistance under the State plan or under a waiver of the plan.

''(iii) MEDICARE PRESCRIPTION DRUG SUBSIDIES DETERMINATIONS.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility for premium and cost-sharing subsidies under and in accordance with section 1860D–14 made by the State pursuant to section 1935(a)(2).

''(iv) LONG-TERM CARE.—Subparagraphs (A), (B), and (C) shall not apply to any determinations of eligibility of individuals for purposes of medical assistance for services described in section 1917(c)(1)(C).

''(v) GRANDFATHER OF CURRENT ENROLLEES UNTIL DATE OF NEXT REGULAR REDETERMINATION.—An individual who, on July 1, 2013, is enrolled in the State plan or under a waiver of the plan and who would be determined ineligible for medical assistance solely because of the application of the modified gross income standard described in subparagraph (A), shall remain

eligible for medical assistance under the State plan or waiver (and subject to the same premiums and cost-sharing as applied to the individual on that date) through March 31, 2014, or the date on which the individual's next regularly scheduled redetermination of eligibility is to occur, whichever is later.

"(E) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B)) under the State plan or under a waiver of the plan and under title XVIII and individuals who require the level of care provided in a hospital, a nursing facility, or an intermediate care facility for the mentally retarded.".

(b) CONFORMING AMENDMENT.—Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by inserting "(e)(14)," before "(l)(3)".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) take effect on July 1, 2013.

SEC. 1603. REQUIREMENT TO OFFER PREMIUM ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE.

(a) IN GENERAL.—Section 1906A of such Act (42 U.S.C. 1396e–1) is amended—

(1) in subsection (a)—

(A) by striking ''may elect to'' and inserting ''shall'';

(B) by striking ''under age 19''; and

(C) by inserting '', in the case of an individual under age 19,'' after ''(and'';

(2) in subsection (c), in the first sentence, by striking ''under age 19''; and

(3) in subsection (d)(2)—

(A) in the first sentence, by striking ''under age 19''; and

(B) by striking the third sentence and inserting ''A State may not require, as a condition of an individual (or the individual's parent) being or remaining eligible for medical assistance under this title, that the individual (or the individual's parent) apply for enrollment in qualified employer-sponsored coverage under this section.''.

(b) CONFORMING AMENDMENT.—The heading for section 1906A of such Act (42 U.S.C. 1396e–1) is amended by striking ''OPTION FOR CHILDREN''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on July 1, 2013.

SEC. 1604. PAYMENTS TO TERRITORIES.

(a) INCREASE IN LIMIT ON PAYMENTS.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking ''paragraph (3)'' and inserting ''paragraphs (3) and (5)'';

(2) in paragraph (4), by striking ''and (3)'' and inserting ''(3), and (4)''; and

(3) by adding at the end the following paragraph:

''(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 30 percent.''.

(b) DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1108(g)(4) of such Act (42 U.S.C. 1308(g)) is amended—

(1) by striking ''to fiscal years beginning'' and inserting ''to—

''(A) fiscal years beginning'';

(2) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following:

''(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa on the basis of the Federal medical assistance percentage as increased under section 1902(gg)(5), and payments made with respect to amounts expended for medical assistance for newly eligible (as defined in section 1905(y)(2)) nonpregnant childless adults who are eligible under subclause (VIII) of section 1902(a)(10)(A)(i) and whose income (as determined under section 1902(e)(14)) does not exceed (in the case of each such commonwealth and territory respectively) the income eligibility level in effect for that population under title XIX or under a

waiver on the date of enactment of the America's Healthy Future Act of 2009, shall not be taken into account in applying subsection (f) (as increased in accordance with paragraphs (1), (2), (3), and (5) of this subsection) to such commonwealth or territory for such fiscal year.''.

(c) INCREASED FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking ''shall be 50 per centum'' and inserting ''shall be 55 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 1605. MEDICAID IMPROVEMENT FUND RESCISSION.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1941 of the Social Security Act (42 U.S.C. 1396w–1) for any of fiscal years 2014 through 2018 that are available for expenditure from the Fund and that are not so obligated as of the date of the enactment of this Act are rescinded.

(b) CONFORMING AMENDMENTS.—Section 1941(b)(1) of the Social Security Act (42 U.S.C. 1396w–1(b)(1)) is amended—

(1) in subparagraph (A), by striking ''$100,000,000'' and inserting ''$0''; and

(2) in subparagraph (B), by striking ''$150,000,000'' and inserting ''$0''.

PART II—CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 1611. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)) is amended by adding at the end the following: ''Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 23 percentage points, but in no case shall exceed 100 percent. The increase in the enhanced FMAP under the preceding sentence shall not apply with respect to determining the payment to a State under subsection (a)(1) for expenditures described in subparagraph (D)(iv), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b).''.

(b) MAINTENANCE OF EFFORT.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397ee(d)) is amended by adding at the end the following:

''(3) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—During the period that begins on the date of enactment of the America's Healthy Future Act of 2009 and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children that are more restrictive than the eligibility standards, methodologies, or procedures, respectively, under such plan (or waiver) as in effect on the date of enactment of that Act. The preceding sentence shall not be construed as preventing a State during such period from—

''(A) applying eligibility standards, methodologies, or procedures for children under the State child health plan or under any waiver of the plan that are less restrictive than the eligibility standards, methodologies, or procedures, respectively, for children under the plan or waiver that are in effect on the date of enactment of such Act; or

''(B) imposing a limitation described in section 2112(b)(7) for a fiscal year in order to limit expenditures under the State child health

plan to those for which Federal financial participation is available under this section for the fiscal year.''.

(c) NO ENROLLMENT BONUS PAYMENTS FOR CHILDREN ENROLLED AFTER FISCAL YEAR 2013.—Section 2105(a)(3)(F)(iii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(F)(iii)) is amended by inserting ''or any children enrolled on or after October 1, 2013'' before the period.

(d) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by adding at the end the following:

''(M) Section 1943(b) (relating to coordination with State health insurance exchanges and the State Medicaid agency).''.

SEC. 1612. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as ''CHIPRA''):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

''(7) ADJUSTMENT OF FISCAL YEARS 2009 AND 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—In the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotments otherwise determined for the State for fiscal years 2009 and 2010 under paragraphs (1) and (2)(A)(i) in order to take into account changes in the projected total Federal payments to the State under this title for such fiscal years that are attributable to the provision of such assistance to such children.''.

(2) Section 605 of CHIPRA is amended by striking ''legal residents'' and insert ''lawfully residing in the United States''.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security

Act (42 U.S.C. 1397ee(a)(3)(ii)), as added by section 104 of CHIPRA, are each amended by striking ", respectively".

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1397ee(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking subclause (IV).

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397e(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking "section 1903(a)(3)(F)" and inserting "section 1903(a)(3)(G)".

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397ii(b)(2)(B)), as added by section 602 of CHIPRA, is amended by striking "the child population growth factor under section 2104(m)(5)(B)" and inserting "a high-performing State under section 2111(b)(3)(B)".

(7) Section 211(a)(1)(B) of CHIPRA is amended—

(A) by striking "is amended" and all that follows through "adding" and inserting "is amended by adding"; and

(B) by redesignating the new subparagraph to be added by such section to section

1903(a)(3) of the Social Security Act as a new subparagraph (H).

(b) ARRA.—Effective as if included in the enactment of section 5006(a) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), the second sentence of section 1916A(a)(1) of the Social Security Act (42 U.S.C. 1396o–1(a)(1)) is amended by striking ''or (i)'' and inserting '', (i), or (j)''.

PART III—ENROLLMENT SIMPLIFICATION

SEC. 1621. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.) is amended by adding at the end the following:

''SEC. 1943. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

''(a) CONDITION FOR PARTICIPATION IN MEDICAID.—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1903(a) for calendar quarters beginning after January 1, 2013, a State shall ensure that the requirements of subsections (b), (c), and (d) are met.

''(b) ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES AND CHIP.—

''(1) IN GENERAL.—A State shall establish procedures for—

''(A) enabling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

''(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an exchange established by the State under section 2235 as being eligible for—

''(i) medical assistance under the State plan or under a waiver of the plan; or

''(ii) child health assistance under the State child health plan under title XXI;

''(C) ensuring that individuals who apply for but are determined to be ineligible for med-

ical assistance under the State plan or a waiver or ineligible for child health assistance under the State child health plan under title XXI, are able to apply for, and be enrolled in, coverage through such an exchange and, if applicable, obtain premium assistance for the purchase of a qualified health benefits plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 2248 of this Act), without having to submit an additional or separate application, and receive information regarding any other assistance or subsidies available for coverage obtained through the exchange;

''(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the 'State Medicaid agency'), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the 'State CHIP agency') and an exchange established by the State under section 2235 utilize a secure electronic interface sufficient to allow for a determination of an individual's eligibility for such medical assistance,

child health assistance, or premium assistance, as appropriate; and

''(E) coordinating, for individuals who are enrolled in the State plan or under a waiver of the plan and who are also enrolled in a qualified health benefits plan offered through such an exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health benefits plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health benefits plan in which they are enrolled.

''(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an exchange established by the State under section 2235 under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health benefits plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 2248 of this Act), so long

as the agreement meets such conditions and requirements as the Secretary of the Treasury may prescribe to reduce administrative costs and the likelihood of eligibility errors and disruptions in coverage.

''(3) STREAMLINED ENROLLMENT SYSTEM.—The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 2239 (relating to streamlined procedures for enrollment through an exchange, Medicaid, and CHIP).

''(4) ENROLLMENT WEBSITE REQUIREMENTS.—The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2013, an Internet website that is linked to any website of an exchange established by the State under section 2235 and to the State CHIP agency (if different from the State Medicaid agency) and allows an individual who is eligible for medical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium credit assistance for the purchase of a qualified health benefits plan under section 36B of the Internal Revenue Code of 1986 to compare the benefits, premiums, and cost-sharing applicable to the individual under the State plan or

waiver with the benefits, premiums, and cost-sharing available to the individual under a qualified health benefits plan offered through such an exchange, including, in the case of a child, the coverage that would be provided for the child through the State plan or waiver with the coverage that would be provided to the child through enrollment in family coverage under that plan and as supplemental coverage by the State under the State plan or waiver.

''(5) CONTINUED NEED FOR ASSESSMENT FOR HOME AND COMMUNITY-BASED SERVICES.—Nothing in paragraph (1) shall limit or modify the requirement that the State assess an individual for purposes of providing home and community-based services under the State plan or under any waiver of such plan for individuals described in subsection (a)(10)(A)(ii)(VI).

''(c) OPTION FOR CERTAIN MEDICAID-ELIGIBLE POPULATIONS TO ELECT SUBSIDIZED EXCHANGE COVERAGE.—

''(1) IN GENERAL.—The State shall establish procedures to ensure that a non-pregnant, non-elderly adult whose income exceeds 100, but does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) who is eligible for med-

ical assistance under the State plan or under a waiver of the plan and who is eligible to receive premium assistance for the purchase of a qualified health benefits plan under section 36B of the Internal Revenue Code of 1986 (and advance payment of the assistance under section 2248 of this Act) is—

''(A) provided with the option to elect to enroll themselves, or if applicable, their family, in such a plan through an exchange established by the State under section 2235 instead of enrolling in the State plan under this title or a waiver of the plan and, in the case of the adult, to waive, as a result of making such an election, receipt of any medical assistance (including medical assistance for premiums and cost-sharing) under the State plan or waiver;

''(B) provided with—

''(i) information, including through the State website established under section 1902(e)(15), comparing the benefits and cost-sharing that would be available under the State plan for the adult, and if applicable, the adult's family, with the benefits and cost-sharing available to the adult, and if applicable, the adult's family, through

qualified health benefits plans offered through such an exchange (including with respect to the various levels of coverage available to the adult or family); and

''(ii) an explanation of the key differences between the benefits and cost-sharing available for the adult, and if applicable, the adult's family, under the State plan or a waiver and the benefits and cost-sharing available to the adult or family through qualified health benefits plans offered through such an exchange for each of the levels of coverage available to the adult or family; and

''(C) if the adult elects to enroll themselves or their family in a plan through such an exchange, provided with assistance in selecting and enrolling in such a plan.

''(2) SUPPLEMENTAL COVERAGE, INCLUDING EPSDT BENEFITS, FOR CHILDREN.—The State shall establish procedures to ensure that any child who is eligible for medical assistance under the State plan or under a waiver who is enrolled in a qualified health benefits plan through such an exchange is provided with supplemental coverage for items and

services for which medical assistance is available under the State plan or waiver and for which benefits are not available under the qualified health benefits plan in which the child is enrolled, including services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43) and medical assistance for premiums and cost-sharing imposed that exceed the amounts permitted under the State plan or waiver and to assure coordination of coverage for the child under the State plan or waiver and under the qualified health benefits plan in which the child is enrolled.

''(3) WAIVER OF RECEIPT OF MEDICAL ASSISTANCE FOR ELECTING ADULTS.—A nonpregnant, nonelderly adult whose income exceeds 100, but does not exceed 133 percent of the poverty line (as defined in section 2110(c)(5)) who elects to enroll in a qualified health benefits plan through an exchange established by the State under section 2235 shall waive, as a result of making such an election, being provided with medical assistance for themself (including medical assistance for premiums and cost-

sharing) under the State plan or waiver while enrolled in the qualified health benefits plan.

''(d) STATE CONTRIBUTION FOR MEDICAID-ELIGIBLE INDIVIDUALS ELECTING COVERAGE THROUGH A STATE EXCHANGE.—

''(1) IN GENERAL.—Each of the 50 States and the District of Columbia shall make an annual payment (beginning with 2014) to the Secretary equal to the sum of the following products determined with respect to each month of the preceding year for each population described in paragraph (2):

''(A) For each such month, the total number of individuals in the population eligible for medical assistance under the State plan or under a waiver of the plan for full benefits (as defined in section 1905(y)(2)(B)) who were enrolled in coverage through an exchange established by the State under section 2235 for any portion of the month.

''(B) Subject to paragraph (3), for each such month, the average cost of providing medical assistance for the population under the State plan or a waiver of the plan for the preceding year.

''(C) For each such month, the State percentage applicable under subsection (b) or (y) of section 1905 to expenditures for providing medical assistance to individuals within the population for that month.

''(2) POPULATIONS DESCRIBED.—The populations described in this paragraph are the following:

''(A) Children.

''(B) Nondisabled, childless adults under age 65.

''(C) Nondisabled adults under age 65 who are parents.

''(D) Disabled, childless adults under age 65.

''(E) Disabled adults under age 65 who are parents.

''(3) AVERAGE COST OF MEDICAL ASSISTANCE FOR CHILDREN.—With respect to children, the average cost of providing medical assistance under the State plan or under a waiver of the plan for the preceding year shall be equal to the average cost of providing children under the State plan or waiver essential benefits described in section 2242 (as defined and specified by the Secretary for that year in accordance with subsection (e) of that section).''.

SEC. 1622. PERMITTING HOSPITALS TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS FOR ALL MEDICAID ELIGIBLE POPULATIONS.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) by striking ''at the option of the State, provide'' and inserting ''provide—

''(A) at the option of the State,'';

(2) by inserting ''and'' after the semicolon; and

(3) by adding at the end the following:

''(B) that any hospital that is a participating provider under the State plan may elect to be a qualified entity for purposes of determining, on the basis of preliminary information, whether any individual is eligible for medical assistance under the State plan or under a waiver of the plan for purposes of providing the individual with medical assistance during a presumptive eligibility period, in the same manner, and subject to the same requirements, as apply to the State options with respect to populations described in section 1920, 1920A, or 1920B (but without regard to whether the State has elected to provide for a presumptive eligibility period under any such sections), subject to such guidance as the Secretary shall establish;''.

(b) CONFORMING AMENDMENT.—Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)v)) is amended—

(1) by striking ''or for'' and inserting ''for''; and

(2) by inserting before the period at the end the following: '', or for medical assistance provided to an individual during a presumptive eligibility period resulting from a determination of presumptive eligibility made by a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose''.

(c) EFFECTIVE DATE.—

(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2014, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the

amendment made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1623. PROMOTING TRANSPARENCY IN THE DEVELOPMENT, IMPLEMENTATION, AND EVALUATION OF MEDICAID AND CHIP WAIVERS AND SECTION 1937 STATE PLAN AMENDMENTS.

(a) WAIVER TRANSPARENCY.—

(1) IN GENERAL.—Section 1115 of the Social Security Act (42 U.S.C. 1315) is amended by inserting after subsection (c) the following:

''(d) In the case of any experimental, pilot, or demonstration project undertaken under subsection (a) to promote the objectives of title XIX or XXI in a State that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing with respect to a State pro-

gram under title XIX or XXI (in this subsection referred to as a 'Medicaid demonstration project' and a 'CHIP demonstration project', respectively,) the following shall apply:

''(1) The Secretary may not approve a proposal for a Medicaid demonstration project, CHIP demonstration project, or a renewal of or an amendment to a previously approved Medicaid demonstration project or CHIP demonstration project unless the State requesting approval certifies that the following process was used to develop the proposal:

''(A) At least 30 days prior to publication of the notice required under subparagraph (C), the State provided notice (which may have been accomplished by electronic mail) of the State's intent to develop the proposal to the medical care advisory committee established for the State for purposes of complying with section 1902(a)(4) and any individual or organization that requests or has requested such notice.

''(B) Subsequent to providing the notice required under subparagraph (A) and prior to the notice required under subparagraph (C), the State convened at least 1 meeting of such medical care advisory committee at which the pro-

posal and any modifications of the proposal were the primary items considered and discussed.

''(C) At least 60 days prior to the date that the State submits the proposal to the Secretary, the State published for written comment (in accordance with the State's procedure for issuing regulations) a notice of the proposal that contained at least the following:

''(i) Information regarding how the public may submit comments to the State on the proposal.

''(ii) A statement of the State's projections regarding the likely effect and impact of the proposal on any individuals who are then eligible for, or receiving, medical assistance, child health assistance, or other health benefits coverage under a State program under title XIX or XXI and the State's assumptions on which such projections are based.

''(iii) A statement of the likely fiscal impact of the proposal, including all relevant calculations, showing how Federal and State spending on the project will

compare to the amount of Federal and State funds that would have been expended had the project not been implemented.

''(D) Concurrent with the publication of the notice required under subparagraph (C), the State—

''(i) posted the proposal (and any modifications of the proposal) on the State's official Medicaid or CHIP Internet website; and

''(ii) provided the notice required under subparagraph (B) (which may have been accomplished by electronic mail) to the medical care advisory committee referred to in subparagraph (A) and to any individual or organization that requested such notice.

''(E) Not later than 30 days after publication of the notice required under subparagraph (C), the State convened at least 1 open meeting of the medical care advisory committee referred to in subparagraph (A), at which the proposal and any modifications of the proposal were the primary items considered and discussed.

"(F) After publication of the notice required under subparagraph (C), the State—

"(i) held at least 2 public hearings on the proposal and any modifications of the proposal; and

"(ii) held the last such public hearing no more than 30 days before the State submitted the proposal to the Secretary.

"(G) The State has a record of all public comments submitted in response to the notice required under subparagraph (B) or at any hearings or meetings required under this paragraph regarding the proposal.

"(2) A State shall include with any proposal submitted to the Secretary for a Medicaid demonstration project, CHIP demonstration project, or a renewal of or an amendment to a previously approved Medicaid demonstration project or CHIP demonstration project, the following:

"(A) A detailed description of the public notice and input process used to develop the proposal in accordance with the requirements of paragraph (1).

"(B) Copies of all notices required under paragraph (1).

''(C) The dates of all meetings and hearings required under paragraph (1).

''(D) A summary of the public comments received in response to the notices required under paragraph (1) or at any hearings or meetings required under that paragraph regarding the proposal and the State's response to the comments.

''(E) A summary of any changes in the proposal that were made in response to the comments.

''(F) A certification that the State complied with any applicable notification requirements with respect to Indian tribes during the development of the proposal in accordance with paragraph (1).

''(3) The Secretary shall return to a State without action any proposal for a Medicaid demonstration project, CHIP demonstration project, or a renewal of or an amendment to a previously approved Medicaid demonstration project or CHIP demonstration project, that fails to demonstrate compliance with the requirements of paragraphs (1) and (2).

''(4) With respect to all proposals for Medicaid demonstration projects, CHIP demonstration

projects, or renewal of or amendments to a previously approved Medicaid or CHIP demonstration project, received by the Secretary the following shall apply:

''(A) On or before the 10th day of each month, the Secretary shall publish a notice in the Federal Register identifying all of the proposals for such demonstration projects or amendments that were received by the Secretary during the preceding month.

''(B) The notice required under subparagraph (A) shall provide information regarding the method by which comments on the proposals will be received from the public.

''(C) Not later than 7 days after receipt of a proposal for a Medicaid demonstration project, CHIP demonstration project, or a renewal of or an amendment to a previously approved Medicaid or CHIP demonstration project, the Secretary shall—

''(i) provide notice (which may be accomplished by electronic mail) to any individual or organization that requests or has requested such notification;

"(ii) publish on the official Internet website of the Centers for Medicare & Medicaid Services a copy of the proposal, including any appendices or modifications of the proposal; and

"(iii) ensure that the information posted on the website is updated at least monthly to accurately reflect the current nature and status of the proposal.

"(D) The Secretary shall provide for a period of not less than 30 days from the later of the date of publication of the notice required under subparagraph (A) that first identifies receipt of the proposal or the date on which an official Internet website containing the information required under subparagraph (C)(ii) with respect to the proposal is first published, in which written comments on the proposal may be submitted from all interested parties.

"(E) After the completion of the public comment period required under subparagraph (D), if the Secretary intends to approve the proposal, as originally submitted or revised, the Secretary shall—

''(i) publish and post on the official Internet website for the Centers for Medicare & Medicaid Services the proposed terms and conditions for such approval and updated versions of the statements required to be published by the State under clauses (ii) and (iii) of paragraph (1)(C);

''(ii) provide at least a 15-day period for the submission of written comments from all interested parties on such proposed terms and conditions and such statements; and

''(iii) retain, and make available upon request, all comments received concerning the proposal, the terms and conditions for approval of the proposal, or the statements required to be published by the State under clauses (ii) and (iii) of paragraph (1)(C).

''(F) In no event may the Secretary approve a proposal for a Medicaid or CHIP demonstration project or renewal of or an amendment to a previously approved Medicaid or CHIP demonstration project unless the Sec-

retary determines that the proposal, renewal, or the amendment—

"(i) is based on a reasonable hypothesis which the Secretary has determined is likely to assist in promoting the objectives of title XIX or XXI; and

"(ii) will be evaluated no less frequently than every 3 years in accordance with paragraph (6).

"(G) Not later than 3 business days after the approval of any proposal for a Medicaid demonstration project, CHIP demonstration project, or renewal of or amendment to a previously approved Medicaid or CHIP demonstration project, the Secretary shall post on the official Internet website for the Centers for Medicare & Medicaid Services the following:

"(i) The text of the approved Medicaid demonstration project, CHIP demonstration project, or renewal of or amendment to a previously approved Medicaid or CHIP demonstration project.

"(ii) A list identifying each provision of title XIX or XXI, and each regulation relating to either such title, for which com-

pliance is waived under the approved demonstration project or amendment and any costs that would otherwise not be permitted that will be allowed under the demonstration project or amendment.

''(iii) The terms and conditions for approval of the demonstration project or amendment.

''(iv) The approval letter.

''(v) The operations protocol for the demonstration project or amendment.

''(vi) The evaluation design for the demonstration project or amendment.

''(vii) Any item required to be posted under this subparagraph that is not available within 3 business days of the approval of the demonstration project or amendment shall be posted as soon as the item becomes available,

''(H) On or before the 10th day of each month the Secretary shall publish a notice in the Federal Register that identifies any proposals for Medicaid demonstration projects, CHIP demonstration projects, or renewal of or amendments to a previously approved Medicaid

or CHIP demonstration project that were approved, denied, or returned to the State without action during the preceding month.

''(I) The Secretary shall post on the official Internet website for the Centers for Medicare and Medicaid Services all quarterly reports submitted by the State (including data on whether the State is meeting its budget neutrality targets), evaluations, and other information the Secretary determines to be appropriate, on Medicaid or CHIP demonstration projects that are operational.

''(5) Any provision under title XIX or XXI, or under any regulation in effect that relates to either such title, that is not explicitly waived by the Secretary and identified in the list required under paragraph (4)(G)(ii) when approving the Medicaid demonstration project, CHIP demonstration project, or renewal of or amendment to any such demonstration project, is not waived and a State shall continue to comply with any such requirement.

''(6)(A) In the case of a proposal for a Medicaid demonstration project or CHIP demonstration project, the Secretary shall, by contract with a qualified research organization described in subparagraph

(B), conduct an independent evaluation consistent with the evaluation criteria described in subparagraph (C) applicable to the individual project.

''(B) A qualified research organization described in this subparagraph is an entity that the Secretary determines—

''(i) has staff with demonstrated expertise regarding Medicaid or CHIP beneficiaries, policies, and data systems (as applicable), and research design and methodology; and

''(ii) does not and did not in the past 24 months, by contract or subcontract, directly or indirectly, receive funds from the State that has proposed the demonstration project.

''(C) The evaluation criteria described in this subparagraph shall include, but not be limited to, the following:

''(i) The use of services by beneficiaries under the project.

''(ii) The amount of out-of-pocket costs for health care services incurred by beneficiaries under the project.

''(iii) The extent to which special populations such as adults with disabilities, adults with chronic illness, and children with special

health care needs are able to access needed health care services.

''(iv) If children are enrolled in the project, the extent to which such children are able to access early and periodic screening, diagnostic, and treatment services described in section 1905(r).

''(v) The level of satisfaction of beneficiaries under the project with respect to the accessibility, quality, and cost of care, including the extent to which beneficiaries under the project understand the choices of health care coverage available to them.

''(vi) The cost of health care services incurred by the State agency administering the project, whether through fee-for-service payments, premium payments, or otherwise.

''(vii) Administrative costs incurred by the State agency administering the project and by any administrative contractors.

''(D) The Secretary shall not approve a proposal for a Medicaid demonstration project or a CHIP demonstration project, or a proposal for the extension of such a demonstration project, unless the State agency proposing to administer the demonstra-

tion project agrees to cooperate fully with the Secretary to the extent necessary to enable the Secretary to conduct the independent evaluation described in subparagraph (B) including collecting, verifying the accuracy of, and submitting to the organization on a timely basis data needed to conduct the independent evaluation.

''(E) The State agency administering the project shall be allowed at least 30 days prior to publication of the independent evaluation to submit comments to the Secretary, and the State agency's comments shall be included in the results of the evaluation.

''(F) The results of all evaluations conducted under this paragraph with respect to a Medicaid demonstration project or CHIP demonstration project shall be submitted to the Committee on Finance of the Senate and the Committee on Energy and Commerce of the House of Representatives not later than 6 months prior to the completion of the initial term of a demonstration project and shall thereafter be posted on the official Internet website of the Centers for Medicare & Medicaid Services.

''(G) Out of any money in the Treasury of the United States not otherwise appropriated, there are

appropriated to the Secretary, $4,500,000 for fiscal year 2010 and each fiscal year thereafter, for the purpose of carrying out the independent evaluations required under this paragraph. Amounts appropriated under this subparagraph for a fiscal year shall remain available until expended.''.

(2) RULE OF CONSTRUCTION.—Nothing in the amendment made by subsection (a) shall be construed to—

(A) authorize the waiver of any provision of title XIX or XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.) that is not otherwise authorized to be waived under such titles or under title XI of such Act (42 U.S.C. 1301 et seq.) as of the date of enactment of this Act; or

(B) imply congressional approval of any experimental, pilot, or demonstration project affecting the Medicaid program under title XIX of the Social Security Act or the Children's health insurance program under title XXI of such Act that has been approved as of such date of enactment.

(b) TRANSPARENCY FOR CERTAIN STATE PLAN AMENDMENTS.—Section 1937 of such Act (42 U.S.C. 1396u–7) is amended by adding at the end the following:

''(d) STATE PLAN AMENDMENT APPROVAL REQUIREMENTS.—In the case of any State plan amendment proposed under subsection (a) that would limit the benefits eligible individuals would receive, the following shall apply:

''(1) The Secretary may not approve a proposal for the amendment unless the State requesting approval certifies that the following process was used to develop the amendment:

''(A) Prior to publication of the notice required under subparagraph (B), the State—

''(i) provided notice (which may have been accomplished by electronic mail) of the State's intent to develop the State plan amendment to the medical care advisory committee established for the State for purposes of complying with section 1902(a)(4) and any individual or organization that requests such notice; and

''(ii) convened at least 1 meeting of such medical care advisory committee at

which the State plan amendment was considered and discussed.

''(B) At least 60 days prior to the date that the State submits the State plan amendment to the Secretary, the State published for written comment (in accordance with the State's procedure for issuing regulations) a notice of the proposal that contains at least the following:

''(i) Information regarding how the public may submit comments to the State on the State plan amendment.

''(ii) A statement of the State's projections regarding the likely effect and impact of the proposal on any individuals who are eligible for, or receiving, medical assistance, under the State program under this title and the State's assumptions on which the projections are based.

''(C) Concurrent with the publication of the notice required under subparagraph (B), the State—

''(i) posted the State plan amendment on the State's official Medicaid or CHIP Internet website; and

"(ii) provided the notice (which may have been accomplished by electronic mail) to the medical care advisory committee referred to in subparagraph (A)(i) and to any individual or organization that requested such notice.

"(D) Not later than 30 days after publication of the notice required under subparagraph (B), the State convened at least 1 open meeting of the medical care advisory committee referred to in subparagraph (A)(i), at which the State plan amendment was considered and discussed.

"(2) A State shall include with any State plan amendment submitted to the Secretary for approval the following:

"(A) A detailed description of the public notice and input process used to develop the State plan amendment in accordance with the requirements of paragraph (1).

"(B) Copies of all notices required under paragraph (1).

"(C) The dates of all meetings required under paragraph (1).

"(D) A certification that the State complied with any applicable notification require-

ments with respect to Indian tribes during the development of the proposal in accordance with paragraph (1).

''(3) The Secretary shall return to a State without action any State plan amendment that fails to satisfy the requirements of paragraphs (1) and (2).

''(4) With respect to all State plan amendments submitted for approval to the Secretary under this section the following shall apply:

''(A) On or before the 10th day of each month the Secretary shall publish a notice in the Federal Register identifying all the State plan amendments submitted for approval during the preceding month.

''(B) The notice required under subparagraph (A) shall provide information regarding the method by which comments on the proposals will be received from the public.

''(C) Not later than 7 days after submission of a State plan amendment for approval the Secretary shall—

''(i) provide notice (which may be accomplished by electronic mail) to any individual or organization that has requested such notification; and

"(ii) publish on the official Internet website of the Centers for Medicare & Medicaid Services a copy of the State plan amendment.

"(D) The Secretary shall provide for a period of not less than 30 days from the later of the date of publication of the notice required under subparagraph (A) that first identifies receipt of the State plan amendment or the date on which an official Internet website containing the information required under subparagraph (C)(ii) with respect to the State plan amendment is first published, in which written comments on the State plan amendment may be submitted from all interested parties.

"(E) On or before the 10th day of each month the Secretary shall publish a notice in the Federal Register that identifies any State plan amendments that were approved, denied, or returned to the State without action during the preceding month.".

(c) EFFECTIVE DATES.—

(1) SECTION 1115 REQUIREMENTS.—Subject to paragraph (2), the amendment made by subsection

(a) shall take effect on the date of enactment of this Act and shall apply to—

(A) any proposal to conduct any experimental, pilot or demonstration project affecting the Medicaid program under title XIX of the Social Security Act or the State Children's Health Insurance Program under title XXI of such Act that is pending on the date of enactment or that is submitted to the Secretary after the date of enactment;

(B) any proposal to extend such a project that is pending on the date of enactment or that is submitted to the Secretary after the date of enactment; and

(C) any proposal to amend such a project that is pending on the date of enactment or that is submitted to the Secretary after the date of enactment.

(2) EVALUATION REQUIREMENTS APPLICABLE TO NEW WAIVERS.—The requirements of section 1115(d)(6) of the Social Security Act (relating to evaluation), as added by subsection (a), shall apply only to a proposal described in paragraph (1)(A) of this subsection.

(3) CERTAIN STATE PLAN AMENDMENTS.—The amendment made by subsection (b) shall take effect on the date of enactment of this Act and shall apply to any State plan amendment for which approval is pending on the date of enactment or that is submitted to the Secretary of Health and Human Services for approval after the date of enactment of this Act.

SEC. 1624. STANDARDS AND BEST PRACTICES TO IMPROVE ENROLLMENT OF VULNERABLE AND UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Not later than April 1, 2011, the Secretary of Health and Human Services shall issue guidance to States regarding standards and best practices for conducting outreach to and enrolling vulnerable and underserved populations eligible for medical assistance under Medicaid under title XIX of the Social Security Act or for child health assistance under CHIP under title XXI of such Act, including children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

(b) REQUIREMENTS.—

(1) IN GENERAL.—The guidance issued under subsection (a) shall—

(A) detail effective ways to inform vulnerable populations about coverage available under Medicaid and CHIP;

(B) identify ways to assist vulnerable populations to enroll in the programs;

(C) identify ways that application and enrollment barriers for such populations can be eliminated; and

(D) address specific methods for outreach and enrollment, including outstationing of eligibility workers, the Express Lane eligibility option, residency requirements, documentation of income and assets, presumptive eligibility, continuous eligibility, and automatic renewal.

(2) DEVELOPMENT AND IMPLEMENTATION.—The Secretary of Health and Human Services may use all available legal authority and shall work with appropriate stakeholders, including representatives of States and children's groups, to ensure that the guidance issued under subsection (a) is developed and implemented effectively.

(3) REPORT TO CONGRESS.—Not later than 2 years after the enactment of this Act and annually

thereafter, the Secretary of Health and Human Services shall review and report to Congress on the progress made by States in implementing the standards and best practices identified in the guidance issued under subsection (a) and increasing the enrollment of vulnerable populations under Medicaid and CHIP.

PART IV—MEDICAID SERVICES

SEC. 1631. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—

(1) in subsection (a)—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(28) freestanding birth center services (as defined in subsection (l)(3)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and''; and

(2) in subsection (l), by adding at the end the following new paragraph:

''(3)(A) The term 'freestanding birth center services' means services furnished to an individual at a freestanding birth center (as defined in subparagraph (B)) at such center.

''(B) The term 'freestanding birth center' means a health facility—

''(i) that is not a hospital;

''(ii) where childbirth is planned to occur away from the pregnant woman's residence;

''(iii) that is licensed or otherwise approved by the State to provide prenatal labor and delivery or postpartum care and other ambulatory services that are included in the plan; and

''(iv) that complies with such other requirements relating to the health and safety of individuals furnished services by the facility as the State shall establish.

''(C) A State shall provide separate payments to providers administering prenatal labor and delivery or postpartum care in a freestanding birth center (as defined in subparagraph (B)), such as nurse midwives and other providers of services such as birth attendants recognized under State law, as determined appropriate by the Sec-

retary. For purposes of the preceding sentence, the term 'birth attendant' means an individual who is recognized or registered by the State involved to provide health care at childbirth and who provides such care within the scope of practice under which the individual is legally authorized to perform such care under State law (or the State regulatory mechanism provided by State law), regardless of whether the individual is under the supervision of, or associated with, a physician or other health care provider. Nothing in this subparagraph shall be construed as changing State law requirements applicable to a birth attendant.''.

(b) CONFORMING AMENDMENT.—Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)), is amended in the matter preceding clause (i) by striking ''and (21)'' and inserting '', (21), and (28)''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to services furnished on or after such date.

(2) EXCEPTION IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical as-

sistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 1632. CONCURRENT CARE FOR CHILDREN.

Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

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

''(C) A voluntary election to have payment made for hospice care for a child (as defined by the State) shall not constitute a waiver of any rights of the child to be provided with, or to have payment made under this title for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made.''.

SEC. 1633. FUNDING TO EXPAND STATE AGING AND DISABILITY RESOURCE CENTERS.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to the Secretary of Health and Human Services, acting through the Assistant Secretary for Aging, $10,000,000 for each of fiscal years 2010 through 2014, to carry out subsections (a)(20)(B)(iii) and (b)(8) of section 202 of the Older Americans Act of 1965 (42 U.S.C. 3012).

SEC. 1634. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

''(k) STATE PLAN OPTION TO PROVIDE HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, during the 5-year period that begins on January 1, 2014, a State may

provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 2110(c)(5)) or, if greater, the income level applicable for an individual who has been determined to require an institutional level of care to be eligible for nursing facility services under the State plan and with respect to whom there has been a determination that, but for the provision of such services, the individuals would require the level of care provided in a hospital, a nursing facility, an intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such home and community-based attendant services and supports, and only if the State meets the following requirements:

"(A) AVAILABILITY.—The State shall make available home and community-based attendant services and supports to eligible individuals, as needed, to assist in accomplishing activities of daily living, instrumental activities

of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

"(i) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to in writing by the individual or, as appropriate, the individual's representative;

"(ii) in a home or community setting, which does not include a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded;

"(iii) under an agency-provider model or other model (as defined in paragraph (6)(C)); and

"(iv) the furnishing of which—

"(I) is selected, managed, and dismissed by the individual, or, as appropriate, with assistance from the individual's representative;

"(II) is controlled, to the maximum extent possible, by the individual or where appropriate, the individual's representative, regardless of

who may act as the employer of record; and

"(III) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).

"(B) INCLUDED SERVICES AND SUPPORTS.—In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health related tasks, the home and community-based attendant services and supports made available include—

"(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and health related tasks;

"(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports; and

"(iii) voluntary training on how to select, manage, and dismiss attendants.

"(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to subparagraph (D), the home and community-based attendant services and supports made available do not include—

"(i) room and board costs for the individual;

"(ii) special education and related services provided under the Individuals with Disabilities Education Act and vocational rehabilitation services provided under the Rehabilitation Act of 1973;

"(iii) assistive technology devices and assistive technology services other than those under (1)(B)(ii);

"(iv) medical supplies and equipment; or

"(v) home modifications.

"(D) PERMISSIBLE SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

"(i) expenditures for transition costs such as rent and utility deposits, first month's rent and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the tran-

sition from a nursing facility, institution for mental diseases, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

''(ii) expenditures relating to a need identified in an individual's person-centered plan of services that increase independence or substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

''(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1903(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year quarter occurring during the period described in paragraph (1), the Federal medical assistance percentage applicable to the State (as determined under sections 1905(b) and 1902(gg)(5)) shall be increased by 6 percentage points.

''(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

''(A) develop and implement such amendment in collaboration with a Development and Implementation Council established by the State that includes a majority of members with disabilities, elderly individuals, and their representatives and consults and collaborates with such individuals;

''(B) provide consumer controlled home and community-based attendant services and supports to individuals on a statewide basis, in a manner that provides such services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of home and community-based attendant services and supports that the individual requires in order to lead an independent life;

''(C) with respect to expenditures during the first full fiscal year in which the State plan amendment is implemented, maintain or exceed the level of State expenditures for medical as-

sistance that is provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding fiscal year;

''(D) establish and maintain a comprehensive, continuous quality assurance system with respect to community- based attendant services and supports that—

''(i) includes standards for agency-based and other delivery models with respect to training, appeals for denials and reconsideration procedures of an individual plan, and other factors as determined by the Secretary;

''(ii) incorporates feedback from consumers and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others and maximizes consumer independence and consumer control;

''(iii) monitors the health and well-being of each individual who receives home and community-based attendant services and supports, including a process for the

mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports; and

"(iv) provides information about the provisions of the quality assurance required under clauses (i) through (iii) to each individual receiving such services; and

"(E) collect and report information, as determined necessary by the Secretary, for the purposes of approving the State plan amendment, providing Federal oversight, and conducting an evaluation under paragraph (5)(A), including data regarding how the State provides home and community-based attendant services and supports and other home and community-based services, the cost of such services and supports, and how the State provides individuals with disabilities who otherwise qualify for institutional care under the State plan or under a waiver the choice to instead receive home and community-based services in lieu of institutional care.

"(4) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the

State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and applicable Federal and State laws regarding—

''(A) withholding and payment of Federal and State income and payroll taxes;

''(B) the provision of unemployment and workers compensation insurance;

''(C) maintenance of general liability insurance; and

''(D) occupational health and safety.

''(5) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS.—

''(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection in order to determine the effectiveness of the provision of such services and supports in allowing the individuals receiving such services and supports to lead an independent life to the maximum extent possible; the impact on the physical and emo-

tional health of the individuals who receive such services; and an comparative analysis of the costs of services provided under the State plan amendment under this subsection and those provided under institutional care in a nursing facility, institution for mental diseases, or an intermediate care facility for the mentally retarded.

''(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:

''(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year.

''(ii) The number of individuals that received such services and supports during the preceding fiscal year.

''(iii) The specific number of individuals served by type of disability, age, gen-

der, education level, and employment status.

''(iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.

''(C) REPORTS.—Not later than—

''(i) December 31, 2017, the Secretary shall submit to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

''(ii) December 31, 2019, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

''(6) DEFINITIONS.—In this subsection:

''(A) ACTIVITIES OF DAILY LIVING.—The term 'activities of daily living' includes tasks such as eating, toileting, grooming, dressing, bathing, and transferring.

''(B) CONSUMER CONTROLLED.—The term 'consumer controlled' means a method of select-

ing and providing services and supports that allow the individual, or where appropriate, the individual's representative, maximum control of the home and community-based attendant services and supports, regardless of who acts as the employer of record.

''(C) DELIVERY MODELS.—

''(i) AGENCY-PROVIDER MODEL.—The term 'agency-provider model' means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

''(ii) OTHER MODELS.—The term 'other models' means, subject to paragraph (4), methods, other than an agency-provider model, for the provision of consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

''(D) HEALTH-RELATED TASKS.—The term 'health-related tasks' means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

''(E) INDIVIDUAL'S REPRESENTATIVE.—The term 'individual's representative' means a parent, family member, guardian, advocate, or other authorized representative of an individual

''(F) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term 'instrumental activities of daily living' includes (but is not limited to) meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communicating by phone or other media, and traveling around and participating in the community.''.

SEC. 1635. PROTECTION FOR RECIPIENTS OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPOUSAL IMPOVERISHMENT.

During the 5-year period that begins on January 1, 2014, section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) shall be applied as though ''is

eligible for medical assistance for home and community-based services provided under subsection (c), (d), or (i) of section 1915, under a waiver approved under section 1115, or who is eligible for such medical assistance by reason of being determined eligible under section 1902(a)(10)(C) or by reason of section 1902(f) or otherwise on the basis of a reduction of income based on costs incurred for medical or other remedial care, or who is eligible for medical assistance for home and community-based attendant services and supports under section 1915(k)'' were substituted in such section for ''(at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI)''.

SEC. 1636. INCENTIVES FOR STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES AS A LONG-TERM CARE ALTERNATIVE TO NURSING HOMES.

(a) STATE BALANCING INCENTIVE PAYMENTS PROGRAM.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), in the case of a balancing incentive payment State, as defined in subsection (b), that meets the conditions described in subsection (c), during the balancing incentive period, the Federal medical assistance percentage determined for the State under section 1905(b) of such Act and increased under section 1902(gg)(5) shall be increased by the applicable percent-

age points determined under subsection (d) with respect to eligible medical assistance expenditures described in subsection (e).

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

(1) in which less than 50 percent of the total expenditures for medical assistance under the State Medicaid program for fiscal year 2009 for long-term services and supports (as defined by the Secretary under subsection (f))(1)) are for non-institutionally-based long-term services and supports described in subsection (f)(1)(B);

(2) that submits an application and meets the conditions described in subsection (c); and

(3) that is selected by the Secretary to participate in the State balancing incentive payment program established under this section.

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

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

(A) a proposed budget that details the State's plan to expand and diversify medical as-

sistance for non-institutionally-based long-term services and supports described in subsection (f)(1)(B) under the State Medicaid program during the balancing incentive period and achieve the target spending percentage applicable to the State under paragraph (2), including through structural changes to how the State furnishes such assistance, such as through the establishment of a ''no wrong door - single entry point system'', optional presumptive eligibility, case management services, and the use of core standardized assessment instruments, and 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; and

(B) in the case of a State that proposes to expand the provision of home and community-based services under its State Medicaid program through a State plan amendment under section 1915(i) of the Social Security Act, at the option of the State, an election to increase the income eligibility for such services from 150 percent of the poverty line to such higher percentage as the State may establish 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.—

(A) In the case of a balancing incentive payment State in which less than 25 percent of the total expenditures for home and community-based services under the State Medicaid program for fiscal year 2009 are for such services, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 25 percent of the total expenditures for home and community-based services under the State Medicaid program are for such services.

(B) In the case of any other balancing incentive payment State, the target spending percentage for the State to achieve by not later than October 1, 2015, is that 50 percent of the total expenditures for home and community-based services under the State Medicaid program are for such 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)(B) under 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)(B) under the State Medicaid program.

(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 statewide system to enable consumers to access all long-term services and supports through an agency, organization, coordinated network, or portal, in accordance with such standards as the State shall establish and that shall provide information regarding the availability of such services,

how to apply for such services, and 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 CASE MANAGEMENT SERVICES.—Conflict-free case management services to develop a service plan, arrange for services and supports, support the beneficiary (and, if appropriate, the beneficiary's caregivers) in directing the provision of services and supports, for the beneficiary, and conduct ongoing monitoring to assure that services and supports are delivered to meet the beneficiary's needs and achieve intended outcomes.

(C) CORE STANDARDIZED ASSESSMENT INSTRUMENTS.—Development of core standardized assessment instruments for determining eligibility for non-institutionally-based long-term services and supports described in subsection (f)(1)(B), which shall be used in a uniform manner throughout the State, to determine a beneficiary's needs for training, support serv-

ices, medical care, transportation, and other services, and develop an individual service plan to address such needs.

(6) DATA COLLECTION.—The State agrees to collect from providers of services and through such other means as the State determines appropriate the following data:

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

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

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

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

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

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

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

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

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

(e) ELIGIBLE MEDICAL ASSISTANCE EXPENDITURES.—

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

payment State under its State Medicaid program during the balancing incentive payment period.

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

(f) DEFINITIONS.—In this section:

(1) LONG-TERM SERVICES AND SUPPORTS DEFINED.—The term ''long-term services and supports'' has the meaning given that term by Secretary and shall include the following (as defined with for purposes of State Medicaid programs under title XIX of the Social Security Act):

(A) INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services provided in an institution, including the following:

(i) Nursing facility services.

(ii) Services in an intermediate care facility for the mentally retarded described in subsection (a)(15) of section 1905 of such Act.

(B) NON-INSTITUTIONALLY-BASED LONG-TERM SERVICES AND SUPPORTS.—Services not

provided in an institution, including the following:

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

(ii) Home health care services.

(iii) Personal care services.

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

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

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

(3) POVERTY LINE.—The term ''poverty line'' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

(4) STATE MEDICAID PROGRAM.—The term ''State Medicaid program'' means the State program for medical assistance provided under a State plan

under title XIX of the Social Security Act and under any waiver approved with respect to such State plan.

SEC. 1636A. REMOVAL OF BARRIERS TO PROVIDING HOME AND COMMUNITY-BASED SERVICES.

(a) OVERSIGHT AND ASSESSMENT OF THE ADMINISTRATION OF HOME AND COMMUNITY-BASED SERVICES.—The Secretary of Health and Human Services shall promulgate regulations to ensure that all States develop service systems that are designed to—

(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports described in section 1936(f)(1)(B) (including such services and supports that are provided under programs other the State Medicaid program), and that provides strategies for beneficiaries receiving such services to maximize their independence;

(2) provide the support and coordination needed for a beneficiary in need of such services (and their family caregivers or representative, if applicable) to design an individualized, self-directed, community-supported life; and

(3) improve coordination among all providers of such services under federally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments; and

(ii) development and service monitoring of a complaint system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

''(6) STATE OPTION TO PROVIDE HOME AND COMMUNITY-BASED SERVICES TO INDIVIDUALS ELIGIBLE FOR SERVICES UNDER A WAIVER.—

''(A) IN GENERAL.—A State that provides home and community-based services in accordance with this subsection to individuals who

satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) may, in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the State under subsection (c), (d), or (e) or under section 1115 to provide such services, but only for those individuals whose income does not exceed 300 percent of the supplemental security income benefit rate established by section 1611(b)(1).

''(B) APPLICATION OF SAME REQUIREMENTS FOR INDIVIDUALS SATISFYING NEEDS-BASED CRITERIA.—Subject to subparagraph (C), a State shall provide home and community-based services to individuals under this paragraph in the same manner and subject to the same requirements as apply under the other paragraphs of this subsection to the provision of home and community-based services to individuals who satisfy the needs-based criteria established under paragraph (1)(A).

"(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), so long as such services are within the scope of services described in paragraph (4)(B) of subsection (c) for which the Secretary has the authority to approve a waiver and do not include room or board.

"(7) STATE OPTION TO OFFER HOME AND COMMUNITY-BASED SERVICES TO SPECIFIC, TARGETED POPULATIONS.—

"(A) IN GENERAL.—A State may elect in a State plan amendment under this subsection to target the provision of home and community-based services under this subsection to specific populations and to differ the type, amount, duration, or scope of such services to such specific populations.

"(B) 5-YEAR TERM.—

"(i) IN GENERAL.—An election by a State under this paragraph shall be for a period of 5 years.

"(ii) PHASE-IN OF SERVICES AND ELIGIBILITY PERMITTED DURING INITIAL 5-YEAR PERIOD.—A State making an election under this paragraph may, during the first 5-year period for which the election is made, phase-in the enrollment of eligible individuals, or the provision of services to such individuals, or both, so long as all eligible individuals in the State for such services are enrolled, and all such services are provided, before the end of the initial 5-year period.

"(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

"(i) adhered to the requirements of this subsection and paragraph in providing services under such an election; and

''(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.''.

(c) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—Paragraph (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking ''or such other services requested by the State as the Secretary may approve''.

(d) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE FULL MEDICAID BENEFITS TO INDIVIDUALS RECEIVING HOME AND COMMUNITY-BASED SERVICES UNDER A STATE PLAN AMENDMENT.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 1639(a)(1), is amended—

(A) in subclause (XX), by striking ''or'' at the end;

(B) in subclause (XXI), by adding ''or'' at the end; and

(C) by inserting after subclause (XXI), the following new subclause:

''(XXII) who are eligible for home and community-based services under needs-based criteria established

under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396b(f)(4)), as amended by section 1639(a)(4)(B), is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XXII),'' after ''1902(a)(10)(A)(ii)(XXI),''.

(B) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) , as so amended, is amended in the matter preceding paragraph (1)—

(i) in clause (xv), by striking ''or'' at the end;

(ii) in clause (xvi), by adding ''or'' at the end; and

(iii) by inserting after clause (xvi) the following new clause:

''(xvii) individuals who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1915(i), or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection,''.

(e) ELIMINATION OF OPTION TO LIMIT NUMBER OF ELIGIBLE INDIVIDUALS OR LENGTH OF PERIOD FOR GRANDFATHERED INDIVIDUALS IF ELIGIBILITY CRITERIA IS MODIFIED.—Paragraph (1) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking subparagraph (C) and inserting the following:

''(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services.''; and

(2) in subclause (II) of subparagraph (D)(ii), by striking ''to be eligible for such services for a pe-

riod of at least 12 months beginning on the date the individual first received medical assistance for such services'' and inserting ''to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standard for receipt of such services under such pre-modified criteria''.

(f) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(3)) is amended by striking ''1902(a)(1) (relating to statewideness)'' and inserting ''1902(a)(10)(B) (relating to comparability)''.

(g) EFFECTIVE DATE.—The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 1637. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in paragraph (1)(E), by striking ''fiscal year 2011'' and inserting ''each of fiscal years 2011 through 2016''; and

(B) in paragraph (2), by striking ''2011'' and inserting ''2016''.

(2) EVALUATION.—Paragraphs (2) and (3) of section 6071(g) of such Act is amended are each amended by striking ''2011'' and inserting ''2016''.

(b) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) is amended—

(A) in subparagraph (A)(i), by striking '', for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the State'' and inserting ''for a period of not less than 90 consecutive days''; and

(B) by adding at the end the following:

''Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into

account for purposes of determining the 90-day period required under subparagraph (A)(i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 1638. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE.

Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by inserting ''or the care and services themselves, or both'' before ''(if provided in or after''.

SEC. 1639. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 1601(e), is amended—

(A) in subclause (XIX), by striking ''or'' at the end;

(B) in subclause (XX), by adding ''or'' at the end; and

(C) by adding at the end the following new subclause:

''(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 1601(d), is amended by adding at the end the following new subsection:

''(ii)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who, had individuals applied on or before January 1, 2007, would have been made eligible pursuant to the standards and processes imposed by that State for benefits described in clause (XV) of the matter following subparagraph (G) of section subsection (a)(10) pursuant to a waiver granted under section 1115.

''(3) At the option of a State, for purposes of subsection (a)(17)(B), in determining eligibility for services under this subsection, the State may consider only the income of the applicant or recipient.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)), as amended by section 1601(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking ''and (XV)'' and inserting ''(XV)''; and

(B) by inserting '', and (XVI) the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting'' before the semicolon.

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)), as amended by section 1601(e)(2)(A), is amended in the matter preceding paragraph (1)—

(i) in clause (xiv), by striking ''or'' at the end;

(ii) in clause (xv), by adding ''or'' at the end; and

(iii) by inserting after clause (xv) the following:

''(xvi) individuals described in section 1902(ii),''.

(B) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 1601(e)(2)(B), is amended by inserting ''1902(a)(10)(A)(ii)(XXI),'' after ''1902(a)(10)(A)(ii)(XX),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ii) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ii), such medical assistance shall be limited to family

planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ii); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection

(b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

"(A) during a presumptive eligibility period; and

"(B) by a entity that is eligible for payments under the State plan; and

"(2) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)), as amended by section 1622(a), is amended—

(i) in subparagraph (A), by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section"; and

(ii) in subparagraph (B), by striking "or 1920B" and inserting "1920B, or 1920C".

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)), as amended by

section 1622(b), is amended by inserting ''or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section,'' after ''1920B during a presumptive eligibility period under such section,''.

(c) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)), as amended by section 1601(c), is amended by adding at the end the following:

''(7) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 1640. GRANTS FOR SCHOOL-BASED HEALTH CENTERS.

Title XIX of the Social Security Act (42 U.S.C. 1397aa et seq.), as amended by section 1621, is amended by adding at the end the following:

"SEC. 1944. GRANTS FOR SCHOOL-BASED HEALTH CENTERS.

''(a) PROGRAM.—The Secretary shall establish a program to award grants to eligible entities to support the operation of school-based health centers (as defined in section 2110(c)(9)).

''(b) ELIGIBILITY.—To be eligible for a grant under this section, an entity shall—

''(1) be a school-based health center or a sponsoring facility (as defined in section 2110(c)(9)(B)) of a school-based health center; and

''(2) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum an assurance that funds awarded under the grant shall not be used to provide any service that is not authorized or allowed by Federal, State, or local law.

''(c) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to awarded grants for school-based health centers that serve a large population of children eligible for medical assistance under the State plan under this title or under a waiver of the

plan or children eligible for child health assistance under the State child health plan under title XXI.

''(d) APPROPRIATIONS.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 and 2011, $100,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.''.

SEC. 1641. THERAPEUTIC FOSTER CARE.

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1601(a)(3) and 1636, is amended by adding at the end the following:

''(aa)(1) Nothing in subsection (a) shall be construed as limiting a State from providing medical assistance for therapeutic foster care for children in foster care under the responsibility of the State in out-of-home placements.

''(2) The term 'therapeutic foster care' means a foster care program that provides—

''(A) to a child in foster care under the responsibility of the State—

''(i) structured daily activities that develop, improve, monitor, and reinforce age-appropriate social, communications, and behavioral skills;

''(ii) crisis intervention and crisis support services;

''(iii) medication monitoring;

''(iv) counseling; and

''(v) case management services; and

''(B) specialized training for the foster parent and consultation with the foster parent on the management of children with mental illnesses and related health and developmental conditions.''.

SEC. 1642. SENSE OF THE SENATE REGARDING LONG-TERM CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also know as the ''Pepper Commission'', released its ''Call for Action'' blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court's decision in *Olmstead v. L.C.,* 527 U.S. 581 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and *Olmstead* decision, the long-term care provided to our Nation's elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while ½ of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) during the 111th session of Congress, Congress should address long-term services and supports

in a comprehensive way that guarantees elderly and disabled individuals the care they need; and

(2) long term services and supports should be made available in the community in addition to in institutions.

PART V—MEDICAID PRESCRIPTION DRUG COVERAGE

SEC. 1651. PRESCRIPTION DRUG REBATES.

(a) INCREASE IN MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—Section 1927(c)(1)(B) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)) is amended—

(1) in clause (i)—

(A) in subclause (IV), by striking ''and'' at the end;

(B) in subclause (V)—

(i) by inserting ''and before January 1, 2010'' after ''December 31, 1995,''; and

(ii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(VI) except as provided in clause (iii), after December 31, 2009, 23.1 percent.''; and

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

"(iii) MINIMUM REBATE PERCENTAGE FOR CERTAIN DRUGS.—

"(I) IN GENERAL.—In the case of a single source drug or an innovator multiple source drug described in subclause (II), the minimum rebate percentage for rebate periods specified in clause (i)(VI) is 17.1 percent.

"(II) DRUG DESCRIBED.—For purposes of subclause (I), a single source drug or an innovator multiple source drug described in this subclause is any of the following drugs:

"(aa) A clotting factor for which a separate furnishing payment is made under section 1842(o)(5) and which is included on a list of such factors specified and updated regularly by the Secretary.

"(bb) A drug approved by the Food and Drug Administra-

tion exclusively for pediatric indications.''.

(b) INCREASE IN REBATE FOR OTHER DRUGS.—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

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

(2) in clause (ii)—

(A) by inserting ''and before January 1, 2010,'' after ''December 31, 1993,''; and

(B) by striking the period and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) after December 31, 2009, is 13 percent.''.

(c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) in clause (xi), by striking ''and'' at the end;

(B) in clause (xii), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following:

"(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection.".

(2) CONFORMING AMENDMENTS.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (d)(4), by inserting after subparagraph (E) the following:

''(F) Notwithstanding the preceding subparagraphs of this paragraph, any formulary established by medicaid managed care organization with a contract under section 1903(m) may be based on positive inclusion of drugs selected by a formulary committee consisting of physicians, pharmacists, and other individuals with appropriate clinical experience as long as drugs excluded from the formulary are available through prior authorization, as described in paragraph (5).''; and

(B) in subsection (j), by striking paragraph (1) and inserting the following:

''(1) Covered outpatient drugs are not subject to the requirements of this section if such drugs are—

''(A) dispensed by health maintenance organizations, including Medicaid managed care organizations that contract under section 1903(m); and

''(B) subject to discounts under section 340B of the Public Health Service Act.''.

(d) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—

(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:

"(C) TREATMENT OF NEW FORMULATIONS.—

"(i) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug or, if greater, the product of—

"(I) the average manufacturer price of the new formulation of the single source drug or innovator multiple source drug;

"(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this

section for any strength of the original single source drug or innovator multiple source drug; and

''(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

''(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bb) for a rare disease or condition, without regard to whether the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs dispensed after December 31, 2009.

(e) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as

amended by subsection (d), is amended by adding at the end the following new subparagraph:

"(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.".

(f) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

(A) in subsection (a)(2)(B)(i), by striking "1927(c)(4)" and inserting "1927(c)(3)"; and

(B) by striking subsection (c); and

(C) redesignating subsection (d) as subsection (c).

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

SEC. 1652. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

(1) in paragraph (2)—

(A) by striking subparagraphs (E), (I), and (J), respectively; and

(B) by redesignating subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

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

''(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

''(A) Agents when used to promote smoking cessation.

''(B) Barbiturates.

''(C) Benzodiazepines.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

SEC. 1653. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

(a) PHARMACY REIMBURSEMENT LIMITS.—

(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

(A) in paragraph (4), by striking ''(or, effective January 1, 2007, two or more)''; and

(B) by striking paragraph (5) and inserting the following:

''(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as no less than 175 percent of the weighted average (determined on the basis of utilization) of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 1847A.''.

(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in subparagraph (A), by striking ''by'' and all that follows through the period and inserting ''by—

''(i) wholesalers for drugs distributed to retail community pharmacies; and

"(ii) retail community pharmacies that purchase drugs directly from the manufacturer."; and

(B) by striking subparagraph (B) and inserting the following:

"(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS AND OTHER PAYMENTS.—

"(i) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

"(I) customary prompt pay discounts extended to wholesalers;

"(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies, including (but not limited to) distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs);

"(III) reimbursement by manufacturers for recalled, damaged, ex-

pired, or otherwise unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

''(IV) payments received from, and rebates or discounts provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long term care providers, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

''(ii) INCLUSION OF OTHER DISCOUNTS AND PAYMENTS.—Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or passed through to, retail community pharmacies shall be included in the average

manufacturer price for a covered outpatient drug.''; and

(C) in subparagraph (C), by striking ''the retail pharmacy class of trade'' and inserting ''retail community pharmacies''.

(3) DEFINITION OF MULTIPLE SOURCE DRUG.—Section 1927(k)(7) of such Act (42 U.S.C. 1396r–8(k)(7)) is amended—

(A) in subparagraph (A)(i)(III), by striking ''the State'' and inserting ''the United States''; and

(B) in subparagraph (C)—

(i) in clause (i), by inserting ''and'' after the semicolon;

(ii) in clause (ii), by striking ''; and'' and inserting a period; and

(iii) by striking clause (iii).

(4) DEFINITIONS OF RETAIL COMMUNITY PHARMACY; WHOLESALER.—Section 1927(k) of such Act (42 U.S.C. 1396r–8(k)) is amended by adding at the end the following new paragraphs:

''(10) RETAIL COMMUNITY PHARMACY.—The term 'retail community pharmacy' means an independent pharmacy, a chain pharmacy, a supermarket pharmacy, or a mass merchandiser phar-

macy that is licensed as a pharmacy by the State and that dispenses medications to the general public at retail prices. Such term does not include a pharmacy that dispenses prescription medications to patients primarily through the mail, nursing home pharmacies, long-term care facility pharmacies, hospital pharmacies, clinics, charitable or not-for-profit pharmacies, government pharmacies, or pharmacy benefit managers.

''(11) WHOLESALER.—The term 'wholesaler' means a drug wholesaler that is engaged in wholesale distribution of prescription drugs to retail community pharmacies, including (but not limited to) manufacturers, repackers, distributors, own-label distributors, private-label distributors, jobbers, brokers, warehouses (including manufacturer's and distributor's warehouses, chain drug warehouses, and wholesale drug warehouses) independent wholesale drug traders, and retail community pharmacies that conduct wholesale distributions.''.

(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), in the matter preceding subclause (I), by inserting ''month of a'' after ''each''; and

(B) in the second sentence, by inserting ''(relating to the weighted average of the most recently reported monthly average manufacturer prices)'' after ''(D)(v)''; and

(2) in subparagraph (D)(v), by striking ''average manufacturer prices'' and inserting ''the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)''.

(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

(1) in subparagraph (A)(i), by inserting ''with respect to a retail community pharmacy,'' before ''the determination''; and

(2) in subparagraph (C)(ii), by striking ''retail pharmacies'' and inserting ''retail community pharmacies''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after

the date of enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1654. STUDY OF BARRIERS TO APPROPRIATE UTILIZATION OF GENERIC MEDICINE IN FEDERAL HEALTH CARE PROGRAMS.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of State laws that have a negative impact on generic drug utilization in Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))) due to restrictions such as (but not limited to) limits on pharmacists' ability to provide a generic drug substitute for a prescribed name brand drug and carve-outs of certain classes of drugs from generic substitution.

(b) REPORT.—Not later than April 1, 2012, the Comptroller General of the United States shall submit a report to Congress on the results of the study conducted under subsection (a).

PART VI—MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

SEC. 1655. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(1) in paragraph (1), by striking ''and (3)'' and inserting '', (3), and (7)'';

(2) in paragraph (3)(A), by striking ''paragraph (6)'' and inserting ''paragraphs (6) and (7)'';

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

''(7) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

''(A) IN GENERAL.—Subject to subparagraph (E), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) (with respect to the State), is equal to the DSH allotment that would be determined under this subsection for the State for the fiscal year without application of this paragraph (but after the application of subparagraph (D)), reduced by the applicable percentage determined for the State for the fiscal year under subparagraph (B).

''(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable

percentage for a State for a fiscal year is the following:

''(i) UNINSURED REDUCTION THRESHOLD FISCAL YEAR.—In the case of the first fiscal year described in subparagraph (C) with respect to the State—

''(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

''(II) if the State is any other State, the applicable percentage is 50 percent.

''(ii) SUBSEQUENT FISCAL YEARS IN WHICH THE PERCENTAGE OF UNINSURED DECREASES.—In the case of any fiscal year after the first fiscal year described in subparagraph (C) with respect to a State, if the Secretary determines on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered individuals residing in the State is less than the percentage of such individuals determined for the State for the preceding fiscal year—

"(I) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to the product of the amount by which the percentage of uncovered individuals for the fiscal year is less than the percentage of such individuals for the preceding fiscal year and 17.5 percent; and

"(II) if the State is any other State, the applicable percentage is equal to the product of the amount by which the percentage of uncovered individuals for the fiscal year is less than the percentage of such individuals for the preceding fiscal year and 35 percent.

"(C) FISCAL YEAR DESCRIBED.—For purposes of subparagraph (A), the fiscal year described in this subparagraph with respect to a State is the first fiscal year that occurs after fiscal year 2012 for which the Secretary determines, on the basis of the most recent American Community Survey of the Bureau of the Census, that the percentage of uncovered indi-

viduals residing in the State is at least 50 percent less than the percentage of such individuals determined for the State for fiscal year 2009.

''(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the applicable percentage reduction under subparagraph (A) to the DSH allotment for a State for a fiscal year, the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (and prior to any such reduction) shall not include any portion of the allotment for which the Secretary has approved the State's diversion to the costs of providing medical assistance or other health benefits coverage under a waiver that is in effect on July 2009.

''(E) MINIMUM ALLOTMENT.—In no event shall the DSH allotment determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after

the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

''(F) UNCOVERED INDIVIDUALS.—In this paragraph, the term 'uncovered individuals' means individuals with no health insurance (as defined in section 2791 of the Public Health Service Act) at any time during a year.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 2011.

PART VII—DUAL ELIGIBLES

SEC. 1661. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting ''(1)'' after ''(h)'';

(2) by inserting '', or a waiver described in paragraph (2)'' after ''(e)''; and

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

''(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), or (d), or a waiver under section 1115, that provides medical assistance

for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled in addition to dual eligible individuals) may be conducted for a period of 5 years and, upon the request of the State, may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

''(B) In this paragraph, the term 'dual eligible individual' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII, or enrolled for benefits under part B of title XVIII, and is eligible for medical assistance under the State plan under this title or under a waiver of such plan.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1915 of such Act (42 U.S.C. 1396n) is amended—

(A) in subsection (b), by adding at the end the following new sentence: ''Subsection (h)(2) shall apply to a waiver under this subsection.'';

(B) in subsection (c)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection'';

(C) in subsection (d)(3), in the second sentence, by inserting ''(other than a waiver described in subsection (h)(2))'' after ''A waiver under this subsection''.

(2) Section 1115 of such Act (42 U.S.C. 1315) is amended—

(A) in subsection (e)(2), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''; and

(B) in subsection (f)(6), by inserting ''(5 years, in the case of a waiver described in section 1915(h)(2))'' after ''3 years''.

SEC. 1662. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR LOW-INCOME MEDICARE BENEFICIARIES.

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

(1) IN GENERAL.—Not later than March 1, 2010, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

(2) ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.—The Federal Coordinated Health Care Office—

(A) shall be established within the Centers for Medicare & Medicaid Services; and

(B) have as the Office a Director who shall be appointed by, and be in direct line of authority to, the Administrator of the Centers for Medicare & Medicaid Services.

(b) PURPOSE.—The purpose of the Federal Coordinated Health Care Office is to bring together officers and employees of the Medicare and Medicaid programs at the Centers for Medicare & Medicaid Services in order to—

(1) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(2) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(c) GOALS.—The goals of the Federal Coordinated Health Care Office are as follows:

(1) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(2) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(3) Improving the quality of health care and long-term services for dual eligible individuals.

(4) Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(5) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(6) Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals.

(7) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(8) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(d) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(1) Providing States, specialized MA plans for special needs individuals (as defined in section

1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6))), physicians and other relevant entities or individuals with the education and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To consult and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social

Security Act and the Medicaid program under title XIX of such Act.

(e) REPORT.—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(f) DUAL ELIGIBLE DEFINED.—In this section, the term ''dual eligible individual'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of such Act, and is eligible for medical assistance under a State plan under title XIX of such Act or under a waiver of such plan.

PART VIII—MEDICAID QUALITY

SEC. 1671. ADULT HEALTH QUALITY MEASURES.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 401 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111-3), is amended by inserting after section 1139A the following new section:

''SEC. 1139B. ADULT HEALTH QUALITY MEASURES.

''(a) DEVELOPMENT OF CORE SET OF HEALTH CARE QUALITY MEASURES FOR ADULTS ELIGIBLE FOR BENE-

FITS UNDER MEDICAID.—The Secretary shall identify and publish a recommended core set of adult health quality measures for Medicaid eligible adults in the same manner as the Secretary identifies and publishes a core set of child health quality measures under section 1139A, including with respect to identifying and publishing existing adult health quality measures that are in use under public and privately sponsored health care coverage arrangements, or that are part of reporting systems that measure both the presence and duration of health insurance coverage over time, that may be applicable to Medicaid eligible adults.

''(b) DEADLINES.—

''(1) RECOMMENDED MEASURES.—Not later than January 1, 2011, the Secretary shall identify and publish for comment a recommended core set of adult health quality measures for Medicaid eligible adults.

''(2) DISSEMINATION.—Not later than January 1, 2012, the Secretary shall publish an initial core set of adult health quality measures that are applicable to Medicaid eligible adults.

''(3) STANDARDIZED REPORTING.—Not later than January 1, 2013, the Secretary, in consultation with States, shall develop a standardized format for

reporting information based on the initial core set of adult health quality measures and create procedures to encourage States to use such measures to voluntarily report information regarding the quality of health care for Medicaid eligible adults.

''(4) REPORTS TO CONGRESS.—Not later than January 1, 2014, and every 3 years thereafter, the Secretary shall include in the report to Congress required under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

''(5) ESTABLISHMENT OF MEDICAID QUALITY MEASUREMENT PROGRAM.—

''(A) IN GENERAL.—Not later than 12 months after the release of the recommended core set of adult health quality measures under paragraph (1)), the Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(b). The aggregate amount awarded by the Secretary for grants and contracts for the development, testing, and validation of emerging and innovative evidence-based meas-

ures under such program shall equal the aggregate amount awarded by the Secretary for grants under section 1139A(b)(4)(A)

"(B) REVISING, STRENGTHENING, AND IMPROVING INITIAL CORE MEASURES.—Beginning not later than 24 months after the establishment of the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

"(c) CONSTRUCTION.—Nothing in this section shall be construed as supporting the restriction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in anyway limiting available services.

"(d) ANNUAL STATE REPORTS REGARDING STATE-SPECIFIC QUALITY OF CARE MEASURES APPLIED UNDER MEDICAID.—

"(1) ANNUAL STATE REPORTS.—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of

the annual report required under section 1139A(c)), to the Secretary on the—

"(A) State-specific adult health quality measures applied by the State under the such plan, including measures described in subsection (a)(5); and

"(B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.

"(2) PUBLICATION.—Not later than September 30, 2014, and annually thereafter, the Secretary shall collect, analyze, and make publicly available the information reported by States under paragraph (1).

"(e) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated for each of fiscal years 2010 through 2014, $60,000,000 for the purpose of carrying out this section. Funds appropriated under this subsection shall remain available until expended.".

SEC. 1672. PAYMENT ADJUSTMENT FOR HEALTH CARE-ACQUIRED CONDITIONS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall conduct surveys to identify current State practices that prohibit payment for health care-acquired conditions and shall promulgate regulations, to be effective as of July 1, 2011, to prohibit payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for such conditions. Such regulations shall ensure that a prohibition on payment for health care-acquired conditions shall not affect care or services provided to a Medicaid beneficiary.

(b) HEALTH CARE-ACQUIRED CONDITION.—In this section. the term ''health care-acquired condition'' means a medical condition for which an individual was diagnosed that could be identified by a secondary diagnostic code described in section 1886(d)(4)(D)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(4)(D)(iv)).

(c) MEDICARE PROVISIONS.—In carrying out this section, the Secretary may elect to apply to State plans (or waivers) under title XIX of the Social Security Act the regulations promulgated pursuant to section 1886(d)(4)(D) of such Act (42 U.S.C. 1395ww(d)(4)(D)) relating to the prohibition of payments based on the pres-

ence of a secondary diagnosis code specified by the Secretary in such regulations. The Secretary may exclude certain conditions identified under title XVIII of the Social Security Act for non-payment under title XIX of such Act when the Secretary finds the inclusion of such conditions to be inapplicable to beneficiaries under title XIX.

SEC. 1673. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) AUTHORITY TO CONDUCT PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(1) with respect to an episode of care that includes a hospitalization; and

(2) for concurrent physicians services provided during a hospitalization.

(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State se-

lected to participate in the demonstration project may target the demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall insure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on conditions where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationale for the selection of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also

vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost sharing than if their care had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such bene-

ficiaries under the State Medicaid program in the absence of the demonstration project.

(c) WAIVER OF PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XVIII, and XI of that Act as may be necessary to accomplish the goals of the demonstration, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(d) EVALUATION AND REPORT.—

(1) DATA.—Each State selected to participate in the demonstration project under this section shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationales for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) REPORT.—Not later than 1 year after the conclusion of the demonstration project, the Secretary shall submit a report to Congress on the results of the demonstration project.

SEC. 1674. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall, in coordination with the Innovation Center (as established under section 3021), establish the Medicaid Global Payment System Demonstration Project under which a participating State shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012. The Secretary shall select not more than 5 States to participate in the demonstration project.

(c) ELIGIBLE SAFETY NET HOSPITAL SYSTEM OR NETWORK.—For purposes of this section, the term ''eligible safety net hospital system or network'' means a large, safety net hospital system or network (as defined by the Secretary) that operates within a State selected by the Secretary under subsection (b).

(d) EVALUATION.—

(1) TESTING.—The Innovation Center shall test and evaluate the demonstration project conducted under this section to examine any changes in health

care quality outcomes and spending by the eligible safety net hospital systems or networks.

(2) BUDGET NEUTRALITY.—During the testing period under paragraph (1), any budget neutrality requirements under section 1115A(b)(3) of the Social Security Act (as added by section 3021) shall not be applicable.

(3) MODIFICATION.—During the testing period under paragraph (1), the Secretary may, in the Secretary's discretion, modify or terminate the demonstration project conducted under this section.

(e) REPORT.—Not later than 12 months after the date of completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation and testing conducted under subsection (d), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

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

SEC. 1675. PEDIATRIC ACCOUNTABLE CARE ORGANIZATION DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Sec-

retary'') shall establish the Pediatric Accountable Care Organization Demonstration Project to authorize a participating State to allow pediatric medical providers that meet specified requirements to be recognized as an accountable care organization for purposes of receiving incentive payments (as described under subsection (d)), in the same manner as an accountable care organization is recognized and provided with incentive payments under section 1899 of the Social Security Act (as added by section 3022).

(b) APPLICATION.—A State that desires to participate in the demonstration project under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS.—

(1) PERFORMANCE GUIDELINES.—The Secretary, in consultation with the States and pediatric providers, shall establish guidelines to ensure that the quality of care delivered to individuals by a provider recognized as an accountable care organization under this section is not less than the quality of care that would have otherwise been provided to such individuals.

(2) SAVINGS REQUIREMENT.—A participating State, in consultation with the Secretary, shall establish an annual minimal level of savings in expenditures for items and services covered under the Medicaid program under title XIX of the Social Security Act and the CHIP program under title XXI of such Act that must be reached by an accountable care organization in order for such organization to receive an incentive payment under subsection (d).

(d) INCENTIVE PAYMENT.—An accountable care organization that meets the performance guidelines established by the Secretary under subsection (c)(1) and achieves savings greater than the annual minimal savings level established by the State under subsection (c)(2) shall receive an incentive payment for such year equal to a portion (as determined appropriate by the Secretary) of the amount of such excess savings. The Secretary may establish an annual cap on incentive payments for an accountable care organization.

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

SEC. 1676. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project for up to 8 States under which an eligible State (as described in subsection (c)) shall provide reimbursement under the State Medicaid plan under title XIX of the Social Security Act to an institution for mental diseases (as defined in section 1905(i) of such Act) that is not publicly owned or operated and that is subject to the requirements of section 1867 of the Social Security Act (42 U.S.C. 1395dd) for the provision of medical assistance available under such plan to an individual who—

(1) has attained age 21, but has not attained age 65;

(2) is eligible for medical assistance under such plan; and

(3) requires such medical assistance to stabilize a psychiatric emergency medical condition, as evidenced by the expression of suicidal or homicidal thoughts or gestures determined dangerous to the individual or others.

(b) IN-STAY REVIEW.—The Secretary shall establish a mechanism for in-stay review to determine whether or

not the patient has been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. States participating in the demonstration project may manage the provision of these benefits under the project through utilization review, authorization, or management practices, or the application of medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED.—

(1) APPLICATION.—Upon approval of an application submitted by a State described in paragraph (2), the State shall be an eligible State for purposes of conducting a demonstration project under this section.

(2) STATE DESCRIBED.—States shall be selected by the Secretary in a manner so as to provide geographic diversity on the basis of the application to conduct a demonstration project under this section submitted by such States.

(d) LENGTH OF DEMONSTRATION PROJECT.—The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2010.

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 3-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2012.

(3) LIMITATION ON PAYMENTS.—In no case may—

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2012.

(4) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to eligible States based on their applications and the availability of funds.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation

under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a).

(f) REPORTS.—

(1) ANNUAL PROGRESS REPORTS.—The Secretary shall submit annual reports to Congress on the progress of the demonstration project conducted under this section.

(2) FINAL REPORT AND RECOMMENDATION.—An evaluation should be conducted of the demonstration project's impact on the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program. This evaluation should include collection of baseline data for one-year prior to the initiation of the demonstration project as well as collection of data from matched comparison states not participating in the demonstration. The evaluation measures shall include the following:

(A) A determination, by State, as to whether the demonstration project resulted in increased access to inpatient mental health services under the Medicaid program and whether average length of stays were longer (or

shorter) for individuals admitted under the demonstration project compared with individuals otherwise admitted in comparison sites.

(B) An analysis by State, regarding whether the demonstration project produced a significant reduction in emergency room visits for individuals eligible for assistance under the Medicaid program or in the duration of emergency room lengths of stay.

(C) An assessment of discharge planning by participating hospitals that ensures access to further (non-emergency) inpatient or residential care as well as continuity of care for those discharged to outpatient care.

(D) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care) under the plan as contrasted with the comparison areas.

(E) Data on the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(F) A recommendation regarding whether the demonstration project should be continued after December 31, 2012, and expanded on a national basis.

(g) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary shall waive the limitation of subdivision (B) following paragraph (28) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) (relating to limitations on payments for care or services for individuals under 65 years of age who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY.—The Secretary may waive other requirements of titles XI and XIX of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(1)(10)(B) (relating to comparability)) only to extent necessary to carry out the demonstration project under this section.

PART IX—IMPROVEMENTS TO THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION (MACPAC)

SEC. 1681. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) IN GENERAL.—Section 1900 of the Social Security Act (42 U.S.C. 1396) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the paragraph heading, by inserting ''FOR ALL STATES'' before ''AND ANNUAL''; and

(ii) in subparagraph (A), by striking ''children's'';

(iii) in subparagraph (B), by inserting '', the Secretary, and States'' after ''Congress'';

(iv) in subparagraph (C), by striking ''March 1'' and inserting ''March 15''; and

(v) in subparagraph (D), by striking ''June 1'' and inserting ''June 15'';

(B) in paragraph (2)—

(i) in subparagraph (A)—

(I) in clause (i)—

(aa) by inserting ''the efficient provision of'' after ''expenditures for''; and

(bb) by striking ''hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees'' and inserting ''payments to medical, dental, and health professionals, hospitals, residential and long-term care providers, providers of home and community based services, Federally-qualified health centers and rural health clinics, managed care entities, and providers of other covered items and services''; and

(II) in clause (iii), by inserting ''(including how such factors and methodologies enable such beneficiaries to obtain the services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate share of low-income

and other vulnerable populations)'' after ''beneficiaries'';

(ii) by redesignating subparagraphs (B) and (C) as subparagraphs (F) and (H), respectively;

(iii) by inserting after subparagraph (A), the following:

''(B) ELIGIBILITY POLICIES.—Medicaid and CHIP eligibility policies, including a determination of the degree to which Federal and State policies provide health care coverage to needy populations.

''(C) ENROLLMENT AND RETENTION PROCESSES.—Medicaid and CHIP enrollment and retention processes, including a determination of the degree to which Federal and State policies encourage the enrollment of individuals who are eligible for such programs and screen out individuals who are ineligible, while minimizing the share of program expenses devoted to such processes.

''(D) COVERAGE POLICIES.—Medicaid and CHIP benefit and coverage policies, including a determination of the degree to which Federal and State policies provide access to the services

enrollees require to improve and maintain their health and functional status.

''(E) QUALITY OF CARE.—Medicaid and CHIP policies as they relate to the quality of care provided under those programs, including a determination of the degree to which Federal and State policies achieve their stated goals and interact with similar goals established by other purchasers of health care services.'';

(iv) by inserting after subparagraph (F) (as redesignated by clause (ii) of this subparagraph), the following:

''(G) INTERACTIONS WITH MEDICARE AND MEDICAID.—Consistent with paragraph (11), the interaction of policies under Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to services, payments, and dual eligible individuals.'' and

(v) in subparagraph (H) (as so redesignated), by inserting ''and preventive, acute, and long-term services and supports'' after ''barriers'';

(C) by redesignating paragraphs (3) through (9) as paragraphs (4) through (10), respectively;

(D) by inserting after paragraph (2), the following new paragraph:

''(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—MACPAC shall—

''(A) review national and State-specific Medicaid and CHIP data; and

''(B) submit reports and recommendations to Congress, the Secretary, and States based on such reviews.'';

(E) in paragraph (4), as redesignated by subparagraph (C), by striking ''or any other problems'' and all that follows through the period and inserting '', as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the health care status of, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or problems identified with respect to the period addressed in the report.'';

(F) in paragraph (5), as so redesignated,—

(i) in the paragraph heading, by inserting ''AND REGULATIONS'' after ''REPORTS''; and

(ii) by striking ''If'' and inserting the following:

''(A) CERTAIN SECRETARIAL REPORTS.—If''; and

(iii) in the second sentence, by inserting ''and the Secretary'' after ''appropriate committees of Congress''; and

(iv) by adding at the end the following:

''(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may comment through submission of a report to the appropriate committees of Congress and the Secretary, on any such regulations that affect access, quality, or efficiency of health care.'';

(G) in paragraph (10), as so redesignated, by inserting '', and shall submit with any recommendations, a report on the Federal and State-specific budget consequences of the recommendations'' before the period; and

(H) by adding at the end the following:

''(11) CONSULTATION AND COORDINATION WITH MEDPAC.—

''(A) IN GENERAL.—MACPAC shall regularly consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section, particularly with respect to the issues specified in paragraph (2) as they relate to those Medicaid beneficiaries who are dually eligible for Medicaid and the Medicare program under title XVIII, adult Medicaid beneficiaries (who are not dually eligible for Medicare), and beneficiaries under Medicare. Responsibility for analysis of and recommendations to change Medicare policy regarding Medicare beneficiaries, including Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with MedPAC.

''(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and records of the other such entity, respectively, upon the request of the other such entity.

''(12) CONSULTATION WITH STATES.—MACPAC shall regularly consult with States in carrying out its duties under this section, including with respect to developing processes for carrying out such duties, and shall ensure that input from States is taken into account and represented in MACPAC's recommendations and reports.

''(13) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—MACPAC shall coordinate and consult with the Federal Coordinated Health Care Office established under section 1662 of the America's Healthy Future Act of 2009 before making any recommendations regarding dual eligible individuals.

''(14) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC's authority to make recommendations in accordance with this section shall not affect, or be considered to duplicate, the Secretary's authority to carry out Federal responsibilities with respect to Medicaid and CHIP.'';

(2) in subsection (c)(2)—

(A) by striking subparagraphs (A) and (B) and inserting the following:

''(A) IN GENERAL.—The membership of MACPAC shall include individuals who have

had direct experience as enrollees or parents or caregivers of enrollees in Medicaid or CHIP and individuals with national recognition for their expertise in Federal safety net health programs, health finance and economics, actuarial science, health plans and integrated delivery systems, reimbursement for health care, health information technology, and other providers of health services, public health, and other related fields, who provide a mix of different professions, broad geographic representation, and a balance between urban and rural representation.

''(B) INCLUSION.—The membership of MACPAC shall include (but not be limited to) physicians, dentists, and other health professionals, employers, third-party payers, and individuals with expertise in the delivery of health services. Such membership shall also include representatives of children, pregnant women, the elderly, individuals with disabilities, caregivers, and dual eligible individuals, current or former representatives of State agencies responsible for administering Medicaid, and current or former representatives of State agencies responsible for administering CHIP.''.

(3) in subsection (d)(2), by inserting ''and State'' after ''Federal'';

(4) in subsection (e)(1), in the first sentence, by inserting ''and, as a condition for receiving payments under sections 1903(a) and 2105(a), from any State agency responsible for administering Medicaid or CHIP,'' after ''United States''; and

(5) in subsection (f)—

(A) in the subsection heading, by striking ''AUTHORIZATION OF APPROPRIATIONS'' and inserting ''FUNDING'';

(B) in paragraph (1), by inserting ''(other than for fiscal year 2010)'' before ''in the same manner''; and

(C) by adding at the end the following:

''(3) FUNDING FOR FISCAL YEAR 2010.—

''(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to MACPAC to carry out the provisions of this section for fiscal year 2010, $9,000,000.

''(B) TRANSFER OF FUNDS.—Notwithstanding section 2104(a)(13), from the amounts appropriated in such section for fiscal year 2010, $2,000,000 is hereby transferred

and made available in such fiscal year to MACPAC to carry out the provisions of this section.

''(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to MACPAC to carry out the provisions of this section shall remain available until expended.''.

(b) CONFORMING MEDPAC AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)), is amended—

(1) in paragraph (1)(C), by striking ''March 1 of each year (beginning with 1998)'' and inserting ''March 15'';

(2) in paragraph (1)(D), by inserting '', and (beginning with 2012) containing an examination of the topics described in paragraph (9), to the extent feasible'' before the period; and

(3) by adding at the end the following:

''(9) REVIEW AND ANNUAL REPORT ON MEDICAID AND COMMERCIAL TRENDS.—The Commission shall review and report on aggregate trends in spending, utilization, and financial performance under the Medicaid program under title XIX and the private market for health care services with respect to providers for which, on an aggregate na-

tional basis, a significant portion of revenue or services is associated with the Medicaid program. Where appropriate, the Commission shall conduct such review in consultation with the Medicaid and CHIP Payment and Access Commission (MACPAC) established under section 1900.

''(10) COORDINATE AND CONSULT WITH THE FEDERAL COORDINATED HEALTH CARE OFFICE.—The Commission shall coordinate and consult with the Federal Coordinated Health Care Office established under section 1662 of the America's Healthy Future Act of 2009 before making any recommendations regarding dual eligible individuals.''.

PART X—AMERICAN INDIANS AND ALASKA NATIVES

SEC. 1691. SPECIAL RULES RELATING TO INDIANS.

(a) NO COST-SHARING FOR INDIANS WITH INCOME AT OR BELOW 300 PERCENT OF POVERTY ENROLLED IN COVERAGE THROUGH A STATE EXCHANGE.—For provisions prohibiting cost sharing for Indians enrolled in any qualified health benefits plan in the individual market through an exchange, see section 2247(d) of the Social Security Act.

(b) PAYER OF LAST RESORT.—Nothing in this Act or the amendments made by this Act shall affect the right

of the United States, an Indian tribe, or a tribal organization to recover reimbursement from third parties for the costs of health services in accordance with section 206 of the Indian Health Care Improvement Act (42 U.S.C. 1621e).

(c) FACILITATING ENROLLMENT OF INDIANS UNDER THE EXPRESS LANE OPTION.—Section 1902(e)(13)(F)(ii) of the Social Security Act (42 U.S.C. 1396a(e)(13)(F)(ii)) is amended—

(1) in the clause heading, by inserting ''AND INDIAN TRIBES AND TRIBAL ORGANIZATIONS'' after ''AGENCIES''; and

(2) by adding at the end the following:

''(IV) The Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (as defined in section 1139(c)).''.

(d) TECHNICAL CORRECTIONS.—Section 1139(c) of the Social Security Act (42 U.S.C. 1320b–9(c)) is amended by striking ''In this section'' and inserting ''For purposes of this section, title XIX, and title XXI''.

SEC. 1692. ELIMINATION OF SUNSET FOR REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1880(e)(1)(A) of the Social Security Act (42 U.S.C. 1395qq(e)(1)(A)) is amended by striking ''during the 5-year period beginning on'' and inserting ''on or after''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

Subtitle H—Addressing Health Disparities

SEC. 1701. STANDARDIZED COLLECTION OF DATA.

(a) UNIFORM CATEGORIES AND COLLECTION REQUIREMENTS.—

(1) APPLICATION OF OMB STANDARDS FOR DATA COLLECTION AND CLASSIFICATION.—The Secretary of Health and Human Services, in consultation with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, and the head of other appropriate Federal agencies, shall establish procedures to ensure that, beginning January 1, 2011, all

data collected under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)) and under the health insurance program under chapter 89 of title 5, United States Code, on race, ethnicity, sex, and primary language, complies with the following:

(A) Office of Management and Budget Directive 15 (Standards for the Classification of Federal Data on Race and Ethnicity).

(B) Guidance for Federal agencies that collect or use aggregate data on race issued by the Office of Management and Budget.

(C) Guidance for Federal agencies for the allocation of multiple race responses for use in civil rights monitoring and enforcement issued by the Office of Management and Budget.

(2) ACCESS AND TREATMENT FOR INDIVIDUALS WITH DISABILITIES.—Not later than January 1, 2012, the Secretary of Health and Human Services, in consultation with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, and the head of other appropriate Federal agencies, shall establish procedures for the Administrator of the Centers on Medicare & Medicaid Services to collect data under

Federal health care programs (as so defined) and the health insurance program under chapter 89 of title 5, United States Code, in order to assess access to care and treatment for individuals with disabilities. Such procedures shall include surveying health care providers to identify—

(A) locations where individuals with disabilities access primary, acute (including intensive), and long-term care;

(B) the number of providers with accessible facilities and equipment to meet the needs of the individuals with disabilities; and

(C) the number of employees of health care providers trained in disability awareness and patient care of individuals with disabilities.

(b) MEDICAID CONFORMING AMENDMENTS.—

(1) STATE PLAN REQUIREMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 1601(d), is amended—

(A) in paragraph (74), by striking ''and'' at the end;

(B) in paragraph (75), by striking the period at the end and inserting ''; and''; and

(C) by inserting after paragraph (75) the following new paragraph:

''(76) provide that any data collected under the State plan meets the requirements of section 1701(a) of the America's Healthy Future Act of 2009.''.

(c) CHIP CONFORMING AMENDMENTS.—Section 2108(e) of the Social Security Act (42 U.S.C. 1397hh(e)) is amended by adding at the end the following new paragraph:

''(7) Data collected and reported in accordance with section 1701(a) of the America's Healthy Future Act of 2009, with respect to individuals enrolled in the State child health plan (and, in the case of enrollees under 19 years of age, their parents or legal guardians), including data regarding the primary language of such individuals, parents, and legal guardians.''.

SEC. 1702. REQUIRED COLLECTION OF DATA.

(a) POPULATION SURVEYS AND QUALITY REPORTING.—Beginning January 1, 2012:

(1) FEDERALLY-FUNDED POPULATION SURVEYS.—All federally funded population survey, including Current Population Surveys and American Community Surveys conducted by the Bureau of

Labor Statistics and the Bureau of the Census, shall collect sufficient data relating to race, ethnicity, sex, primary language, and types of disability subgroups to generate statistically reliable estimates in studies comparing health disparities populations.

(2) QUALITY REPORTING REQUIREMENTS.—Any reporting requirements imposed for purposes of measuring quality under a Federal health care program (as defined in section 1128B(f) of the such Act (42 U.S.C. 1320a–7b(f)) or under the health insurance program under chapter 89 of title 5, United States Code, shall include requirements for the collection of data on individuals receiving health care items or services under such programs by race, ethnicity, sex, primary language, and types of disability.

(b) EXTENDING MEDICARE REQUIREMENT TO ADDRESS HEALTH DISPARITIES DATA COLLECTION TO MEDICAID AND CHIP.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), as amended by section 1640 is amended by adding at the end the following new section:

"SEC. 1945. ADDRESSING HEALTH CARE DISPARITIES.

''(a) EVALUATING DATA COLLECTION APPROACHES.—The Secretary shall evaluate approaches for the collection of data under this title and title XXI, to be performed in conjunction with existing quality report-

ing requirements and programs under this title and title XXI, that allow for the ongoing, accurate, and timely collection and evaluation of data on disparities in health care services and performance on the basis of race, ethnicity, sex, primary language, and types of disability. In conducting such evaluation, the Secretary shall consider the following objectives:

''(1) Protecting patient privacy.

''(2) Minimizing the administrative burdens of data collection and reporting on States, providers, and health plans participating under this title or title XXI.

''(3) Improving program data under this title and title XXI on race, ethnicity, sex, primary language, and types of disability.

''(b) REPORTS TO CONGRESS.—

''(1) REPORT ON EVALUATION.—Not later than 18 months after the date of the enactment of this section, the Secretary shall submit to Congress a report on the evaluation conducted under subsection (a). Such report shall, taking into consideration the results of such evaluation—

''(A) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities

on the basis of race, ethnicity, sex, primary language, and types of disability for the programs under this title and title XXI; and

''(B) include recommendations on the most effective strategies and approaches to reporting HEDIS quality measures as required under section 1852(e)(3) and other nationally recognized quality performance measures, as appropriate, on such bases.

''(2) REPORTS ON DATA ANALYSES.—Not later than 4 years after the date of the enactment of this section, and 4 years thereafter, the Secretary shall submit to Congress a report that includes recommendations for improving the identification of health care disparities for beneficiaries under this title and under title XXI based on analyses of the data collected under subsection (c).

''(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not later than 24 months after the date of the enactment of this section, the Secretary shall implement the approaches identified in the report submitted under subsection (b)(1) for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, sex, primary language, and types of disability.''.

SEC. 1703. DATA SHARING AND PROTECTION.

The Secretary of Health and Human Services, in consultation with the Director of the Office of Personnel Management, the Secretary of Defense, the Secretary of Veterans Affairs, and the head of other appropriate Federal agencies, shall establish procedures —

(1) for sharing data collected under a Federal health care program (as defined in section 1128B(f) of the such Act (42 U.S.C. 1320a–7b(f)) or under the health insurance program under chapter 89 of title 5, United States Code, on race, ethnicity, sex primary language, and type of disability, measures relating to such data, and analyses of such data, with other relevant Federal and State agencies including, within the Department of Health and Human Services, the Office of Minority Health, the Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, and the Centers for Medicare & Medicaid Services; and

(2) establish procedures to ensure that all appropriate privacy and information security safeguards are used in the collection, analysis, and sharing of such data.

SEC. 1704. INCLUSION OF INFORMATION ABOUT THE IMPORTANCE OF HAVING A HEALTH CARE POWER OF ATTORNEY IN TRANSITION PLANNING FOR CHILDREN AGING OUT OF FOSTER CARE AND INDEPENDENT LIVING PROGRAMS.

(a) TRANSITION PLANNING.—Section 475(5)(H) of the Social Security Act (42 U.S.C. 675(5)(H)) is amended by inserting ''includes information about the importance of designating another individual to make health care treatment decisions on behalf of the child if the child becomes unable to participate in such decisions and the child does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, and provides the child with the option to execute a health care power of attorney, health care proxy, or other similar document recognized under State law,'' after ''employment services,''.

(b) INDEPENDENT LIVING EDUCATION.—Section 477(b)(3) of such Act (42 U.S.C. 677(b)(3)) is amended by adding at the end the following:

''(K) A certification by the chief executive officer of the State that the State will ensure that an adolescent participating in the program under this section are provided with education about the importance of designating another individual to make health care treatment deci-

sions on behalf of the adolescent if the adolescent becomes unable to participate in such decisions and the adolescent does not have, or does not want, a relative who would otherwise be authorized under State law to make such decisions, whether a health care power of attorney, health care proxy, or other similar document is recognized under State law, and how to execute such a document if the adolescent wants to do so.''.

(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking ''and'' at the end; and

(2) by adding at the end the following:

''(vii) steps to ensure that the components of the transition plan development process required under section 475(5)(H) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under

State law, and to provide the child with the option to execute such a document, are met; and''.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

Subtitle I—Maternal and Child Health Services

SEC. 1801. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 701 et seq.) is amended by adding at the end the following new section:

''SEC. 511. MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAMS.

''(a) PURPOSES.—The purposes of this section are—

''(1) to strengthen and improve the programs and activities carried out under this title;

''(2) to improve coordination of services for at risk communities; and

''(3) to identify and provide comprehensive services to improve outcomes for families who reside in at risk communities.

''(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies—

''(A) communities with concentrations of—

''(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

''(ii) poverty;

''(iii) crime;

''(iv) domestic violence;

''(v) high rates of high-school drop-outs;

''(vi) substance abuse;

''(vii) unemployment; or

''(viii) child maltreatment;

''(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

"(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

"(ii) the gaps in early childhood home visitation in the State; and

"(iii) the extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and

"(C) the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.

"(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment required under section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 640(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs

and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State required under section 205(3) of the Child Abuse Prevention and Treatment Act.

''(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

''(A) the results of the statewide needs assessment required under paragraph (1); and

''(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include applying for a grant to conduct an early childhood home visitation program in accordance with the requirements of this section.

''(c) GRANTS FOR EARLY CHILDHOOD HOME VISITATION PROGRAMS.—

''(1) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to enable the entities to deliver services under early childhood home visitation programs that satisfy the requirements of subsection (d) to eligible

families in order to promote improvements in maternal and prenatal health, infant health, child health and development, parenting related to child development outcomes, school readiness, and the socioeconomic status of such families, and reductions in child abuse, neglect, and injuries.

''(2) AUTHORITY TO USE INITIAL GRANT FUNDS FOR PLANNING OR IMPLEMENTATION.—An eligible entity that receives a grant under paragraph (1) may use a portion of the funds made available to the entity during the first 6 months of the period for which the grant is made for planning or implementation activities to assist with the establishment of early childhood home visitation programs that satisfy the requirements of subsection (d).

''(3) GRANT DURATION.—The Secretary shall determine the period of years for which a grant is made to an eligible entity under paragraph (1).

''(d) REQUIREMENTS.—The requirements of this subsection for an early childhood home visitation program conducted with a grant made under this section are as follows:

''(1) QUANTIFIABLE, MEASURABLE IMPROVEMENT IN BENCHMARK AREAS.—

''(A) IN GENERAL.—The eligible entity establishes, subject to the approval of the Secretary, quantifiable, measurable 3- and 5-year benchmarks for demonstrating that the program results in improvements for the eligible families participating in the program in each of the following areas:

''(i) Improved maternal and newborn health.

''(ii) Prevention of child injuries and reduction of emergency department visits.

''(iii) Improvement in school readiness and achievement.

''(iv) Reduction in crime or domestic violence.

''(v) Improvements in family economic self-sufficiency.

''(vi) Improvements in the coordination and referrals for other community resources and supports.

''(B) DEMONSTRATION OF IMPROVEMENTS AFTER 3 YEARS.—

''(i) REPORT TO THE SECRETARY.—Not later than 30 days after the end of the 3rd year in which the eligible entity con-

ducts the program, the entity submits to the Secretary a report demonstrating improvement in at least 4 of the areas specified in subparagraph (A).

''(ii) CORRECTIVE ACTION PLAN.—If the report submitted by the eligible entity under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement a plan to improve outcomes in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

''(iii) TECHNICAL ASSISTANCE.—

''(I) IN GENERAL.—The Secretary shall provide an eligible entity required to develop and implement an improvement plan under clause (ii) with technical assistance to develop and implement the plan. The Sec-

retary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

''(II) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of obtaining recommendations regarding the technical assistance provided to entities in accordance with subclause (I).

''(iv) NO IMPROVEMENT OR FAILURE TO SUBMIT REPORT.—If the Secretary determines after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (ii) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the report required under clause (i), the Secretary shall terminate the entity's grant and may include any unexpended grant funds in grants made to nonprofit organizations under subsection (h)(2)(B).

''(C) FINAL REPORT.—Not later than December 31, 2014, the eligible entity shall sub-

mit a report to the Secretary demonstrating improvements (if any) in each of the areas specified in subparagraph (A).

''(2) IMPROVEMENTS IN OUTCOMES FOR INDIVIDUAL FAMILIES.—

''(A) IN GENERAL.—The program is designed, with respect to an eligible family participating in the program, to result in the participant outcomes described in subparagraph (B) that the eligible entity identifies on the basis of an individualized assessment of the family, are relevant for that family.

''(B) PARTICIPANT OUTCOMES.—The participant outcomes described in this subparagraph are the following:

''(i) Improvements in prenatal, maternal, and newborn health, including improved pregnancy outcomes

''(ii) Improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators.

"(iii) Improvements in parenting skills.

"(iv) Improvements in school readiness and child academic achievement.

"(v) Reductions in crime or domestic violence.

"(vi) Improvements in family economic self-sufficiency.

"(vii) Improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training.

"(3) CORE COMPONENTS.—The program includes the following core components:

"(A) SERVICE DELIVERY MODEL OR MODELS.—

"(i) IN GENERAL.—Subject to clause (ii), the program is conducted using 1 or more of the service delivery models described in item (aa) or (bb) of subclause (I) or in subclause (II) selected by the eligible entity:

"(I) The model conforms to a clear consistent home visitation model

that has been in existence for at least 3 years and is research-based, grounded in relevant empirically-based knowledge, linked to program determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous program quality improvement, and has demonstrated significant, (and in the case of the service delivery model described in item (aa), sustained) positive outcomes, as described in the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), when evaluated using well-designed and rigorous—

"(aa) randomized controlled research designs, and the evaluation results have been published in a peer-reviewed journal; or

"(bb) quasi-experimental research designs.

"(II) The model conforms to a promising and new approach to achieving the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B), has been developed or identified by a national organization or institution of higher education, and will be evaluated through well-designed and rigorous process.

"(ii) MAJORITY OF GRANT FUNDS USED FOR EVIDENCE-BASED MODELS.—An eligible entity shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in clause (i)(III).

"(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models (which may be tiered) and for assessing such evidence with respect to each such

model. The Secretary shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

''(B) ADDITIONAL REQUIREMENTS.—

''(i) The program adheres to a clear, consistent model that satisfies the requirements of being grounded in empirically-based knowledge related to home visiting and linked to the benchmark areas specified in paragraph (1)(A) and the participant outcomes described in paragraph (2)(B).

''(ii) The program employs well-trained and competent staff, as demonstrated by education or training, such as nurses, social workers, child development specialists, or other well-trained and competent staff, and provides ongoing and specific training on the model being delivered.

''(iii) The program maintains high quality supervision to establish home visitor competencies.

''(iv) The program demonstrates strong organizational capacity to implement the activities involved.

''(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

''(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

''(4) PRIORITY FOR SERVING HIGH-RISK POPULATIONS.—The eligible entity gives priority to providing services under the program to the following:

''(A) Eligible families who reside in communities in need of such services, as identified in the statewide needs assessment required under subsection (b)(1)(A).

''(B) Low-income eligible families.

''(C) Eligible families who are pregnant women who have not attained age 21.

''(D) Eligible families that have a history of child abuse or neglect.

''(E) Eligible families that have had interactions with child welfare services.

"(F) Eligible families that have a history of substance abuse or need substance abuse treatment.

"(G) Eligible families that have users of tobacco products in the home.

"(H) Eligible families that are or have children with low student achievement.

"(I) Eligible families with children with developmental delays or disabilities.

"(J) Eligible families who, or that include individuals who, are serving or formerly served in the Armed Forces, including such families that have members of the Armed Forces who have had multiple deployments outside of the United States.

"(e) APPLICATION REQUIREMENTS.—An eligible entity desiring a grant under this section shall submit an application to the Secretary for approval, in such manner as the Secretary may require, that includes the following:

"(1) A description of the populations to be served by the entity, including specific information regarding how the entity will serve high risk populations described in subsection (d)(4).

"(2) An assurance that the entity will give priority to serving low-income eligible families and eligi-

ble families who reside in at risk communities identified in the statewide needs assessment required under subsection (b)(1)(A).

''(3) The service delivery model or models described in subsection (d)(3)(A) that the entity will use under the program and the basis for the selection of the model or models.

''(4) A statement identifying how the selection of the populations to be served and the service delivery model or models that the entity will use under the program for such populations is consistent with the results of the statewide needs assessment conducted under subsection (b).

''(5) The quantifiable, measurable benchmarks established by the State to demonstrate that the program contributes to improvements in the areas specified in subsection (d)(1)(A).

''(6) An assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the service delivery model or models used under the program to verify that the program is implemented and services are delivered according to the model specifications.

''(7) Assurances that the entity will establish procedures to ensure that—

''(A) the participation of each eligible family in the program is voluntary; and

''(B) services are provided to an eligible family in accordance with the individual assessment for that family.

''(8) Assurances that the entity will—

''(A) submit annual reports to the Secretary regarding the program and activities carried out under the program that include such information and data as the Secretary shall require; and

''(B) participate in, and cooperate with, data and information collection necessary for the evaluation required under subsection (g)(2) and other research and evaluation activities carried out under subsection (h)(3).

''(9) A description of other State programs that include home visitation services, including, if applicable to the State, other programs carried out under this title with funds made available from allotments under section 502(c), programs funded under title IV, title II of the Child Abuse Prevention and Treatment Act (relating to community-based grants for

the prevention of child abuse and neglect), and section 645A of the Head Start Act (relating to Early Head Start programs).

''(10) Other information as required by the Secretary.

''(f) MAINTENANCE OF EFFORT.—Funds provided to an eligible entity receiving a grant under this section shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives.

''(g) EVALUATION.—

''(1) INDEPENDENT, EXPERT ADVISORY PANEL.—The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation and research, education, and early childhood programs—

''(A) to review, and make recommendations on, the design and plan for the evaluation required under paragraph (2) within 1 year after the date of enactment of this section;

''(B) to maintain and advise the Secretary regarding the progress of the evaluation; and

''(C) to comment, if the panel so desires, on the report submitted under paragraph (3).

''(2) AUTHORITY TO CONDUCT EVALUATION.—On the basis of the recommendations of the advisory panel under paragraph (1), the Secretary shall, by grant, contract, or interagency agreement, conduct an evaluation of the statewide needs assessments submitted under subsection (b) and the grants made under subsections (c) and (h)(3)(B). The evaluation shall include—

''(A) an analysis, on a State-by-State basis, of the results of such assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments; and

''(B) an assessment of—

''(i) the effect of early childhood home visitation programs on child and parent outcomes, including with respect to each of the benchmark areas specified in subsection (d)(1)(A) and the participant outcomes described in subsection (d)(2)(B);

''(ii) the effectiveness of such programs on different populations, including the extent to which the ability of programs

to improve participant outcomes varies across programs and populations; and

''(iii) the potential for the activities conducted under such programs, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs.

''(3) REPORT.—Not later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted under paragraph (2) and shall make the report publicly available.

''(h) OTHER PROVISIONS.—

''(1) INTRA-AGENCY COLLABORATION.—The Secretary shall ensure that the Maternal and Child Health Bureau and the Administration for Children and Families collaborate with respect to all aspects of carrying out this section, including with respect to—

''(A) reviewing and analyzing the statewide needs assessments required under subsection (b), the awarding and oversight of grants awarded under this section, the establishment of the advisory panels required under sub-

sections (d)(1)(B)(iii)(II) and (g)(1), and the evaluation and report required under subsection (g); and

''(B) consulting with other Federal agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate with respect to research related to such programs and families, including the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services, the Centers for Disease Control and Prevention, the National Institute of Child Health and Human Development of the National Institutes of Health, the Office of Juvenile Justice and Delinquency Prevention of the Department of Justice, and the Institute of Education Sciences of the Department of Education.

''(2) GRANTS TO ELIGIBLE ENTITIES THAT ARE NOT STATES.—

''(A) INDIAN TRIBES, TRIBAL ORGANIZATIONS, OR URBAN INDIAN ORGANIZATIONS.—The Secretary shall specify requirements for eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organiza-

tions, or Urban Indian Organizations to apply for and conduct an early childhood home visitation program with a grant under this section. Such requirements shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium), Tribal Organization, or Urban Indian Organization to—

"(i) conduct a needs assessment similar to the assessment required for all States under subsection (b); and

"(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

"(B) NONPROFIT ORGANIZATIONS.—If, as of the beginning of fiscal year 2012, a State has not applied and been approved for a grant under this section, the Secretary may use amounts appropriated under paragraph (1) of subsection (j) that are available for expenditure under paragraph (3) of that subsection to make a grant to an eligible entity that is a nonprofit organization described in subsection (k)(1)(B) to conduct an early childhood home visitation

program in the State. The Secretary shall specify the requirements for such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

''(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

''(ii) establish quantifiable, measurable 3- and 5-year benchmarks consistent with subsection (d)(1)(A).

''(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

''(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, or through grants, cooperative agreements, or contracts.

''(B) REQUIREMENTS.—The Secretary shall ensure that—

''(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

''(ii) the conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

''(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

''(A) information regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A);

''(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of any such assistance provided; and

"(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

"(i) APPLICATION OF OTHER PROVISIONS OF TITLE.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

"(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

"(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(C) Section 504(d) (relating to a limitation on administrative expenditures).

"(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(E) Section 507 (relating to penalties for false statements).

''(F) Section 508 (relating to non-discrimination).

''(G) Section 509(a) (relating to the administration of the grant program).

''(j) APPROPRIATIONS.—

''(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section—

''(A) $100,000,000 for fiscal year 2010;

''(B) $250,000,000 for fiscal year 2011;

''(C) $350,000,000 for fiscal year 2012;

''(D) $400,000,000 for fiscal year 2013; and

''(E) $400,000,000 for fiscal year 2014.

''(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

''(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

''(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(iii), (g), and (h)(3).

''(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be used for grants to nonprofit organizations under subsection (h)(2)(B).

''(k) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—

''(A) IN GENERAL.—The term 'eligible entity' means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and American Samoa.

''(B) NONPROFIT ORGANIZATIONS.—Only for purposes of awarding grants under subsection (h)(2)(B), such term shall include a nonprofit organization with an established record of providing early childhood home visita-

tion programs or initiatives in a State or several States.

''(2) ELIGIBLE FAMILY.—The term 'eligible family' means—

''(A) a woman who is pregnant, and the father of the child if the father is available; or

''(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents, who are serving as the child's primary caregiver from birth until entry into kindergarten, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical care for, the child.

''(3) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian Tribe' and 'Tribal Organization', and 'Urban Indian Organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act.''.

SEC. 1802. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) DEFINITIONS.—In this section:

(1) The term ''postpartum condition'' means postpartum depression or postpartum psychosis.

(2) The term ''Secretary'' means the Secretary of Health and Human Services.

(b) RESEARCH ON POSTPARTUM CONDITIONS.—

(1) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—

(A) CONTINUATION OF ACTIVITIES.—The Secretary is encouraged to continue activities on postpartum conditions.

(B) PROGRAMS FOR POSTPARTUM CONDITIONS.—In carrying out subparagraph (A), the Secretary is encouraged to continue research to expand the understanding of the causes of, and treatments for, postpartum conditions. Activities under such subsection shall include conducting and supporting the following:

(i) Basic research concerning the etiology and causes of the conditions.

(ii) Epidemiological studies to address the frequency and natural history of the conditions and the differences among racial and ethnic groups with respect to the conditions.

(iii) The development of improved screening and diagnostic techniques.

(iv) Clinical research for the development and evaluation of new treatments.

(v) Information and education programs for health care professionals and the public, which may include a coordinated national campaign to increase the awareness and knowledge of postpartum conditions. Activities under such a national campaign may—

(I) include public service announcements through television, radio, and other means; and

(II) focus on—

(aa) raising awareness about screening;

(bb) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(cc) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms,

methods of coping with the illness, and treatment resources.

(2) SENSE OF CONGRESS REGARDING LONGITUDINAL STUDY OF RELATIVE MENTAL HEALTH CONSEQUENCES FOR WOMEN OF RESOLVING A PREGNANCY.—

(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the relative mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and parenting the child, carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(B) REPORT.—Subject to the completion of the study under subsection (a), beginning not later than 5 years after the date of the enact-

ment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(c) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 1801, is amended by adding at the end the following new section:

"SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

''(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of essential services to individuals with a postpartum condition and their families.

''(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under subsection (a) provide education and services with respect to the diagnosis and management of postpartum conditions. The Secretary may allow such projects to include the following:

''(1) Delivering or enhancing outpatient and home-based health and support services, including case management and comprehensive treatment services for individuals with or at risk for postpartum conditions, and delivering or enhancing support services for their families.

''(2) Delivering or enhancing inpatient care management services that ensure the well-being of the mother and family and the future development of the infant.

''(3) Improving the quality, availability, and organization of health care and support services (including transportation services, attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance) for individuals with a postpartum condition and support services for their families.

''(4) Providing education to new mothers and, as appropriate, their families about postpartum conditions to promote earlier diagnosis and treatment. Such education may include—

''(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

''(B) in the case of a grantee that is a State, hospital, or birthing facility—

''(i) providing education to new mothers and fathers, and other family members as appropriate, concerning postpartum conditions before new mothers leave the health facility; and

''(ii) ensuring that training programs regarding such education are carried out at the health facility.

''(c) INTEGRATION WITH OTHER PROGRAMS.—To the extent practicable and appropriate, the Secretary may integrate the grant program under this section with other grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

''(d) CERTAIN REQUIREMENTS.—A grant may be made under this section only if the applicant involved makes the following agreements:

''(1) Not more than 5 percent of the grant will be used for administration, accounting, reporting, and program oversight functions.

''(2) The grant will be used to supplement and not supplant funds from other sources related to the treatment of postpartum conditions.

''(3) The applicant will abide by any limitations deemed appropriate by the Secretary on any charges to individuals receiving services pursuant to the grant. As deemed appropriate by the Secretary, such limitations on charges may vary based on the financial circumstances of the individual receiving services.

''(4) The grant will not be expended to make payment for services authorized under subsection (a) to the extent that payment has been made, or can reasonably be expected to be made, with respect to such services—

''(A) under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

''(B) by an entity that provides health services on a prepaid basis.

''(5) The applicant will, at each site at which the applicant provides services funded under subsection (a), post a conspicuous notice informing individuals who receive the services of any Federal policies that apply to the applicant with respect to the imposition of charges on such individuals.

''(6) For each grant period, the applicant will submit to the Secretary a report that describes how grant funds were used during such period.

''(e) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

''(f) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

''(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

''(A) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

''(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

''(C) Section 504(d) (relating to a limitation on administrative expenditures).

''(D) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

''(E) Section 507 (relating to penalties for false statements).

''(F) Section 508 (relating to nondiscrimination).

''(G) Section 509(a) (relating to the administration of the grant program).

''(g) DEFINITIONS.—In this section:

''(1) The term 'eligible entity'—

''(A) means a public or nonprofit private entity; and

''(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospice, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

''(2) The term 'postpartum condition' means postpartum depression or postpartum psychosis.''.

(d) GENERAL PROVISIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and the amendment made by subsection (c), there are authorized to be appropriated, in addition to such other sums as may be available for such purpose—

(A) $3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) REPORT BY THE SECRETARY.—

(A) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

(3) LIMITATION.—Notwithstanding any other provision of this section or the amendment made by subsection (c), the Secretary may not utilize amounts made available under this section or such amendment to carry out activities or programs that are duplicative of activities or programs that are al-

ready being carried out through the Department of Health and Human Services.

SEC. 1803. PERSONAL RESPONSIBILITY EDUCATION FOR ADULTHOOD TRAINING.

Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by sections 1801 and 1802(c), is amended by adding at the end the following:

"SEC. 513. PERSONAL RESPONSIBILITY EDUCATION FOR ADULTHOOD (PRE-ADULTHOOD) TRAINING.

''(a) ALLOTMENTS TO STATES.—

''(1) AMOUNT.—

''(A) IN GENERAL.—For the purpose described in subsection (b), subject to the succeeding provisions of this section, for each of fiscal years 2010 through 2014, the Secretary shall allot to each State an amount equal to the product of—

''(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c); and

''(ii) the State youth population percentage determined under paragraph (2).

''(B) MINIMUM ALLOTMENT.—

''(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

''(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

''(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

''(i) IN GENERAL.—A State shall not be paid from its allotment for a fiscal year unless the State submits an application to the Secretary for the fiscal year and the Secretary approves the application (or requires changes to the application that the State satisfies) and meets such additional requirements as the Secretary may specify.

''(ii) REQUIREMENTS.—The State application shall contain an assurance that the State has complied with the requirements of this section in preparing and submitting the application and shall include

the following as well as such additional information as the Secretary may require:

''(I) Based on data from the Centers for Disease Control and Prevention National Center for Health Statistics, the most recent pregnancy rates for the State for youth ages 10 to 14 and youth ages 15 to 19 for which data are available, the most recent birth rates for such youth populations in the State for which data are available, and trends in those rates for the most recently preceding 5-year period for which such data are available.

''(II) State-established goals for reducing the pregnancy rates and birth rates for such youth populations.

''(III) A description of the State's plan for using the State allotments provided under this section to achieve such goals, especially among youth populations that are the most high-risk or vulnerable for pregnancies or otherwise have special cir-

cumstances, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

''(2) STATE YOUTH POPULATION PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the State youth population percentage is, with respect to a State, the proportion (expressed as a percentage) of—

''(i) the number of individuals who have attained age 10 but not attained age 20 in the State; to

''(ii) the number of such individuals in all States.

''(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent Bureau of the Census data.

''(3) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a

State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

''(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

''(A) GRANTS FROM UNEXPENDED ALLOTMENTS.—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allotted for the State for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the end of the period in which the allotments are available for expenditure under paragraph (3) for awarding grants under this paragraph.

''(B) 3-YEAR GRANTS.—

''(i) IN GENERAL.—The Secretary shall solicit applications to award 3-year

grants in each of fiscal years 2012, 2013, and 2014 to local organizations and entities to conduct, consistent with subsection (b), programs and activities in States that do not submit an application for an allotment under this section for fiscal year 2010 or 2011.

''(ii) FAITH-BASED ORGANIZATIONS OR CONSORTIA.—The Secretary may solicit and award grants under this paragraph to faith-based organizations or consortia, consistent with the requirements of section 1955 of the Public Health Service Act relating to a grant award to nongovernmental entities.

''(C) EVALUATION.—An organization or entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation.

''(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment determined for the State under this subsection or to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State, organization, or entity for activi-

ties, programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

''(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and reporting on outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

''(b) PURPOSE.—

''(1) IN GENERAL.—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants made under subsection (a)(4)(B), to enable a local organization or entity) to carry out personal responsibility education for adulthood programs consistent with this subsection.

''(2) PERSONAL RESPONSIBILITY EDUCATION FOR ADULTHOOD PROGRAMS.—

''(A) IN GENERAL.—In this section, the term 'personal responsibility education for

adulthood program' means a program that is designed to educate adolescents on—

''(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

''(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

''(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

''(i) The program replicates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth.

''(ii) The program is medically-accurate and complete.

''(iii) The program includes activities to educate youth who are sexually active

regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

''(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

''(v) The program provides age-appropriate information and activities.

''(vi) The information and activities carried out under the program are provided in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

''(C) ADULTHOOD PREPARATION SUBJECTS.—The adulthood preparation subjects described in this subparagraph are the following:

''(i) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

''(ii) Adolescent development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other related subjects.

''(iii) Financial literacy.

''(iv) Parent-child communication.

''(v) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

''(vi) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

''(D) FAITH-BASED ORGANIZATIONS.—A faith-based entity carrying out a program funded in whole or in part with funds made available under this section through a State allotment or a grant shall agree that information, activities, and services are carried out with funds made available to the entity from the allotment consistent with the requirements of section 1955 of the Public Health Service Act re-

lating to a grant award to nongovernmental entities.

''(c) RESERVATIONS OF FUNDS.—

''(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for youth. An entity awarded a grant under this paragraph shall agree to participate in a rigorous Federal evaluation of the activities carried out with grant funds.

''(2) OTHER RESERVATIONS.—From the amount appropriated under subsection (f) for the fiscal year that remains after the application of paragraph (1), the Secretary shall reserve the following amounts:

"(A) GRANTS FOR INDIAN TRIBES OR TRIBAL ORGANIZATIONS.—The Secretary shall reserve 5 percent of such remainder for purposes of awarding grants to Indian tribes and tribal organizations in such manner, and subject to such requirements, as the Secretary, in consultation with Indian tribes and tribal organizations, determines appropriate.

"(B) SECRETARIAL RESPONSIBILITIES.—The Secretary shall reserve 10 percent of such remainder for expenditures by the Secretary for the following:

"(i) To award a grant to establish and operate a national teen pregnancy prevention resource center consistent with subparagraph (C).

"(ii) To conduct research, training, and technical assistance with respect to the programs and activities carried out with funds made available through allotments or grants made under this section.

"(iii) To evaluate the programs and activities carried out with funds made available through such allotments and grants.

''(C) NATIONAL TEEN PREGNANCY PREVENTION RESOURCE CENTER.—

''(i) IN GENERAL.—The Secretary shall award a grant to a nationally recognized, nonpartisan, nonprofit organization that meets the requirements described in clause (ii) to establish and operate a national teen pregnancy prevention resource center (in this subparagraph referred to as the 'Resource Center') to carry out the purpose and activities described in clause (iii).

''(ii) REQUIREMENTS.—The requirements described in this clause are the following:

''(I) The organization has demonstrated experience working with and providing assistance to a broad range of individuals and entities to reduce teen pregnancy.

''(II) The organization is research-based and has comprehensive knowledge and data about teen pregnancy prevention strategies.

"(iii) PURPOSE AND ACTIVITIES.—The Resource Center shall provide information and technical assistance to public and private entities seeking to reduce teen pregnancy rates through activities that include the following:

"(I) Synthesizing and disseminating research and information regarding effective and promising practices.

"(II) Developing and providing information on how to identify, select, and implement effective programs.

"(III) Linking organizations to existing resources, experts, and peers.

"(IV) Providing consultation and resources on a broad array of strategies and messages, including messages that focus on abstinence, contraception, responsible behavior and choices, family communication, relationships, and values.

"(iv) COLLABORATION WITH OTHER ORGANIZATIONS.—The organization operating the Resource Center shall collaborate

with other entities that have expertise in the prevention of HIV and sexually transmitted infections, healthy relationships, financial literacy, and other topics addressed through the personal responsibility for adulthood educational programs to develop resources and materials, provide technical assistance to States, Indian tribes, and communities, and undertake other activities as necessary.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—The Secretary shall administer this section through the Assistant Secretary for the Administration for Children and Families within the Department of Health and Human Services.

''(2) APPLICATION OF OTHER PROVISIONS OF TITLE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the other provisions of this title shall not apply to allotments or grants made under this section.

''(B) EXCEPTIONS.—The following provisions of this title shall apply to allotments and grants made under this section to the same ex-

tent and in the same manner as such provisions apply to allotments made under section 502(c):

"(i) Section 504(b)(6) (relating to prohibition on payments to excluded individuals and entities).

"(ii) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

"(iii) Section 504(d) (relating to a limitation on administrative expenditures).

"(iv) Section 506 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

"(v) Section 507 (relating to penalties for false statements).

"(vi) Section 508 (relating to nondiscrimination).

"(e) DEFINITIONS.—In this section:

"(1) AGE-APPROPRIATE.—The term 'age-appropriate', with respect to the information in pregnancy prevention, means topics, messages, and teaching methods suitable to particular ages or age groups of children and adolescents, based on developing cog-

nitive, emotional, and behavioral capacity typical for the age or age group.

''(2) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete' means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

''(A) published in peer-reviewed journals, where applicable; or

''(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

''(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The terms 'Indian tribe' and 'Tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)).

''(4) YOUTH.—The term 'youth' means an individual who has attained age 10 but has not attained age 20.

''(f) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2010 through 2014. Amounts ap-

propriated under this subsection shall remain available until expended.''.

SEC. 1804. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

(1) in subsection (a), by striking ''fiscal year 1998 and each subsequent fiscal year'' and inserting ''each of fiscal years 2010 through 2014''; and

(2) in subsection (d)—

(A) in the first sentence, by striking ''1998 through 2003'' and inserting ''2010 through 2014''; and

(B) in the second sentence, by inserting ''(except that such appropriation shall be made on the date of enactment of the America's Healthy Future Act of 2009 in the case of fiscal year 2010)'' before the period.

Subtitle J—Programs of Health Promotion and Disease Prevention

SEC. 1901. PROGRAMS OF HEALTH PROMOTION AND DISEASE PREVENTION.

(a) INTERNAL REVENUE CODE OF 1986.—Section 9802 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating the second subsection (f) as subsection (g); and

(2) by adding at the end the following:

''(h) PROGRAMS OF HEALTH PROMOTION AND DISEASE PREVENTION.—

''(1) APPLICABILITY.—The following shall apply with respect to a program of health promotion or disease prevention for purposes of subsection (b)(2)(B). Such programs shall be referred to as 'wellness programs'.

''(2) DEFINITION AND GENERAL RULE.—

''(A) DEFINITION.—For purposes of this subsection, a wellness program is any program designed to promote health or prevent disease, including a program designed to encourage individuals to adopt healthy behaviors.

''(B) GENERAL RULE.—For purposes of subsections (a)(2) and (b)(2) (which provide exceptions to the general prohibitions against discrimination based on a health factor for group health plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program that satisfies the requirements of this sub-

section), if none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor, under this subsection, such wellness program does not violate this section if participation in the program is made available to all similarly situated individuals. If any of the conditions for obtaining a reward under such a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program shall not violate this section if the requirements of paragraph (4) of this section are satisfied.

''(3) WELLNESS PROGRAMS NOT SUBJECT TO REQUIREMENTS.—If none of the conditions for obtaining a reward under a wellness program are based on an individual satisfying a standard that is related to a health factor (or if a wellness program does not provide a reward), the wellness program shall not violate this section, if participation in the program is made available to all similarly situated individuals. Such programs need not satisfy the requirements of paragraph (4), if participation in the program is made available to all similarly situated

individuals. Wellness programs described in this paragraph include the following:

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

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

"(C) A program that encourages preventive care through the waiver of the copayment or deductible requirement under a group health plan for the costs of, for example, prenatal care or well-baby visits.

"(D) A program that reimburses employees for the costs of smoking cessation programs without regard to whether the employee quits smoking.

"(E) A program that provides a reward to employees for attending a monthly health education seminar.

"(4) WELLNESS PROGRAMS SUBJECT TO REQUIREMENTS.—If any of the conditions for obtaining a reward under a wellness program is based on an individual satisfying a standard that is related to a health factor, the wellness program shall not violate

this section if the requirements of this paragraph are satisfied.

''(A) The reward for the wellness program, coupled with the reward for other wellness programs with respect to the plan that require satisfaction of a standard related to a health factor, shall not exceed 30 percent of the cost of employee-only coverage under the plan. However, if, in addition to employees, any class of dependents (such as spouses or spouses and dependent children) may participate in the wellness program, the reward shall not exceed 30 percent of the cost of the coverage in which an employee and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employer and employee contributions for the benefit package under which the employee is (or the employee and any dependents are) receiving coverage. A reward may be in the form of a discount or rebate of a premium or contribution, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the absence of a surcharge, or the value of a benefit that would oth-

erwise not be provided under the plan. The Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage under the plan if such Secretaries determine that such an increase is appropriate.

''(B) The wellness program shall be reasonably designed to promote health or prevent disease. A program satisfies this subparagraph if it has a reasonable chance of improving the health of or preventing disease in participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health factor, and is not highly suspect in the method chosen to promote health or prevent disease. At least once per year, each plan or issuer offering a wellness program shall evaluate the reasonableness of such program.

''(C) The program shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once per year.

''(D)(i) The reward under the program shall be available to all similarly situated individuals.

''(ii) For purposes of clause (i), a reward is not available to all similarly situated individuals for a period unless the program allows—

''(I) a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

''(II) a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is medically inadvisable to attempt to satisfy the otherwise applicable standard.

''(iii) A plan or issuer may seek verification, such as a statement from an individual's physician, that a health factor makes it unreasonably difficult or medically inadvisable for the individual to satisfy or attempt to satisfy the otherwise applicable standard.

"(E)(i) The plan or issuer shall disclose in all plan materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials merely mention that a program is available, without describing its terms, such disclosure is not required.

"(ii) The following language, or similar language, may be used to satisfy the requirement of this subparagraph: 'If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at [insert telephone number] and we will work with you to develop another way to qualify for the reward.'.

"(5) REGULATIONS.—The Secretaries of Labor, Health and Human Services, and the Treasury may promulgate regulations, as appropriate, to carry out this subsection.

''(6) EFFECTIVE DATE.—This subsection shall take effect on the date of enactment of the America's Healthy Future Act of 2009.

''(7) EXISTING WELLNESS PROGRAMS.—During the period of time between the date of enactment of the America's Healthy Future Act of 2009 and the date on which the Secretaries of Labor, Health and Human Services, and the Treasury establish regulations to effectuate this subsection, a wellness program that was established prior to the date of enactment of the America's Healthy Future Act of 2009 may continue to operate in accordance with the requirements in effect on the day before such date of enactment.''.

(b) PHSA GROUP MARKET.—Section 2702(b) of the Public Health Service Act (42 U.S.C. 300gg-1(b)) is amended by adding at the end the following:

''(4) PROGRAMS OF HEALTH PROMOTION AND DISEASE PREVENTION.—The provisions of section 9802(h) of the Internal Revenue Code of 1986 shall apply to programs of health promotion and disease prevention offered through a group health plan or a health insurance issuer offering group health insurance coverage.''.

(c) ERISA.—Section 702(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1182(b)) is amended by adding at the end the following:

''(4) PROGRAMS OF HEALTH PROMOTION AND DISEASE PREVENTION.—The provisions of section 9802(h) of the Internal Revenue Code of 1986 shall apply to programs of health promotion and disease prevention offered through a group health plan or a health insurance issuer offering group health insurance coverage.''.

(d) APPLICATION OF WELLNESS PROGRAMS PROVISIONS TO CARRIERS PROVIDING FEDERAL EMPLOYEE HEALTH BENEFITS PLANS.—

(1) IN GENERAL.—Notwithstanding section 8906 of title 5, United States Code (including subsections (b)(1) and (b)(2) of such section), subsections (a), (b), and (c) of this section, including the amendments made by those subsections, (relating to wellness programs) shall apply to carriers entering into contracts under section 8902 of title 5, United States Code.

(2) PROPOSALS.—Carriers may submit separate proposals relating to voluntary wellness program offerings as part of the annual call for benefit and

rate proposals to the Office of Personnel Management.

(3) EFFECTIVE DATE.—This subsection shall take effect on the date of enactment of this Act and shall apply to contracts entered into under section 8902 of title 5, United States Code, that take effect with respect to calendar years that begin more than 1 year after that date.

(e) STATE DEMONSTRATION PROJECT.—Subpart 1 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.) is amended by adding at the end the following:

"SEC. 2746. WELLNESS PROGRAM DEMONSTRATION PROJECT.

"(a) IN GENERAL.—Not later than July 1, 2014, the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, shall establish a 10-State demonstration project under which participating States shall apply the provisions of 9802(h) of the Internal Revenue Code of 1986 to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

"(b) EXPANSION OF DEMONSTRATION PROJECT.—If the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury, determines that

the demonstration project described in subsection (a) is effective, such Secretaries may, beginning on July 1, 2017 expand such demonstration project to include additional participating States.

''(c) REQUIREMENTS.—States that participate in the demonstration project under this section shall—

''(1) ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

''(2) require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

''(A) do not create undue burdens for individuals insured in the individual market;

''(B) do not lead to cost shifting; and

''(C) are not a subterfuge for discrimination; and

''(3) ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).

''(d) EXISTING PROGRAMS OF HEALTH PROMOTION OR DISEASE PREVENTION.—Nothing in this section shall preempt any State law related to programs of health pro-

motion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State that was established or adopted by State law on or after the date of enactment of this Act.

''(e) REGULATIONS.—The Secretaries of Health and Human Services and the Treasury may promulgate regulations, as appropriate, to carry out this section.''.

(f) REPORT.—

(1) IN GENERAL.—Not later than 3 years after the date of enactment of this Act, the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

(A) the effectiveness of wellness programs (as defined in section 9802(h)(2) of the Internal Revenue Code of 1986, as added by subsection (a)) in promoting health and preventing disease;

(B) the impact of such wellness programs on the access to care and affordability of coverage for participants and non-participants of such programs;

(C) the impact of premium-based and cost-sharing incentives on participant behavior and

the role of such programs in changing behavior; and

(D) the effectiveness of different types of rewards.

(2) DATA COLLECTION.—In preparing the report described in paragraph (1), the Secretaries shall gather relevant information from employers who provide employees with access to wellness programs, including State and Federal agencies.

Subtitle K—Elder Justice Act

SEC. 1911. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the ''Elder Justice Act of 2009''.

SEC. 1912. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 1913(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 1913. ELDER JUSTICE.

(a) ELDER JUSTICE.—

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting ''**AND ELDER JUSTICE**'' after ''**SOCIAL SERVICES**'';

(B) by inserting before section 2001 the following:

"Subtitle A—Block Grants to States for Social Services";

and

(C) by adding at the end the following:

"Subtitle B—Elder Justice

"SEC. 2011. DEFINITIONS.

''In this subtitle:

''(1) ABUSE.—The term 'abuse' means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

''(2) ADULT PROTECTIVE SERVICES.—The term 'adult protective services' means such services provided to adults as the Secretary may specify and includes services such as—

''(A) receiving reports of adult abuse, neglect, or exploitation;

''(B) investigating the reports described in subparagraph (A);

''(C) case planning, monitoring, evaluation, and other case work and services; and

''(D) providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

''(3) CAREGIVER.—The term 'caregiver' means an individual who has the responsibility for the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law, and means a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

''(4) DIRECT CARE.—The term 'direct care' means care by an employee or contractor who provides assistance or long-term care services to a recipient.

''(5) ELDER.—The term 'elder' means an individual age 60 or older.

''(6) ELDER JUSTICE.—The term 'elder justice' means—

''(A) from a societal perspective, efforts to—

''(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

''(ii) protect elders with diminished capacity while maximizing their autonomy; and

''(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

''(7) ELIGIBLE ENTITY.—The term 'eligible entity' means a State or local government agency, Indian tribe or tribal organization, or any other public or private entity that is engaged in and has expertise in issues relating to elder justice or in a field necessary to promote elder justice efforts.

''(8) EXPLOITATION.—The term 'exploitation' means the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

''(9) FIDUCIARY.—The term 'fiduciary'—

"(A) means a person or entity with the legal responsibility—

"(i) to make decisions on behalf of and for the benefit of another person; and

"(ii) to act in good faith and with fairness; and

"(B) includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.

"(10) GRANT.—The term 'grant' includes a contract, cooperative agreement, or other mechanism for providing financial assistance.

"(11) GUARDIANSHIP.—The term 'guardianship' means—

"(A) the process by which a State court determines that an adult individual lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker;

"(B) the manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

"(C) the manner in which the court exercises oversight of the surrogate decisionmaker.

"(12) INDIAN TRIBE.—

"(A) IN GENERAL.—The term 'Indian tribe' has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

"(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term 'Indian tribe' includes any Pueblo or Rancheria.

"(13) LAW ENFORCEMENT.—The term 'law enforcement' means the full range of potential responders to elder abuse, neglect, and exploitation including—

"(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

"(B) prosecutors;

"(C) medical examiners;

"(D) investigators; and

"(E) coroners.

"(14) LONG-TERM CARE.—

"(A) IN GENERAL.—The term 'long-term care' means supportive and health services specified by the Secretary for individuals who need assistance because the individuals have a loss of

capacity for self-care due to illness, disability, or vulnerability.

''(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term 'loss of capacity for self-care' means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, management of one's financial affairs, and other activities the Secretary determines appropriate.

''(15) LONG-TERM CARE FACILITY.—The term 'long-term care facility' means a residential care provider that arranges for, or directly provides, long-term care.

''(16) NEGLECT.—The term 'neglect' means—

''(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

''(B) self-neglect.

''(17) NURSING FACILITY.—

''(A) IN GENERAL.—The term 'nursing facility' has the meaning given such term under section 1919(a).

''(B) INCLUSION OF SKILLED NURSING FACILITY.—The term 'nursing facility' includes a

skilled nursing facility (as defined in section 1819(a)).

''(18) SELF-NEGLECT.—The term 'self-neglect' means an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

''(A) obtaining essential food, clothing, shelter, and medical care;

''(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

''(C) managing one's own financial affairs.

''(19) SERIOUS BODILY INJURY.—

''(A) IN GENERAL.—The term 'serious bodily injury' means an injury—

''(i) involving extreme physical pain;

''(ii) involving substantial risk of death;

''(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

''(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

''(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or 2242 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

''(20) SOCIAL.—The term 'social', when used with respect to a service, includes adult protective services.

''(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term 'State legal assistance developer' means an individual described in section 731 of the Older Americans Act of 1965.

''(22) STATE LONG-TERM CARE OMBUDSMAN.—The term 'State Long-Term Care Ombudsman' means the State Long-Term Care Ombudsman described in section 712(a)(2) of the Older Americans Act of 1965.

''SEC. 2012. GENERAL PROVISIONS.

''(a) PROTECTION OF PRIVACY.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 264(c) of the Health

Insurance Portability and Accountability Act of 1996 and applicable State and local privacy regulations.

''(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder's right to practice his or her religion through reliance on prayer alone for healing when this choice—

''(1) is contemporaneously expressed, either orally or in writing, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision;

''(2) is previously set forth in a living will, health care proxy, or other advance directive document that is validly executed and applied under State law; or

''(3) may be unambiguously deduced from the elder's life history.

"PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH

"Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

"SEC. 2021. ELDER JUSTICE COORDINATING COUNCIL.

''(a) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the 'Council').

''(b) MEMBERSHIP.—

''(1) IN GENERAL.—The Council shall be composed of the following members:

''(A) The Secretary (or the Secretary's designee).

''(B) The Attorney General (or the Attorney General's designee).

''(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

''(2) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

''(c) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(d) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

''(e) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

''(f) DUTIES.—

''(1) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

''(2) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

''(A) describes the activities and accomplishments of, and challenges faced by—

''(i) the Council; and

''(ii) the entities represented on the Council; and

''(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

''(g) POWERS OF THE COUNCIL.—

''(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair of the Council, the head of such department or agency shall furnish such information to the Council.

''(2) POSTAL SERVICES.—The Council may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Council shall not receive compensation for the performance of services for the Council. The members shall be allowed travel expenses, including per diem in lieu of sub-

sistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Council.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

''(a) ESTABLISHMENT.—There is established a board to be known as the 'Advisory Board on Elder Abuse, Neglect, and Exploitation' (in this section referred to as the 'Advisory Board') to create short- and long-term multidisciplinary strategic plans for the development of the field

of elder justice and to make recommendations to the Elder Justice Coordinating Council established under section 2021.

''(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

''(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b).

''(d) TERMS.—

''(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

''(A) 9 shall be appointed for a term of 3 years;

''(B) 9 shall be appointed for a term of 2 years; and

''(C) 9 shall be appointed for a term of 1 year.

''(2) VACANCIES.—

''(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

''(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

''(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member's successor takes office.

''(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall elect its initial Chair and Vice Chair at its initial meeting.

''(f) DUTIES.—

''(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative and innovative approaches to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

''(2) COLLABORATIVE EFFORTS TO DEVELOP CONSENSUS AROUND THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

''(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address, and develop consensus on, subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for managing resident-to-resident abuse in long-term care.

''(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

''(3) REPORT.—Not later than the date that is 18 months after the date of enactment of the Elder Justice Act of 2009, and annually thereafter, the Advisory Board shall prepare and submit to the Elder Justice Coordinating Council, the Committee on Finance of the Senate, and the Committee on

Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing—

"(A) information on the status of Federal, State, and local public and private elder justice activities;

"(B) recommendations (including recommended priorities) regarding—

"(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

"(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

"(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

"(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, and treatment (including diagnosis) of, inter-

vention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

"(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, and elder abuse, neglect, and exploitation; and

"(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

"(g) POWERS OF THE ADVISORY BOARD.—

"(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 2012(a), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

"(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by that Act,

any data, reports, or recommendations generated in connection with such activities.

''(3) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(h) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Advisory Board. The members shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

''(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(j) STATUS AS PERMANENT ADVISORY COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the advisory board.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''SEC. 2023. RESEARCH PROTECTIONS.

''(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protections.

''(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subpart A of part 46 of title 45, Code of Federal Regulations, to research conducted under this subpart, the term 'legally authorized representative' means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

''SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

''There are authorized to be appropriated to carry out this subpart—

''(1) for fiscal year 2011, $6,500,000; and

''(2) for each of fiscal years 2012 through 2014, $7,000,000.

"Subpart B—Elder Abuse, Neglect, and Exploitation Forensic Centers

"SEC. 2031. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

''(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers, to develop forensic expertise regarding, and provide services relating to, elder abuse, neglect, and exploitation.

''(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make 4 of the grants described in subsection (a) to institutions of higher education with demonstrated expertise in forensics or commitment to preventing or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

''(c) MOBILE CENTERS.—The Secretary shall make 6 of the grants described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

''(d) AUTHORIZED ACTIVITIES.—

''(1) DEVELOPMENT OF FORENSIC MARKERS AND METHODOLOGIES.—An eligible entity that re-

ceives a grant under this section shall use funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

''(A) forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

''(B) methodologies for determining, in such a case, when and how health care, emergency service, social and protective services, and legal service providers should intervene and when the providers should report the case to law enforcement authorities.

''(2) DEVELOPMENT OF FORENSIC EXPERTISE.—An eligible entity that receives a grant under this section shall use funds made available through the grant to develop forensic expertise regarding elder abuse, neglect, and exploitation in order to provide medical and forensic evaluation, therapeutic intervention, victim support and advocacy, case review, and case tracking.

''(3) COLLECTION OF EVIDENCE.—The Secretary, in coordination with the Attorney General,

shall use data made available by grant recipients under this section to develop the capacity of geriatric health care professionals and law enforcement to collect forensic evidence, including collecting forensic evidence relating to a potential determination of elder abuse, neglect, or exploitation.

''(e) APPLICATION.—To be eligible to receive a grant under this section, an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $4,000,000;

''(2) for fiscal year 2012, $6,000,000; and

''(3) for each of fiscal years 2013 and 2014, $8,000,000.

"PART II—PROGRAMS TO PROMOTE ELDER JUSTICE

"SEC. 2041. ENHANCEMENT OF LONG-TERM CARE.

''(a) GRANTS AND INCENTIVES FOR LONG-TERM CARE STAFFING.—

''(1) IN GENERAL.—The Secretary shall carry out activities, including activities described in paragraphs (2) and (3), to provide incentives for individ-

uals to train for, seek, and maintain employment providing direct care in long-term care.

''(2) SPECIFIC PROGRAMS TO ENHANCE TRAINING, RECRUITMENT, AND RETENTION OF STAFF.—

''(A) COORDINATION WITH SECRETARY OF LABOR TO RECRUIT AND TRAIN LONG-TERM CARE STAFF.—The Secretary shall coordinate activities under this subsection with the Secretary of Labor in order to provide incentives for individuals to train for and seek employment providing direct care in long-term care.

''(B) CAREER LADDERS AND WAGE OR BENEFIT INCREASES TO INCREASE STAFFING IN LONG-TERM CARE.—

''(i) IN GENERAL.—The Secretary shall make grants to eligible entities to carry out programs through which the entities—

''(I) offer, to employees who provide direct care to residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity, continuing training and varying levels of certification, based on observed clinical care prac-

tices and the amount of time the employees spend providing direct care; and

"(II) provide, or make arrangements to provide, bonuses or other increased compensation or benefits to employees who achieve certification under such a program.

"(ii) APPLICATION.—To be eligible to receive a grant under this subparagraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

"(iii) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subparagraph.

''(3) SPECIFIC PROGRAMS TO IMPROVE MANAGEMENT PRACTICES.—

''(A) IN GENERAL.—The Secretary shall make grants to eligible entities to enable the entities to provide training and technical assistance.

''(B) AUTHORIZED ACTIVITIES.—An eligible entity that receives a grant under subparagraph (A) shall use funds made available through the grant to provide training and technical assistance regarding management practices using methods that are demonstrated to promote retention of individuals who provide direct care, such as—

''(i) the establishment of standard human resource policies that reward high performance, including policies that provide for improved wages and benefits on the basis of job reviews;

''(ii) the establishment of motivational and thoughtful work organization practices;

''(iii) the creation of a workplace culture that respects and values caregivers and their needs;

"(iv) the promotion of a workplace culture that respects the rights of residents of an eligible entity or individuals receiving community-based long-term care from an eligible entity and results in improved care for the residents or the individuals; and

"(v) the establishment of other programs that promote the provision of high quality care, such as a continuing education program that provides additional hours of training, including on-the-job training, for employees who are certified nurse aides.

"(C) APPLICATION.—To be eligible to receive a grant under this paragraph, an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require (which may include evidence of consultation with the State in which the eligible entity is located with respect to carrying out activities funded under the grant).

"(D) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this paragraph shall be construed as prohibiting the Secretary from

limiting the number of applicants for a grant under this paragraph.

''(4) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection benefit individuals who provide direct care and increase the stability of the long-term care workforce.

''(5) DEFINITIONS.—In this subsection:

''(A) COMMUNITY-BASED LONG-TERM CARE.—The term 'community-based long-term care' has the meaning given such term by the Secretary.

''(B) ELIGIBLE ENTITY.—The term 'eligible entity' means the following:

''(i) A long-term care facility.

''(ii) A community-based long-term care entity (as defined by the Secretary).

''(b) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM.—

''(1) GRANTS AUTHORIZED.—The Secretary is authorized to make grants to long-term care facilities for the purpose of assisting such entities in offsetting the costs related to purchasing, leasing, developing, and implementing certified EHR tech-

nology (as defined in section 1848(o)(4)) designed to improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(2) USE OF GRANT FUNDS.—Funds provided under grants under this subsection may be used for any of the following:

''(A) Purchasing, leasing, and installing computer software and hardware, including handheld computer technologies.

''(B) Making improvements to existing computer software and hardware.

''(C) Making upgrades and other improvements to existing computer software and hardware to enable e-prescribing.

''(D) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

''(3) APPLICATION.—

''(A) IN GENERAL.—To be eligible to receive a grant under this subsection, a long-term care facility shall submit an application to the Secretary at such time, in such manner, and

containing such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

''(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

''(4) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall, where available, participate in activities conducted by a State or a qualified State-designated entity (as defined in section 3013(f) of the Public Health Service Act) under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

''(5) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures to ensure that the activities conducted using funds made available under this subsection help improve patient safety and reduce adverse events and health care complications resulting from medication errors.

''(c) ADOPTION OF STANDARDS FOR TRANSACTIONS INVOLVING CLINICAL DATA BY LONG-TERM CARE FACILITIES.—

''(1) STANDARDS AND COMPATIBILITY.—The Secretary shall adopt electronic standards for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature. Standards adopted by the Secretary under the preceding sentence shall be compatible with standards established under part C of title XI, standards established under subsections (b)(2)(B)(i) and (e)(4) of section 1860D–4, standards adopted under section 3004 of the Public Health Service Act, and general health information technology standards.

''(2) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—

''(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

''(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

''(3) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines are necessary to satisfy the requirements of this subsection.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

''(1) for fiscal year 2011, $20,000,000;

''(2) for fiscal year 2012, $17,500,000; and

''(3) for each of fiscal years 2013 and 2014, $15,000,000.

"SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

''(a) SECRETARIAL RESPONSIBILITIES.—

''(1) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services—

"(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

"(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

"(C) develops and disseminates information on best practices regarding, and provides training on, carrying out adult protective services;

"(D) conducts research related to the provision of adult protective services; and

"(E) provides technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsections (b) and (c).

"(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 through 2014.

''(b) GRANTS TO ENHANCE THE PROVISION OF ADULT PROTECTIVE SERVICES.—

''(1) ESTABLISHMENT.—There is established an adult protective services grant program under which the Secretary shall annually award grants to States in the amounts calculated under paragraph (2) for the purposes of enhancing adult protective services provided by States and local units of government.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—Subject to the availability of appropriations and subparagraphs (B) and (C), the amount paid to a State for a fiscal year under the program under this subsection shall equal the amount appropriated for that year to carry out this subsection multiplied by the percentage of the total number of elders who reside in the United States who reside in that State.

''(B) GUARANTEED MINIMUM PAYMENT AMOUNT.—

''(i) 50 STATES.—Subject to clause (ii), if the amount determined under subparagraph (A) for a State for a fiscal year is less than 0.75 percent of the amount appropriated for such year, the Secretary

shall increase such determined amount so that the total amount paid under this subsection to the State for the year is equal to 0.75 percent of the amount so appropriated.

''(ii) TERRITORIES.—In the case of a State other than 1 of the 50 States, clause (i) shall be applied as if each reference to '0.75' were a reference to '0.1'.

''(C) PRO RATA REDUCTIONS.—The Secretary shall make such pro rata reductions to the amounts described in subparagraph (A) as are necessary to comply with the requirements of subparagraph (B).

''(3) AUTHORIZED ACTIVITIES.—

''(A) ADULT PROTECTIVE SERVICES.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

''(B) USE BY AGENCY.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State

government having legal responsibility for providing adult protective services within the State.

''(C) SUPPLEMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

''(4) STATE REPORTS.—Each State receiving funds under this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

''(c) STATE DEMONSTRATION PROGRAMS.—

''(1) ESTABLISHMENT.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

''(2) DEMONSTRATION PROGRAMS.—Funds made available pursuant to this subsection may be

used by States and local units of government to conduct demonstration programs that test—

"(A) training modules developed for the purpose of detecting or preventing elder abuse;

"(B) methods to detect or prevent financial exploitation of elders;

"(C) methods to detect elder abuse;

"(D) whether training on elder abuse forensics enhances the detection of elder abuse by employees of the State or local unit of government; or

"(E) other matters relating to the detection or prevention of elder abuse.

"(3) APPLICATION.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(4) STATE REPORTS.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such manner, and containing such information as the Secretary may require on the results of the demonstration program conducted by the State using funds made available under this subsection.

''(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, $25,000,000 for each of fiscal years 2011 through 2014.

"SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

''(a) GRANTS TO SUPPORT THE LONG-TERM CARE OMBUDSMAN PROGRAM.—

''(1) IN GENERAL.—The Secretary shall make grants to eligible entities with relevant expertise and experience in abuse and neglect in long-term care facilities or long-term care ombudsman programs and responsibilities, for the purpose of—

''(A) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

''(B) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

''(C) providing support for such State long-term care ombudsman programs and such pilot programs (such as through the establishment of a national long-term care ombudsman resource center).

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection—

''(A) for fiscal year 2011, $5,000,000;

''(B) for fiscal year 2012, $7,500,000; and

''(C) for each of fiscal years 2013 and 2014, $10,000,000.

''(b) OMBUDSMAN TRAINING PROGRAMS.—

''(1) IN GENERAL.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

''(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, for each of fiscal years 2011 through 2014, $10,000,000.

''SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

''(a) PROVISION OF INFORMATION.—To be eligible to receive a grant under this part, an applicant shall agree—

''(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through

the grant with such information as the eligible entity may require in order to conduct such evaluation; or

''(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

''(b) USE OF ELIGIBLE ENTITIES TO CONDUCT EVALUATIONS.—

''(1) EVALUATIONS REQUIRED.—Except as provided in paragraph (2), the Secretary shall—

''(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

''(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

''(2) CERTIFIED EHR TECHNOLOGY GRANT PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

''(3) AUTHORIZED ACTIVITIES.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available through the assistance to

conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

''(4) APPLICATIONS.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

''(5) REPORTS.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

''(c) EVALUATIONS AND AUDITS OF CERTIFIED EHR TECHNOLOGY GRANT PROGRAM BY THE SECRETARY.—

''(1) EVALUATIONS.—The Secretary shall conduct an evaluation of the activities funded under the certified EHR technology grant program under section 2041(b). Such evaluation shall include an eval-

uation of whether the funding provided under the grant is expended only for the purposes for which it is made.

''(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2041(b).

''SEC. 2045. REPORT.

''Not later than October 1, 2014, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

''(1) compiling, summarizing, and analyzing the information contained in the State reports submitted under subsections (b)(4) and (c)(4) of section 2042; and

''(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.''.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) IN GENERAL.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C.

602(a)(1)(B)) is amended by adding at the end the following new clause:

"(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

"(I) providing direct care in a long-term care facility (as such terms are defined under section 2011); or

"(II) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel,

and, if so, shall include an overview of such assistance.".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(b) PROTECTING RESIDENTS OF LONG-TERM CARE FACILITIES.—

(1) NATIONAL TRAINING INSTITUTE FOR SURVEYORS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into a

contract with an entity for the purpose of establishing and operating a National Training Institute for Federal and State surveyors. Such Institute shall provide and improve the training of surveyors with respect to investigating allegations of abuse, neglect, and misappropriation of property in programs and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(B) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute established and operated under such contract to carry out the following activities:

(i) Assess the extent to which State agencies use specialized surveyors for the investigation of reported allegations of abuse, neglect, and misappropriation of property in such programs and long-term care facilities.

(ii) Evaluate how the competencies of surveyors may be improved to more effectively investigate reported allegations of such abuse, neglect, and misappropriation of property, and provide feedback to Fed-

eral and State agencies on the evaluations conducted.

(iii) Provide a national program of training, tools, and technical assistance to Federal and State surveyors on investigating reports of such abuse, neglect, and misappropriation of property.

(iv) Develop and disseminate information on best practices for the investigation of such abuse, neglect, and misappropriation of property.

(v) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(vi) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure optimum national responsiveness to complaints of such abuse, neglect, and misappropriation of property.

(vii) Analyze and report annually on the following:

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(viii) Conduct a national study of the cost to State agencies of conducting complaint investigations of skilled nursing facilities and nursing facilities under sections 1819 and 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1396r), and making recommendations to the Secretary of Health and Human Services with respect to options to increase the efficiency and cost-effectiveness of such investigations.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this para-

graph, for the period of fiscal years 2011 through 2014, $12,000,000.

(2) GRANTS TO STATE SURVEY AGENCIES.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall make grants to State agencies that perform surveys of skilled nursing facilities or nursing facilities under sections 1819 or 1919, respectively, of the Social Security Act (42 U.S.C. 1395i–3; 1395r).

(B) USE OF FUNDS.—A grant awarded under subparagraph (A) shall be used for the purpose of designing and implementing complaint investigations systems that—

(i) promptly prioritize complaints in order to ensure a rapid response to the most serious and urgent complaints;

(ii) respond to complaints with optimum effectiveness and timeliness; and

(iii) optimize the collaboration between local authorities, consumers, and providers, including—

(I) such State agency;

(II) the State Long-Term Care Ombudsman;

(III) local law enforcement agencies;

(IV) advocacy and consumer organizations;

(V) State aging units;

(VI) Area Agencies on Aging; and

(VII) other appropriate entities.

(C) AUTHORIZATION.—There are authorized to be appropriated to carry out this paragraph, for each of fiscal years 2011 through 2014, $5,000,000.

(3) REPORTING OF CRIMES IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 1611(c), is amended by inserting after section 1150A the following new section:

''REPORTING TO LAW ENFORCEMENT OF CRIMES OCCURRING IN FEDERALLY FUNDED LONG-TERM CARE FACILITIES

''SEC. 1150B. (a) DETERMINATION AND NOTIFICATION.—

''(1) DETERMINATION.—The owner or operator of each long-term care facility that receives Federal funds under this Act shall annually determine

whether the facility received at least $10,000 in such Federal funds during the preceding year.

''(2) NOTIFICATION.—If the owner or operator determines under paragraph (1) that the facility received at least $10,000 in such Federal funds during the preceding year, such owner or operator shall annually notify each covered individual (as defined in paragraph (3)) of that individual's obligation to comply with the reporting requirements described in subsection (b).

''(3) COVERED INDIVIDUAL DEFINED.—In this section, the term 'covered individual' means each individual who is an owner, operator, employee, manager, agent, or contractor of a long-term care facility that is the subject of a determination described in paragraph (1).

''(b) REPORTING REQUIREMENTS.—

''(1) IN GENERAL.—Each covered individual shall report to the Secretary and 1 or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime (as defined by the law of the applicable political subdivision) against any individual who is a resident of, or is receiving care from, the facility.

''(2) TIMING.—If the events that cause the suspicion—

''(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion; and

''(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

''(c) PENALTIES.—

''(1) IN GENERAL.—If a covered individual violates subsection (b)—

''(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

''(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

''(2) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of the crime or results in harm to another individual—

"(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

"(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

"(3) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

"(4) EXTENUATING CIRCUMSTANCES.—

"(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

"(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term 'underserved population' means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a

population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

"(i) areas or groups that are geographically isolated (such as isolated in a rural area);

"(ii) racial and ethnic minority populations; and

"(iii) populations underserved because of special needs (such as language barriers, disabilities, alien status, or age).

"(d) ADDITIONAL PENALTIES FOR RETALIATION.—

"(1) IN GENERAL.—A long-term care facility may not—

"(A) discharge, demote, suspend, threaten, harass, or deny a promotion or other employment-related benefit to an employee, or in any other manner discriminate against an employee in the terms and conditions of employment because of lawful acts done by the employee; or

"(B) file a complaint or a report against a nurse or other employee with the appropriate State professional disciplinary agency because of lawful acts done by the nurse or employee,

for making a report, causing a report to be made, or for taking steps in furtherance of making a report pursuant to subsection (b)(1).

''(2) PENALTIES FOR RETALIATION.—If a long-term care facility violates subparagraph (A) or (B) of paragraph (1) the facility shall be subject to a civil money penalty of not more than $200,000 or the Secretary may classify the entity as an excluded entity for a period of 2 years pursuant to section 1128(b), or both.

''(3) REQUIREMENT TO POST NOTICE.—Each long-term care facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of employees under this section. Such sign shall include a statement that an employee may file a complaint with the Secretary against a long-term care facility that violates the provisions of this subsection and information with respect to the manner of filing such a complaint.

''(e) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under this section in the same manner as such

provisions apply to a penalty or proceeding under section 1128A(a).

''(f) DEFINITIONS.—In this section, the terms 'elder justice', 'long-term care facility', and 'law enforcement' have the meanings given those terms in section 2011.''.

(c) NATIONAL NURSE AIDE REGISTRY.—

(1) DEFINITION OF NURSE AIDE.—In this subsection, the term ''nurse aide'' has the meaning given that term in sections 1819(b)(5)(F) and 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)(F); 1396r(b)(5)(F)).

(2) STUDY AND REPORT.—

(A) IN GENERAL.—The Secretary, in consultation with appropriate government agencies and private sector organizations, shall conduct a study on establishing a national nurse aide registry.

(B) AREAS EVALUATED.—The study conducted under this subsection shall include an evaluation of—

(i) who should be included in the registry;

(ii) how such a registry would comply with Federal and State privacy laws and regulations;

(iii) how data would be collected for the registry;

(iv) what entities and individuals would have access to the data collected;

(v) how the registry would provide appropriate information regarding violations of Federal and State law by individuals included in the registry;

(vi) how the functions of a national nurse aide registry would be coordinated with the nationwide program for national and State background checks on direct patient access employees of long-term care facilities and providers under section 4301; and

(vii) how the information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)) would be provided as part of a national nurse aide registry.

(C) CONSIDERATIONS.—In conducting the study and preparing the report required under this subsection, the Secretary shall take into

consideration the findings and conclusions of relevant reports and other relevant resources, including the following:

(i) The Department of Health and Human Services Office of Inspector General Report, Nurse Aide Registries: State Compliance and Practices (February 2005).

(ii) The General Accounting Office (now known as the Government Accountability Office) Report, Nursing Homes: More Can Be Done to Protect Residents from Abuse (March 2002).

(iii) The Department of Health and Human Services Office of the Inspector General Report, Nurse Aide Registries: Long-Term Care Facility Compliance and Practices (July 2005).

(iv) The Department of Health and Human Services Health Resources and Services Administration Report, Nursing Aides, Home Health Aides, and Related Health Care Occupations—National and Local Workforce Shortages and Associated

Data Needs (2004) (in particular with respect to chapter 7 and appendix F).

(v) The 2001 Report to CMS from the School of Rural Public Health, Texas A&M University, Preventing Abuse and Neglect in Nursing Homes: The Role of Nurse Aide Registries.

(vi) Information included in State nurse aide registries developed and maintained under sections 1819(e)(2) and 1919(e)(2) of the Social Security Act (42 U.S.C. 1395i–3(e)(2); 1396r(e)(2)(2)).

(D) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall submit to the Elder Justice Coordinating Council established under section 2021 of the Social Security Act, as added by section 1805(a), the Committee on Finance of the Senate, and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the findings and recommendations of the study conducted under this paragraph.

(E) FUNDING LIMITATION.—Funding for the study conducted under this subsection shall not exceed $500,000.

(3) CONGRESSIONAL ACTION.—After receiving the report submitted by the Secretary under paragraph (2)(D), the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives shall, as they deem appropriate, take action based on the recommendations contained in the report.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary for the purpose of carrying out this subsection.

(d) CONFORMING AMENDMENTS.—

(1) TITLE XX.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.), as amended by section 1913(a), is amended—

(A) in the heading of section 2001, by striking ''TITLE'' and inserting ''SUBTITLE''; and

(B) in subtitle 1, by striking ''this title'' each place it appears and inserting ''this subtitle''.

(2) TITLE IV.—Title IV of the Social Security Act (42 U.S.C. 601 et seq.) is amended—

(A) in section 404(d)—

(i) in paragraphs (1)(A), (2)(A), and (3)(B), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears;

(ii) in the heading of paragraph (2), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(iii) in the heading of paragraph (3)(B), by inserting ''SUBTITLE 1 OF'' before ''TITLE XX''; and

(B) in sections 422(b), 471(a)(4), 472(h)(1), and 473(b)(2), by inserting ''subtitle 1 of'' before ''title XX'' each place it appears.

(3) TITLE XI.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended—

(A) in section 1128(h)(3)—

(i) by inserting ''subtitle 1 of'' before ''title XX''; and

(ii) by striking ''such title'' and inserting ''such subtitle''; and

(B) in section 1128A(i)(1), by inserting ''subtitle 1 of'' before ''title XX''.

Subtitle L—Provisions of General Application

SEC. 1921. PROTECTING AMERICANS AND ENSURING TAXPAYER FUNDS IN GOVERNMENT HEALTH CARE PLANS DO NOT SUPPORT OR FUND PHYSICIAN-ASSISTED SUICIDE; PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.

(a) PROTECTING AMERICANS AND ENSURING TAXPAYER FUNDS IN GOVERNMENT HEALTH CARE PLANS DO NOT SUPPORT OR FUND PHYSICIAN-ASSISTED SUICIDE.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), shall not pay for or reimburse any health care entity to provide for any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(b) PROHIBITION AGAINST DISCRIMINATION ON ASSISTED SUICIDE.—

(1) IN GENERAL.—The Federal Government, and any State or local government or health care

provider that receives Federal financial assistance under this Act (or under an amendment made by this Act) or any health plan created under this Act (or under an amendment made by this Act), may not subject an individual or institutional health care entity to discrimination on the basis that the entity does not provide any health care item or service furnished for the purpose of causing, or for the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing.

(2) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this subsection.

(c) CONSTRUCTION AND TREATMENT OF CERTAIN SERVICES.—Nothing in subsection (a) or (b) shall be construed to apply to or to affect any limitation relating to—

(1) the withholding or withdrawing of medical treatment or medical care;

(2) the withholding or withdrawing of nutrition or hydration;

(3) abortion; or

(4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or dis-

comfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

(d) DEFINITION.—In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

SEC. 1922. PROTECTION OF ACCESS TO QUALITY HEALTH CARE THROUGH THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

(a) HEALTH CARE THROUGH DEPARTMENT OF VETERANS AFFAIRS.—Nothing is in this Act shall be construed to prohibit, limit, or otherwise penalize veterans and dependents eligible for health care through the Department of Veterans Affairs under the laws administered by the Secretary of Veterans Affairs from receiving timely access to quality health care in any facility of the Department or from any non-Department health care provider through which the Secretary provides health care.

(b) HEALTH CARE THROUGH DEPARTMENT OF DEFENSE.—

(1) IN GENERAL.—Nothing is in this Act shall be construed to prohibit, limit, or otherwise penalize eligible beneficiaries from receiving timely access to quality health care in any military medical treatment facility or under the TRICARE program.

(2) DEFINITIONS.—In this subsection:

(A) The term ''eligible beneficiaries'' means covered beneficiaries (as defined in section 1072(5) of title 10, United States Code) for purposes of eligible for mental and dental care under chapter 55 of title 10, United States Code.

(B) The term ''TRICARE program'' has the meaning given that term in section 1072(7) of title 10, United States Code.

SEC. 1923. CONTINUED APPLICATION OF ANTITRUST LAWS.

Nothing in this Act shall be construed to modify, impair, or supersede the operation of any of the antitrust laws. For the purposes of this Act, the term ''antitrust laws'' has the meaning given such term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade

Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

TITLE II—PROMOTING DISEASE PREVENTION AND WELLNESS

Subtitle A—Medicare

SEC. 2001. COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.

(a) COVERAGE OF PERSONALIZED PREVENTION PLAN SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by adding ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(FF) personalized prevention plan services (as defined in subsection (hhh));''.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ''subsection (ww)(1)'' and inserting ''subsections (ww)(1) and (hhh)''.

(b) PERSONALIZED PREVENTION PLAN SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Annual Wellness Visit

''(hhh)(1) The term 'personalized prevention plan services' means the creation of a plan for an individual—

''(A) that includes a health risk assessment (that meets the guidelines established by the Secretary under paragraph (5)(A)) of the individual that is completed prior to or as part of the same visit with a health professional described in paragraph (4); and

''(B) that—

''(i) takes into account the results of the health risk assessment;

''(ii) contains the elements described in paragraph (2); and

''(iii) may contain the elements described in paragraph (3).

''(2) Subject to paragraph (5)(H), the elements described in this paragraph are the following:

''(A) The establishment of, or an update to, the individual's medical and family history.

''(B) The establishment of, or an update to, the following:

''(i) A screening schedule for the next 5 to 10 years, as appropriate, based on recommendations of the United States Preventive Services Task Force and the individual's health status, screening history, and age-appropriate preventive services covered under this title.

''(ii) A list of risk factors and conditions that are of concern with respect to the individual, development of a strategy to improve health status through lifestyle or other interventions that emphasize primary prevention, and recommendations for appropriate programs and informational resources for reducing or eliminating such risk factors and conditions.

''(iii) A list of risk factors and conditions for which secondary or tertiary prevention interventions are recommended or are underway, and a list of treatment options and their associated risks and benefits.

''(iv) A list of all medications currently prescribed for the individual.

''(v) A list of all providers of services and suppliers regularly involved in providing care to the individual.

''(C) The furnishing of personalized health advice and a referral, as appropriate, to health education or preventive counseling services aimed at reducing identified risk factors, or community-based lifestyle interventions to reduce health risks and promote wellness, including weight loss, physical activity, smoking cessation, and nutrition.

''(D) A measurement of height, weight, body mass index (or waist circumference, if appropriate), and blood pressure.

''(E) Any other element determined appropriate by the Secretary.

''(3) Subject to paragraph (5)(H), the elements described in this paragraph are the following:

''(A) Referral for additional testing related to a diagnosis of a possible chronic condition.

''(B) In the case of an individual with a diagnosed chronic condition, referral for or review of the available treatment options.

''(C) The furnishing of or referral for any preventive services described in subparagraphs (A) and (B) of subsection (ddd)(3).

''(D) Cognitive impairment assessment.

''(E) Any other element determined appropriate by the Secretary.

''(4) A health professional described in this paragraph is—

''(A) a physician;

''(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

''(C) a medical professional (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

''(5)(A) For purposes of paragraph (1)(A), the Secretary, not later than 1 year after the date of enactment of the America's Healthy Future Act of 2009, shall establish publicly available guidelines for health risk assessments. Such guidelines shall be developed in consultation with relevant groups and entities and shall provide that a health risk assessment—

''(i) identify chronic diseases, modifiable risk factors, and urgent health needs of the individual; and

''(ii) may be furnished—

"(I) through an interactive telephonic or web-based program that meets the standards established under subparagraph (D);

"(II) during an encounter with a health care professional; or

"(III) through any other means the Secretary determines appropriate to maximize accessibility and ease of use by beneficiaries, while ensuring the privacy of such beneficiaries.

"(B) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to—

"(i) ensure that health risk assessments are accessible to beneficiaries; and

"(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

"(C) The Secretary shall establish procedures to make beneficiaries and providers aware of the requirement that a beneficiary complete a health risk assessment prior to or at the same time as receiving personalized prevention plan services.

"(D) Not later than 1 year after the date of enactment of the America's Healthy Future Act of 2009, the Secretary shall establish standards for interactive tele-

phonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I).

''(E) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technology that is compatible with electronic medical records and personal health records) and may experiment with the use of personalized technology to aid in the management of and adherence to provider recommendations in order to improve the health status of beneficiaries.

''(F) A beneficiary shall be eligible to receive personalized prevention plan services under this subsection provided that the beneficiary has not received such services within the preceding 12-month period. During the period of 12 months after the date that the beneficiary's first coverage begins under part B, payment shall be made under such part for only one of the following services:

''(i) An initial preventive physical examination (as defined under subsection (ww)(1)).

''(ii) Personalized prevention plan services provided under this subsection.

''(G)(i) Not later than 1 year after the date of enactment of the America's Healthy Future Act of 2009, the Secretary shall develop and make available to the public a health risk assessment model. Such model shall meet

the guidelines under subparagraph (A) and may be used to meet the requirement under paragraph (1)(A).

''(ii) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

''(H)(i) Subject to clause (ii), the Secretary shall issue guidance that—

''(I) identifies elements under paragraphs (2) and (3) that are not required to be provided to a beneficiary during each annual visit; and

''(II) establishes a yearly schedule for appropriate provision of such elements.

''(ii) Personalized prevention plan services that are provided to a beneficiary within the period of 12 months after the date that such beneficiary's first coverage period begins under part B shall be required to include any elements included under paragraphs (2) and (3).''.

(c) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) PAYMENT AND ELIMINATION OF COINSURANCE.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) in subparagraph (N), by inserting ''other than personalized prevention plan serv-

ices (as defined in section 1861(hhh)(1))'' after ''(as defined in section 1848(j)(3))'';

(B) by striking ''and'' before ''(W)''; and

(C) by inserting before the semicolon at the end the following: '', and (X) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)), the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the payment basis determined under section 1848''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(FF) (including administration of the health risk assessment) ,'' after ''(2)(EE),''.

(3) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''and diagnostic mammography'' and inserting '', diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is amended—

(i) in subparagraph (F), by striking ''and'' at the end;

(ii) in subparagraph (G)(ii), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (G)(ii) the following new subparagraph:

''(H) with respect to personalized prevention plan services (as defined in section 1861(hhh)(1)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(X),''.

(4) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(9)''; and

(B) by inserting before the period the following: '', and (10) such deductible shall not apply with respect to personalized prevention plan services (as defined in section 1861(hhh)(1))''.

(d) FREQUENCY LIMITATION.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (N), by striking ''and'' at the end;

(B) in subparagraph (O), by striking the semicolon at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(P) in the case of personalized prevention plan services (as defined in section 1861(hhh)(1)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''or (K)'' and inserting ''(K), or (P)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

SEC. 2002. REMOVAL OF BARRIERS TO PREVENTIVE SERVICES.

(a) DEFINITION OF PREVENTIVE SERVICES.—Section 1861(ddd) of the Social Security Act (42 U.S.C. 1395x(ddd)) is amended—

(1) in the heading, by inserting ''; Preventive Services'' after ''Services'';

(2) in paragraph (1), by striking ''not otherwise described in this title'' and inserting ''not described in subparagraph (A) or (C) of paragraph (3)''; and

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

''(3) The term 'preventive services' means the following:

''(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).

''(B) An initial preventive physical examination (as defined in subsection (ww)).

''(C) Personalized prevention plan services (as defined in subsection (hhh)(1)).''.

(b) COINSURANCE.—

(1) GENERAL APPLICATION.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 2001(c)(1), is amended—

(i) in subparagraph (T), by inserting ''(or 100 percent if such services are recommended with a grade of A or B by the

United States Preventive Services Task Force for any indication or population and are appropriate for the individual)'' after ''80 percent'';

(ii) in subparagraph (W)—

(I) in clause (i), by inserting ''(if such subparagraph were applied, by substituting '100 percent' for '80 percent')'' after ''subparagraph (D)''; and

(II) in clause (ii), by striking ''80 percent'' and inserting ''100 percent'';

(iii) by striking ''and'' before ''(X)''; and

(iv) by inserting before the semicolon at the end the following: '', and (Y) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount paid shall be 100 percent of the

lesser of the actual charge for the services or the amount determined under the fee schedule that applies to such services under this part''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)), as amended by section 2001(c)(3)(A), is amended—

(i) by striking ''or'' before ''personalized prevention plan services''; and

(ii) by inserting before the period the following: '', or preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42

U.S.C. 1395l(a)(2)), as amended by section 2001(c)(3)(B), is amended—

(i) in subparagraph (G)(ii), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (H), by striking the comma at the end and inserting ''; and''; and

(iii) by inserting after subparagraph (H) the following new subparagraph:

''(I) with respect to preventive services described in subparagraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1)(W) or (1)(Y),''.

(c) WAIVER OF APPLICATION OF DEDUCTIBLE FOR PREVENTIVE SERVICES AND COLORECTAL CANCER SCREENING TESTS.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 2001(c)(4) is amended—

(1) in paragraph (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services described in subparagraph (A) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.''; and

(2) by adding at the end the following new sentence: ''Paragraph (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure that is furnished in connection with, as a result of, and in the same clinical encounter as the screening test.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 2003. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—

(1) IN GENERAL.—Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Notwithstanding any other provision of this title, effective beginning on January 1, 2010, if the Secretary determines appropriate, the Secretary may—

''(1) modify—

''(A) the coverage of any preventive service described in subparagraph (A) of section 1861(ddd)(3) to the extent that such modification is consistent with the recommendations of the United States Preventive Services Task Force; and

''(B) the services included in the initial preventive physical examination described in subparagraph (B) of such section; and

''(2) provide that no payment shall be made under this title for a preventive service described in subparagraph (A) of such section that is not recommended with a grade of A, B, C, or I by such Task Force.''.

(2) CONSTRUCTION.—Nothing in the amendment made by paragraph (1) shall be construed to

affect the coverage of diagnostic or treatment services under title XVIII of the Social Security Act.

(b) SUPPORT FOR OUTREACH AND EDUCATION REGARDING PREVENTIVE SERVICES.—

(1) FUNDING.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for fiscal year 2010, $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the purposes described in subparagraph (B). Amounts appropriated under this subparagraph shall—

(i) be disbursed to such Account on January 1, 2010; and

(ii) remain available until expended.

(B) PURPOSES DESCRIBED.—The purposes described in this subparagraph are as follows:

(i) To conduct education and outreach activities to Medicare beneficiaries and health care providers regarding the coverage of preventive services (as defined in section 1861(ddd)(3) of the Social Security Act, as added by section 2002(a)) under the Medicare program under title XVIII of

such Act in order to encourage optimal utilization of such services.

(ii) To coordinate such education and outreach activities with community-based entities, including State Health Insurance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers, that are carrying out the activities described in section 1861(hhh)(5)(B) of the Social Security Act, as added by section 2001(b).

(C) ACTIVITY SUPPORT.—Out of the amounts appropriated under subparagraph (A), the Secretary may provide support and assistance for activities conducted by community-based entities as described under subparagraph (B)(ii).

(2) HHS STUDY AND REPORT TO CONGRESS.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on preventive services under the Medicare program. Such study shall include an analysis of—

(i) the implementation of the amendments made by section 101(a) of the Medicare Improvements for Patients and Pro-

viders Act of 2008 (Public Law 110–275; 122 Stat. 2496), including a description of plans to add coverage of additional preventive services pursuant to such amendments; and

(ii) the implementation of the education and outreach activities under paragraph (1)(B).

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(C) FUNDING.—Out of the amounts appropriated under paragraph (1)(A), an amount not greater than $1,000,000 shall be made available to carry out this paragraph.

(3) GAO STUDY AND REPORT TO CONGRESS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on existing efforts by the Secretary of Health and Human Services to improve utilization of pre-

ventive services under the Medicare program, including primary, secondary, and tertiary services and the use of health information technology to coordinate such services. Such study shall include an analysis of—

(i) the utilization of and payment for preventive services under the Medicare program; and

(ii) whether barriers to optimal utilization of and access to such services exist and if so, what are those barriers.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for—

(i) improving access to, and utilization and coordination of, primary, secondary, and tertiary preventive services under the Medicare program, with an emphasis on the most costly chronic conditions affecting Medicare population; and

(ii) such legislation and administrative action as the Comptroller General determines appropriate.

(C) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $2,000,000 to carry out this paragraph. Amounts appropriated under this subparagraph shall remain available until expended.

SEC. 2004. GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS TO VACCINES.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the ability of Medicare beneficiaries who were 65 years of age or older to access routinely recommended vaccines covered under the prescription drug program under part D of title XVIII of the Social Security Act over the period since the establishment of such program. Such study shall include the following:

(1) An analysis and determination of—

(A) the number of Medicare beneficiaries who were 65 years of age or older and were eligible for a routinely recommended vaccination that was covered under part D;

(B) the number of such beneficiaries who actually received a routinely recommended vaccination that was covered under part D; and

(C) any barriers to access by such beneficiaries to routinely recommended vaccinations that were covered under part D.

(2) A summary of the findings and recommendations by government agencies, departments, and advisory bodies (as well as relevant professional organizations) on the impact of coverage under part D of routinely recommended adult immunizations for access to such immunizations by Medicare beneficiaries.

(b) REPORT.—Not later than June 1, 2010, the Comptroller General shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $1,000,000 for fiscal year 2010 to carry out this section.

SEC. 2005. INCENTIVES FOR HEALTHY LIFESTYLES.

(a) MEDICARE DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall establish and implement a demonstration project under title XVIII of the Social Security Act to test programs that provide incentives to Medicare beneficiaries to reduce their risk of avoidable health outcomes that are associated with lifestyle choices, including smoking, exercise, and diet.

(B) EVIDENCE REVIEW.—Prior to the establishment of the demonstration project, the Secretary shall review the available evidence, literature, best practices, and resources relevant to the Medicare population that are related to—

(i) programs that promote a healthy lifestyle and reduce health risk factors; and

(ii) providing individuals with incentives for participating in such programs.

(2) DURATION AND SCOPE.—

(A) DURATION.—The Secretary shall conduct the demonstration project for an initial period of 3 years, beginning not later than July 1, 2010, with authority to continue for an additional 2 years any program or program compo-

nent that is determined to be effective under the interim evaluation and report described under subsection (b).

(B) SCOPE.—

(i) IN GENERAL.—The Secretary shall select not more than 10 sites to conduct the programs described in paragraph (3), and may select such sites in coordination with other community-based programs that are oriented towards promoting healthy lifestyles, reducing risk factors, and reducing the impact of chronic diseases (including programs conducted by the Administration on Aging, the Centers for Disease Control and Prevention, and the Agency for Healthcare Research and Quality).

(ii) SELECTION.—In selecting sites to participate in the demonstration project, the Secretary shall select—

(I) not less than 2 sites that are located in rural areas; and

(II) not less than 2 sites that serve a minority community (including Native American communities).

(iii) PREFERENCE.—In selecting sites to participate in the demonstration project, the Secretary may give preference to organizations that have demonstrated experience in designing and implementing programs that provide incentives to adults to make healthy lifestyle choices.

(3) PROGRAM DESCRIBED.—The Secretary shall select programs that are evidence-based and designed to help Medicare beneficiaries make healthy lifestyle choices to reduce their health risks, including—

(A) ceasing use of tobacco products;

(B) controlling or reducing their weight;

(C) controlling or lowering their cholesterol;

(D) lowering their blood pressure;

(E) learning strategies to avoid the onset of diabetes or, in the case of a diabetic, improving the management of such condition;

(F) reducing the risks of falls; and

(G) other approaches as determined by the Secretary.

(4) MONITORING PARTICIPATION AND MEASURING OUTCOMES.—Each participating site shall establish a system to—

(A) monitor participation by Medicare beneficiaries in programs described in paragraph (3); and

(B) validate changes in health risks and outcomes, including adoption and maintenance of healthy behaviors by Medicare beneficiaries participating in such programs; and

(C) establish standards and health status targets for Medicare beneficiaries participating in such programs and measure the degree to which such standards and targets are met.

(b) EVALUATIONS AND REPORTS.—

(1) IN GENERAL.—

(A) INDEPENDENT EVALUATIONS.—The Secretary shall provide for an interim and final independent evaluation of the demonstration project that shall assess—

(i) the extent to which participating Medicare beneficiaries achieved the program goals described in subsection (a)(3); and

(ii) any impact on utilization of health services and costs to the Medicare program as compared to the cost of the programs conducted under the demonstration project.

(B) INTERIM DETERMINATION.—Not later than July 1, 2013, the Secretary shall make a determination, pursuant to subsection (a)(2)(A), as to any programs or program components that should be extended through July 1, 2015.

(2) INTERIM REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an interim report on the demonstration project. The interim report shall include—

(A) a preliminary evaluation of the effectiveness of the programs or program components conducted through the demonstration project; and

(B) a description of any programs or program components that have been extended under paragraph (1)(B).

(3) FINAL REPORT.—Not later than January 1, 2016, the Secretary shall submit to Congress a final report on the demonstration project that includes

the results of the independent evaluation required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate, including a recommendation as to any programs conducted under the demonstration project that should be extended or expanded.

(c) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, OTHER BENEFITS.—Any incentives provided to a Medicare beneficiary participating in the demonstration project shall not be taken into account for purposes of determining the beneficiary's eligibility for, or amount of, benefits under the Medicare program or any other program funded in whole or in part with Federal funds.

(d) FUNDING.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $15,000,000 for each of fiscal years 2010 through 2015 to the Centers for Medicare & Medicaid Services Program Management Account to carry out the demonstration project. Amounts appropriated under this paragraph shall remain available until expended.

(2) USE OF CERTAIN FUNDS.—Out of the amounts appropriated under paragraph (1), an

amount not greater than $5,000,000 shall be made available to design, implement, and evaluate programs conducted under the demonstration project, with such amount to remain available until expended.

(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the selection, testing, and evaluation of programs, or the expansion of such programs, under this section.

(f) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term ''demonstration project'' means the demonstration project conducted under this section.

(2) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

Subtitle B—Medicaid

SEC. 2101. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to read as follows:

''(13) other diagnostic, screening, preventive, and rehabilitative services, including—

''(A) any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force;

''(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary, acting through the Director of the Centers for Disease Control and Prevention) and their administration; and

''(C) any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability

and restoration of an individual to the best possible functional level;''.

(b) INCREASED FMAP.—Section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), as amended by sections 1601(a)(3)(A) and 1604(c)(1), is amended in the first sentence—

(1) by striking '', and (4)'' and inserting '', (4)''; and

(2) by inserting before the period the following: '', and (5) in the case of a State that provides medical assistance for services and vaccines described in subparagraphs (A) and (B) of subsection (a)(13), and prohibits cost-sharing for such services and vaccines, the Federal medical assistance percentage, as determined under this subsection and subsection (y) (without regard to paragraph (1)(C) of such subsection), shall be increased by 1 percentage point with respect to medical assistance for such services and vaccines and for items and services described in subsection (a)(4)(D)''.

(c) EFFECTIVE DATE.—The amendments made under this section shall take effect on January 1, 2013.

SEC. 2102. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN.

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 1601(a)(3)(B), 1636, and 1642, is further amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in subsection (bb))''; and

(2) by adding at the end the following:

''(bb)(1) For purposes of this title, the term 'counseling and pharmacotherapy for cessation of tobacco use by pregnant women' means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who—

''(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(2) Subject to paragraph (3), such term is limited to—

''(A) services recommended with respect to pregnant women in 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

''(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use by pregnant women.

''(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—

Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 1652(a), is amended by inserting before the period at the end the following: ", except, in the case of pregnant women when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation".

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE BY PREGNANT WOMEN.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(B) and (b)(2)(B) by inserting ", and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation by pregnant women in accordance with the

Guideline referred to in section 1905(bb)(2)(A)'' after ''complicate the pregnancy''.

(2) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B)(iii) of such Act (42 U.S.C. 1396o–1(b)(3)(B)(iii)) is amended by inserting '', and counseling and pharmacotherapy for cessation of tobacco use by pregnant women (as defined in section 1905(bb))'' after ''complicate the pregnancy''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

SEC. 2103. INCENTIVES FOR HEALTHY LIFESTYLES.

(a) INITIATIVES.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary shall award grants to States to carry out initiatives to provide incentives to Medicaid beneficiaries who—

(i) successfully participate in a program described in paragraph (3); and

(ii) upon completion of such participation, demonstrate changes in health risk and outcomes, including the adoption and maintenance of healthy behaviors by meet-

ing specific targets (as described in subsection (c)(2)).

(B) PURPOSE.—The purpose of the initiatives under this section is to test approaches that may encourage behavior modification and determine scalable solutions.

(2) DURATION.—

(A) INITIATION OF PROGRAM; RESOURCES.—The Secretary shall awards grants to States beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever is earlier. The Secretary shall develop program criteria for initiatives under this section using relevant evidence-based research and resources, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry of Evidence-Based Programs and Practices.

(B) DURATION OF PROGRAM.—A State awarded a grant to carry out initiatives under this section shall carry out such initiatives within the 5-year period beginning on January 1, 2011, or beginning on the date on which the Secretary develops program criteria, whichever

is earlier. Initiatives under this section shall be carried out by a State for a period of not less than 3 years.

(3) PROGRAM DESCRIBED.—

(A) IN GENERAL.—A program described in this paragraph is a comprehensive, evidence-based, widely available, and easily accessible program, proposed by the State and approved by the Secretary, that is designed and uniquely suited to address the needs of Medicaid beneficiaries and has demonstrated success in helping individuals achieve one or more of the following:

(i) Ceasing use of tobacco products.

(ii) Controlling or reducing their weight.

(iii) Lowering their cholesterol.

(iv) Lowering their blood pressure.

(v) Avoiding the onset of diabetes or, in the case of a diabetic, improving the management of that condition.

(B) CO-MORBIDITIES.—A program under this section may also address co-morbidities (including depression) that are related to any of the conditions described in subparagraph (A).

(C) WAIVER AUTHORITY.—The Secretary may waive the requirements of sections 1902(a)(1) (relating to statewideness) and 1902(a)(10)(B) (relating to comparability) of the Social Security Act for a State awarded a grant to conduct an initiative under this section and shall ensure that a State makes any program described in subparagraph (A) widely available and accessible to Medicaid beneficiaries in the State.

(D) FLEXIBILITY IN IMPLEMENTATION.—A State may enter into arrangements with providers participating in Medicaid, community-based organizations, faith-based organizations, public-private partnerships, Indian tribes, or similar entities or organizations to carry out programs described in subparagraph (A).

(4) APPLICATION.—Following the development of program criteria by the Secretary, a State may submit an application, in such manner and containing such information as the Secretary may require, that shall include a proposal for programs described in paragraph (3)(A) and a plan to make Medicaid beneficiaries and providers participating in

Medicaid who reside in the State aware and informed about such programs.

(b) EDUCATION AND OUTREACH CAMPAIGN.—

(1) STATE AWARENESS.—The Secretary shall conduct an outreach and education campaign to make States aware of the grants under this section.

(2) PROVIDER AND BENEFICIARY EDUCATION.—A State awarded a grant to conduct an initiative under this section shall conduct an outreach and education campaign to make Medicaid beneficiaries and providers participating in Medicaid who reside in the State aware of the programs described in subsection (a)(3) that are to be carried out by the State under the grant.

(c) MONITORING.—A State awarded a grant to conduct an initiative under this section shall develop and implement a system to—

(1) monitor Medicaid beneficiary participation in the program and validate changes in health risk and outcomes with clinical data, including the adoption and maintenance of health behaviors by such beneficiaries;

(2) to the extent practicable, establish standards and health status targets for Medicaid beneficiaries participating in the program and measure

the degree to which such standards and targets are met;

(3) evaluate the effectiveness of the program and provide the Secretary with such evaluations;

(4) report to the Secretary on processes that have been developed and lessons learned from the program; and

(5) report on preventive services as part of reporting on quality measures for Medicaid managed care programs.

(d) INDEPENDENT ASSESSMENTS.—

(1) IN GENERAL.—The Secretary shall provide for an independent assessment of the initiatives carried out under this section.

(2) STATE REPORTING.—A State awarded a grant to carry out initiatives under this section shall submit reports to the Secretary, on a semi-annual basis, regarding the programs that are supported by the grant funds. Such report shall include information, as specified by the Secretary, regarding—

(A) the specific uses of the grant funds;

(B) an assessment of program implementation and lessons learned from the programs;

(C) an assessment of quality improvements and clinical outcomes under such programs; and

(D) estimates of cost savings resulting from such programs.

(3) INITIAL REPORT.—Not later than January 1, 2014, the Secretary shall submit to Congress an initial report on such initiatives based on information provided by States through reports required under paragraph (2). The initial report shall include an interim evaluation of the effectiveness of the initiatives carried out with grants awarded under this section and a recommendation regarding whether funding for expanding or extending the initiatives should be extended beyond January 1, 2016.

(4) FINAL REPORT.—Not later than July 1, 2016, the Secretary shall submit to Congress a final report on the program that includes the results of the independent assessment required under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary's eligibility for, or

amount of, benefits under any program funded in whole or in part with Federal funds.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000 to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) DEFINITIONS.—In this section:

(1) MEDICAID BENEFICIARY.—The term ''Medicaid beneficiary'' means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

SEC. 2104. STATE OPTION TO PROVIDE HEALTH HOMES FOR ENROLLEES WITH CHRONIC CONDITIONS.

(a) STATE PLAN AMENDMENT.—Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.), as amended

by sections 1621, 1640, and 1702(b), is amended by adding at the end the following new section:

''SEC. 1946. STATE OPTION TO PROVIDE COORDINATED CARE THROUGH A HEALTH HOME FOR INDIVIDUALS WITH CHRONIC CONDITIONS.—

''(a) IN GENERAL.—Notwithstanding section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and any other provision of this title for which the Secretary determines it is necessary to waive in order to implement this section, beginning January 1, 2011, a State, at its option as a State plan amendment, may provide for medical assistance under this title to eligible individuals with chronic conditions who select a designated provider as the individual's health home for purposes of providing the individual with health home services.

''(b) HEALTH HOME QUALIFICATION STANDARDS.—The Secretary shall establish standards for qualification as a designated provider (as described under subsection (h)(3)) for the purpose of being eligible to be a health home for purposes of this section.

''(c) PAYMENTS.—

''(1) IN GENERAL.—A State shall provide a designated provider, or a team of health care professionals operating with such a provider, with pay-

ments for the provision of health home services to each eligible individual with chronic conditions that selects the provider as the individual's health home. Payments made to a designated provider or a team for such services shall be treated as medical assistance for purposes of section 1903(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be equal to 90 percent.

''(2) METHODOLOGY.—

''(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State will use for determining payment for the provision of health home services. Such methodology for determining payment—

''(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider or a team of health care professionals operating with such a provider, the severity or number of each such individual's chronic conditions or the specific capabilities of the provider or team; and

"(ii) shall be established consistent with section 1902(a)(30)(A).

"(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month basis and may provide (as proposed by the State and subject to approval by the Secretary) for alternate models of payment.

"(3) PLANNING GRANTS.—The Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A State awarded a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 5001 of Public Law 111–5) for each fiscal year for which the grant is awarded. The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

"(d) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions who seek

or need treatment in a hospital emergency department to designated providers.

''(e) COORDINATION.—A State shall consult and coordinate, as appropriate, with the Substance Abuse and Mental Health Services Administration in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

''(f) MONITORING.—A State shall include in the State plan amendment—

''(1) a methodology for tracking avoidable hospital readmissions and calculating savings that result from improved chronic care coordination and management under this section; and

''(2) a proposal for use of health information technology in providing health home services under this section and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

''(g) REPORT ON QUALITY MEASURES.—As a condition for receiving payment for health home services provided to an eligible individual with chronic conditions, a designated provider shall report to the State, in accord-

ance with such requirements as the Secretary shall specify, on all applicable measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the State with such information.

''(h) DEFINITIONS.—In this section:

''(1) ELIGIBLE INDIVIDUAL WITH CHRONIC CONDITIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'eligible individual with chronic conditions' means an individual who—

''(i) is eligible for medical assistance under the State plan or under a waiver of such plan; and

''(ii) has at least—

''(I) 2 chronic conditions;

''(II) 1 chronic condition and is at risk of having a second chronic condition; or

''(III) 1 serious and persistent mental health condition.

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall prevent the Secretary from establishing higher levels as to the number or severity of chronic or mental health condi-

tions for purposes of determining eligibility for receipt of health home services under this section.

''(2) CHRONIC CONDITION.—The term 'chronic condition' has the meaning given that term by the Secretary and shall include, but is not limited to, the following:

''(A) A mental health condition.

''(B) Substance abuse.

''(C) Asthma.

''(D) Diabetes.

''(E) Heart disease.

''(F) Being overweight, as evidenced by having a Body Mass Index (BMI) over 25.

''(3) DESIGNATED PROVIDER.—The term 'designated provider' means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including pediatricians and obstetricians) that is determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions on the basis of documentation evidencing that the physician, practice, or clinic—

''(A) has the systems and infrastructure in place to provide health home services; and

''(B) satisfies the qualification standards established by the Secretary under subsection (b).

''(4) HEALTH HOME.—The term 'health home' means a designated provider (including a provider that operates in coordination with a team of health care professionals) selected by an eligible individual with chronic conditions to provide health home services.

''(5) HEALTH HOME SERVICES.—

''(A) IN GENERAL.—The term 'health home services' means comprehensive and timely high-quality services described in subparagraph (B) that are provided by a designated provider or a team of health care professionals (as described in subparagraph (C)) operating with such a provider.

''(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

''(i) comprehensive care management;

''(ii) care coordination and health promotion;

"(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

"(iv) patient and family support;

"(v) referral to community and social support services, if relevant; and

"(vi) use of health information technology to link services, as feasible and appropriate.

"(C) TEAM OF HEALTH CARE PROFESSIONALS DESCRIBED.—A team of health care professionals described in this subparagraph is a team of professionals (as described in the State plan amendment) that may—

"(i) include physicians and other professionals, such as a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State; and

"(ii) be free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any

entity deemed appropriate by the State and approved by the Secretary.''.

(b) EVALUATION.—

(1) INDEPENDENT EVALUATION.—

(A) IN GENERAL.—Not later than January 1, 2013, the Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under section 1946 of the Social Security Act (as added by subsection (a)) for the purpose of determining the effect of such option on reducing hospital admissions, emergency room visits, and admissions to skilled nursing facilities.

(B) EVALUATION REPORT.—Not later than January 1, 2017, the Secretary shall report to Congress on the evaluation and assessment conducted under subparagraph (A).

(2) SURVEY AND INTERIM REPORT.—

(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1946 of the Social Se-

curity Act (as added by subsection (a)) and report to Congress on the nature, extent, and use of such option, particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation;

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORTING.—A State that has elected the option under section 1946 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2105. FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

Section 1139A(e)(8) of the Social Security Act (42 U.S.C. 1320b–9a(e)(8)) is amended to read as follows:

''(8) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this subsection, $25,000,000 for the period of fiscal years 2010 through 2014.''.

SEC. 2106. PUBLIC AWARENESS OF PREVENTIVE AND OBESITY-RELATED SERVICES.

(a) INFORMATION TO STATES.—The Secretary of Health and Human Services shall provide guidance and relevant information to States and health care providers regarding preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

(b) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign to educate Medicaid enrollees regarding availability and coverage of such services, with the goal of reducing incidences of obesity.

(c) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under subsections (a) and (b), including summaries of the

States' efforts to increase awareness of coverage of obesity-related services.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

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

SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4102(a) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

''(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the 'Program') under which value-based

incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

''(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

''(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term 'hospital' means a subsection (d) hospital (as defined in subsection (d)(1)(B)).

''(ii) EXCLUSIONS.—The term 'hospital' shall not include, with respect to a fiscal year, a hospital—

''(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

''(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies

that pose immediate jeopardy to the health or safety of patients;

''(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year; or

''(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

''(iii) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (III) and (IV) of clause (ii), the Secretary shall have conducted an independent analysis of what numbers are appropriate.

''(2) MEASURES.—

''(A) IN GENERAL.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B)(viii).

''(B) REQUIREMENTS.—

"(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall ensure the following:

"(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:

"(aa) Acute myocardial infarction (AMI).

"(bb) Heart failure.

"(cc) Pneumonia.

"(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as 'Surgical Infection Prevention' for discharges occurring before July 2006).

"(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Asso-

ciated Infections (or any successor plan) of the Department of Health and Human Services.

''(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

''(ii) INCLUSION OF EFFICIENCY MEASURES.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of 'Medicare spending per beneficiary'. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

''(C) LIMITATIONS.—

''(i) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with

respect to a performance period for a fiscal year (as established under paragraph (4)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Compare Internet website for at least 1 year prior to the beginning of such performance period.

''(ii) MEASURE NOT APPLICABLE UNLESS HOSPITAL FURNISHES SERVICES APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to such measure.

''(D) REPLACING MEASURES.—Subclause (VI) of subsection (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the same manner as such subclause applies to measures selected under such subsection.

''(3) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

"(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

"(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

"(D) CONSIDERATIONS IN ESTABLISHING STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

"(i) practical experience with the measures involved, including whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods;

"(ii) historical performance standards;

"(iii) improvement rates; and

"(iv) the opportunity for continued improvement.

"(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the per-

formance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

''(5) HOSPITAL PERFORMANCE SCORE.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under paragraph (2) for a performance period (as established under paragraph (4)). Using such methodology, the Secretary shall provide for an assessment (in this subsection referred to as the 'hospital performance score') for each hospital for each performance period.

''(B) APPLICATION.—

''(i) APPROPRIATE DISTRIBUTION.—The Secretary shall ensure that the application of the methodology developed under subparagraph (A) results in an appropriate distribution of value-based incentive payments under paragraph (6) among hospitals achieving different levels of hospital performance scores, with hospitals achieving the highest hospital performance scores

receiving the largest value-based incentive payments.

''(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

''(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

''(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall not set a minimum performance standard in determining the hospital performance score for any hospital.

''(v) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

"(6) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance standards under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year by the value-based incentive payment amount.

"(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each discharge of a hospital in a fiscal year shall be equal to the product of—

"(i) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and

"(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

"(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

"(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

"(ii) REQUIREMENTS.—In specifying the value-based incentive payment percentage for each hospital for a fiscal year under clause (i), the Secretary shall ensure that—

"(I) such percentage is based on the hospital performance score of the hospital under paragraph (5); and

"(II) the total amount of value-based incentive payments under this paragraph to all hospitals in such fiscal year is equal to the total amount available for value-based incentive payments for such fiscal year under paragraph (7)(A), as estimated by the Secretary.

"(7) FUNDING FOR VALUE-BASED INCENTIVE PAYMENTS.—

''(A) AMOUNT.—The total amount available for value-based incentive payments under paragraph (6) for all hospitals for a fiscal year shall be equal to the total amount of reduced payments for all hospitals under subparagraph (B) for such fiscal year, as estimated by the Secretary.

''(B) ADJUSTMENT TO PAYMENTS.—

''(i) IN GENERAL.—The Secretary shall reduce the base operating DRG payment amount (as defined in subparagraph (D)) for a hospital for each discharge in a fiscal year (beginning with fiscal year 2013) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the base operating DRG payment amount for the discharge for the hospital for such fiscal year. The Secretary shall make such reductions for all hospitals in the fiscal year involved, regardless of whether or not the hospital has been determined by the Secretary to have earned a value-based incentive payment under paragraph (6) for such fiscal year.

''(ii) NO EFFECT ON OTHER PAYMENTS.—Payments described in items (aa) and (bb) of subparagraph (D)(i)(II) for a hospital shall be determined as if this subsection had not been enacted.

''(C) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (B), the term 'applicable percent' means—

''(i) with respect to fiscal year 2013, 1.0 percent;

''(ii) with respect to fiscal year 2014, 1.25 percent;

''(iii) with respect to fiscal year 2015, 1.5 percent;

''(iv) with respect to fiscal year 2016, 1.75 percent; and

''(v) with respect to fiscal year 2017 and succeeding fiscal years, 2 percent.

''(D) BASE OPERATING DRG PAYMENT AMOUNT DEFINED.—

''(i) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term 'base operating DRG payment amount' means, with respect to a hospital for a fiscal year—

"(I) the payment amount that would otherwise be made under subsection (d) for a discharge if this subsection did not apply; reduced by

"(II) any portion of such payment amount that is attributable to—

"(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

"(bb) such other payments under subsection (d) determined appropriate by the Secretary.

"(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

"(I) SOLE COMMUNITY HOSPITALS AND MEDICARE-DEPENDENT, SMALL RURAL HOSPITALS.—In the case of a medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraph (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined with-

out regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (d)(5).

''(II) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term 'base operating DRG payment amount' means the payment amount under such section.

''(8) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall, not later than 60 days prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

''(9) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

"(10) PUBLIC REPORTING.—

"(A) HOSPITAL SPECIFIC INFORMATION.—

"(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

"(I) the performance of the hospital with respect to each measure that applies to the hospital;

"(II) the performance of the hospital with respect to each condition or procedure; and

"(III) the hospital performance score assessing the total performance of the hospital.

"(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

''(iii) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(B) AGGREGATE INFORMATION.—The Secretary shall periodically post on the Hospital Compare Internet website aggregate information on the Program, including—

''(i) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

''(ii) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

''(11) IMPLEMENTATION.—

''(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital's performance assessment with respect to the performance standards established under paragraph (3)(A) and the hospital performance score under para-

graph (5). The Secretary shall ensure that such process provides for resolution of such appeals in a timely manner.

''(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(i) The methodology used to determine the amount of the value-based incentive payment under paragraph (6) and the determination of such amount.

''(ii) The determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

''(iii) The establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

''(iv) The measures specified under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

''(v) The methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

''(vi) The validation methodology specified in subsection (b)(3)(B)(viii)(XI).

''(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

''(12) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out the Program, including the selection of measures under paragraph (2), the methodology developed under paragraph (5) that is used to calculate hospital performance scores, and the methodology used to determine the amount of value-based incentive payments under paragraph (6).''.

(2) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1886(b)(3)(B)(viii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(viii)) is amended—

(A) in subclause (II), by adding at the end the following sentence: ''The Secretary may require hospitals to submit data on measures that

are not used for the determination of value-based incentive payments under subsection (o).'';

(B) in subclause (V), by striking ''beginning with fiscal year 2008'' and inserting ''for fiscal years 2008 through 2012'';

(C) in subclause (VII), in the first sentence, by striking ''data submitted'' and inserting ''information regarding measures submitted''; and

(D) by adding at the end the following new subclauses:

''(VIII) Effective for payments beginning with fiscal year 2013, with respect to quality measures for outcomes of care, the Secretary shall provide for such risk adjustment as the Secretary determines to be appropriate to maintain incentives for hospitals to treat patients with severe illnesses or conditions.

''(IX) Effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed under paragraph (1) of section 1890C(f) or used as a result of a determination under paragraph (2) of such section.

''(X) To the extent practicable, the Secretary shall, with input from consensus organizations and other stake-

holders, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

''(aa) physicians under section 1848(k); and

''(bb) other providers of services and suppliers under this title.

''(XI) The Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.''.

(3) WEBSITE IMPROVEMENTS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 4102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:

''(ix)(I) The Secretary shall develop standard Internet website reports tailored to meet the needs of various stakeholders such as hospitals, patients, researchers, and policymakers. The Secretary shall seek input from such stakeholders in determining the type of information that is useful and the formats that best facilitate the use of the information.

''(II) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.''.

(4) GAO STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, including diverse Medicare beneficiary populations (such as diverse in terms of race, ethnicity, and socioeconomic status);

(ii) expenditures under the Medicare program, including any reduced expenditures under Part A of title XVIII of such Act that are attributable to the improvement in the delivery of inpatient hospital services by reason of such hospital value-based purchasing program;

(iii) the quality performance among safety net hospitals and any barriers such

hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program; and

(iv) the quality performance among small rural and small urban hospitals and any barriers such hospitals face in meeting the performance standards applicable under such hospital value-based purchasing program.

(B) REPORTS.—

(i) INTERIM REPORT.—Not later than October 1, 2015, the Comptroller General of the United States shall submit to Congress an interim report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(ii) FINAL REPORT.—Not later than July 1, 2017, the Comptroller General of the United States shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such leg-

islation and administrative action as the Comptroller General determines appropriate.

(5) HHS STUDY AND REPORT.—

(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis—

(i) of ways to improve the hospital value-based purchasing program and ways to address any unintended consequences that may occur as a result of such program;

(ii) of whether the hospital value-based purchasing program resulted in lower spending under the Medicare program under title XVIII of such Act or other financial savings to hospitals;

(iii) the appropriateness of the Medicare program sharing in any savings generated through the hospital value-based purchasing program; and

(iv) any other area determined appropriate by the Secretary.

(B) REPORT.—Not later than January 1, 2016, the Secretary of Health and Human Services shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(b) VALUE-BASED PURCHASING DEMONSTRATION PROGRAMS.—

(1) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR INPATIENT CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined

in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality health care furnished by such hospitals.

(ii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iii) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) REPORT.—Not later than 18 months after the completion of the demonstration pro-

gram under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for critical access hospitals with respect to inpatient critical access hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(2) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR HOSPITALS EXCLUDED FROM HOSPITAL VALUE-BASED PURCHASING PROGRAM AS A RESULT OF INSUFFICIENT NUMBERS OF MEASURES AND CASES.—

(A) ESTABLISHMENT.—

(i) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security

Act for applicable hospitals (as defined in clause (ii)) with respect to inpatient hospital services (as defined in section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b))) in order to test innovative methods of measuring and rewarding quality health care furnished by such hospitals.

(ii) APPLICABLE HOSPITAL DEFINED.—For purposes of this paragraph, the term ''applicable hospital'' means a hospital described in subclause (III) or (IV) of section 1886(o)(1)(C)(ii) of the Social Security Act, as added by subsection (a)(1).

(iii) DURATION.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(iv) SITES.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the

spectrum of such hospitals that participate in the Medicare program.

(B) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(C) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) EXTENSION.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ''2010'' and inserting ''2012''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

''(iii) for 2011, 1.0 percent; and

''(iv) for 2012, 0.5 percent.'';

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting ''(or, for purposes of subsection (a)(8), for the quality reporting period for the year)'' after ''reporting period''; and

(B) in subparagraph (C)(i), by inserting '', or, for purposes of subsection (a)(8), for a quality reporting period for the year'' after ''(a)(5), for a reporting period for a year'';

(3) in paragraph (5)(E)(iv), by striking ''subsection (a)(5)(A)'' and inserting ''paragraphs (5)(A) and (8)(A) of subsection (a)''; and

(4) in paragraph (6)(C)—

(A) in clause (i)(II), by striking '', 2009, 2010, and 2011'' and inserting ''and subsequent years''; and

(B) in clause (iii)—

(i) by inserting ''(a)(8)'' after ''(a)(5)''; and

(ii) by striking ''under subparagraph (D)(iii) of such subsection'' and inserting ''under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(8)(D)(iii), respectively''.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(8) INCENTIVES FOR QUALITY REPORTING.—

''(A) ADJUSTMENT.—

''(i) IN GENERAL.—With respect to covered professional services furnished by an eligible professional during 2013 or any subsequent year, if the eligible professional

does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), and (7), but without regard to this paragraph).

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2013, 98.5 percent; and

''(II) for 2014 and each subsequent year, 98 percent.

''(B) APPLICATION.—

''(i) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of

this paragraph in the same manner as they apply for purposes of such subsection.

''(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

''(C) DEFINITIONS.—For purposes of this paragraph:

''(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

''(ii) PHYSICIAN REPORTING SYSTEM.—The term 'physician reporting system' means the system established under subsection (k).

''(iii) QUALITY REPORTING PERIOD.—The term 'quality reporting period' means, with respect to a year, a period specified by the Secretary.''.

(c) ADDITIONAL MECHANISM FOR DETERMINING SATISFACTORY AND SUCCESSFUL REPORTING.—Section 1848(m)(3) of the Social Security Act (42 U.S.C. 1395w–

4(m)(3)) is amended by adding at the end the following new subparagraph:

"(E) ADDITIONAL MECHANISM FOR SATISFACTORY AND SUCCESSFUL REPORTING OF MEASURES.—

"(i) IN GENERAL.—Not later than January 1, 2011, the Secretary shall establish and have in place a process under which an eligible professional shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii) for covered professional services for reporting periods for 2 consecutive years (or, for purposes of subsection (a)(5), for reporting periods for 2 consecutive years, or, for purposes of subsection (a)(8), for quality reporting periods for 2 consecutive years) if, during the reporting period of the first of such years, the eligible professional—

"(I) participates in a program described in clause (ii); and

"(II) completes a qualified MOC practice assessment.

''(ii) PROGRAM DESCRIBED.—A program described in this clause is a qualified American Board of Medical Specialties Maintenance of Certification program (commonly referred to as a 'Maintenance of Certification program' or 'MOC') or an equivalent program (as determined by the Secretary) that—

''(I) satisfactorily submits data through the mechanism described in subsection (k)(4) on quality measures under subparagraph (A) with respect to the eligible professional for the reporting period for the first year of such 2 consecutive years (as determined as determined by the Secretary); and

''(II) submits to the Secretary (in accordance with procedures established by the Secretary under clause (iv)(II)) the information described in clause (iv)(I).

''(iii) QUALIFIED MOC PRACTICE ASSESSMENT.—For purposes of clauses (i)(II), the term 'qualified MOC practice

assessment' means an assessment of a physician's practice that includes an initial assessment of an eligible professional's practice, is designed to demonstrate the eligible professional's use of evidence-based medicine, and would seek to improve quality of care through follow-up assessments.

''(iv) INFORMATION DESCRIBED AND ESTABLISHMENT OF PROCEDURES.—

''(I) INFORMATION DESCRIBED.—The information described in this subclause is the methods, measures, and data used under a program described in clause (ii) or a qualified MOC practice assessment under clause (iii).

''(II) PROCEDURES.—The Secretary, in consultation with programs described in clause (ii), shall establish procedures for the submission of information under clause (ii). Such procedures shall ensure that the information described in subclause (I) allows for innovation and appropriateness

with respect to the specialty of the eligible professional.''.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

''(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

''(A) The selection of measures, the reporting of which would both demonstrate—

''(i) meaningful use of an electronic health record for purposes of subsection (o); and

''(ii) quality of care furnished to an individual.

''(B) Such other activities as specified by the Secretary.''.

(e) FEEDBACK.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w–4(m)(5)) is amended by adding at the end the following new subparagraph:

''(H) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.''.

(f) APPEALS.—Such section is further amended—

(1) in subparagraph (E), by striking ''There shall'' and inserting ''Except as provided in subparagraph (I), there shall''; and

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

''(I) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on quality measures under this subsection.''.

SEC. 3003. IMPROVEMENTS TO THE PHYSICIAN FEEDBACK PROGRAM.

(a) IMPROVEMENTS.—

(1) IN GENERAL.—Section 1848(n) of the Social Security Act (42 U.S.C. 1395w–4(n)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A)—

(I) by striking ''GENERAL.—The Secretary'' and inserting ''GENERAL.—

''(i) ESTABLISHMENT.—The Secretary'';

(II) in clause (i), as added by clause (i), by striking ''the 'Program')'' and all that follows through the period at the end of the second sentence and inserting ''the 'Program').''; and

(III) by adding at the end the following new clauses:

''(ii) REPORTS ON RESOURCES.—The Secretary shall use claims data under this title (and may use other data) to provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the

resources involved in furnishing care to individuals under this title.

''(iii) INCLUSION OF CERTAIN INFORMATION.—If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.''; and

(ii) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''subparagraph (A)(ii)'';

(B) in paragraph (4)—

(i) in the heading, by inserting ''INITIAL'' after ''FOCUS''; and

(ii) in the matter preceding subparagraph (A), by inserting ''initial'' after ''focus the'';

(C) in paragraph (6), by adding at the end the following new sentence: ''For adjustments for reports on utilization under paragraph (9), see subparagraph (D) of such paragraph.''; and

(D) by adding at the end the following new paragraphs:

''(9) REPORTS ON UTILIZATION.—

''(A) DEVELOPMENT OF EPISODE GROUPER.—

''(i) IN GENERAL.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

''(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

''(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

''(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper described in subparagraph (A) by the entity with a contract under section 1890(a).

''(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, pat-

terns of resource use of the individual physician to such patterns of other physicians.

''(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

''(i) attribute episodes of care, in whole or in part, to physicians;

''(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

''(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

''(D) DATA ADJUSTMENT.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

''(i) to account for differences in socio-economic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

"(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

"(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

"(i) the methodologies established under subparagraph (C);

"(ii) information regarding any adjustments made to data under subparagraph (D); and

"(iii) aggregate reports with respect to physicians.

"(F) DEFINITION OF PHYSICIAN.—In this paragraph:

"(i) IN GENERAL.—The term 'physician' has the meaning given that term in section 1861(r)(1).

"(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

"(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise or otherwise of the establishment of the meth-

odology under subparagraph (C), including the determination of an episode of care under such methodology.

''(10) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.''.

(2) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by adding at the end the following new paragraph:

''(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPER UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1848(n)(9)(A). Such review shall be conducted on an expedited basis.''.

(b) INCENTIVES FOR AVOIDING EXCESS UTILIZATION.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)), as amended by section 3002(b), is amended by adding at the end the following new paragraph:

"(9) INCENTIVE FOR AVOIDING EXCESS UTILIZATION.—

"(A) IN GENERAL.—With respect to physicians' services furnished by an applicable physician on or after January 1, 2014, the fee schedule amount for such services furnished by the applicable physician during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be 95 percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraphs (3), (5), (7), and (8), but without regard to this paragraph).

"(B) APPLICABLE PHYSICIAN.—In this paragraph:

"(i) IN GENERAL.—The term 'applicable physician' means a physician which the Secretary determines is at or above the 90th percentile of resource use (or, if applicable, the standard measure of utilization specified under subparagraph (C)) with respect to a composite measure per individual, such as the composite measure

under the methodology established under subsection (n)(9)(C)(iii).

''(ii) DEFINITION OF PHYSICIAN.—In this paragraph:

''(I) IN GENERAL.—The term 'physician' has the meaning given that term in section 1861(r)(1).

''(II) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

''(C) AUTHORITY TO REVISE STANDARD MEASURE OF RESOURCE USE FOR DETERMINING APPLICABLE PHYSICIANS.—With respect to physicians' services furnished by an applicable physician on or after January 1, 2020, the Secretary may substitute a standard measure of resource use, such as deviation from the national mean, (as specified by the Secretary) for the percentile of resource use described in subparagraph (B)(i).

''(D) REPORTING PERIOD.—In this paragraph, the term 'reporting period' means a period specified by the Secretary.

''(E) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise or otherwise of—

''(i) the determination of any incentive payment under subparagraph (A);

''(ii) the determination of who is an applicable physician under subparagraph (B)(i), including the specification and application of the standard measure of utilization under subparagraph (C); and

''(iii) the specification of the reporting period under subparagraph (D).''.

SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U. S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—Under the system described in paragraph (1), for rate year 2014 and each subsequent rate year, in the case of a long-term

care hospital that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a rate year, the update for payments for discharges occurring during such rate year shall be reduced by 2 percentage points.

''(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 long-term care hospital shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—The quality measures specified under this subparagraph shall be such measures selected by the Sec-

retary from measures that have been endorsed under paragraph (1) of section 1890C(f) or used as a result of a determination under paragraph (2) of such section.

''(ii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to rate year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a long-term care hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in long-term care hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

(b) INPATIENT REHABILITATION HOSPITALS.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(1) by redesignating paragraph (7) as paragraph (8); and

(2) by inserting after paragraph (6) the following new paragraph:

"(7) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a rehabilitation facility that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, the increase factor to be applied under paragraph (3)(C) for payments for discharges occurring during such fiscal year shall be reduced by 2 percentage points.

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent rate year, each rehabilitation facility shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—The quality measures specified under this subparagraph shall be such measures selected by the Secretary from measures that have been endorsed under paragraph (1) of section 1890C(f) or used as a result of a determination under paragraph (2) of such section.

''(ii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under sub-

paragraph (C) available to the public. Such procedures shall ensure that a rehabilitation facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public. The Secretary shall report quality measures that relate to services furnished in inpatient settings in rehabilitation facilities on the Internet website of the Centers for Medicare & Medicaid Services.''.

(c) HOSPICE PROGRAMS.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) QUALITY REPORTING.—

''(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, the market basket percentage increase to be applied under clause (ii) or (iii) of paragraph (1)(C), as applicable, for payments for routine home care

and other services included in hospice care furnished during such fiscal year shall be reduced by 2 percentage points.

''(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and the Secretary shall not take into account such reduction in computing the payment amount under this subsection for a subsequent fiscal year.

''(C) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary data on quality measures specified under subparagraph (D). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(D) QUALITY MEASURES.—

''(i) IN GENERAL.—The quality measures specified under this subparagraph shall be such measures selected by the Secretary from measures that have been endorsed under paragraph (1) of section 1890C(f) or used as a result of a deter-

mination under paragraph (2) of such section.

''(ii) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this subparagraph that will be applicable with respect to fiscal year 2014.

''(E) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subparagraph (C) available to the public. Such procedures shall ensure that a hospice program has the opportunity to review the data that is to be made public with respect to the hospice program prior to such data being made public. The Secretary shall report quality measures that relate to hospice care provided by hospice programs on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (U), by striking ''and'' at the end;

(B) in subparagraph (V), by striking the period at the end and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(W) in the case of a hospital described in section 1886(d)(1)(B)(v), to report quality data to the Secretary in accordance with subsection (k).''; and

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

''(k) QUALITY REPORTING BY CANCER HOSPITALS.—

''(1) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

''(2) SUBMISSION OF QUALITY DATA.—For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph (3). Such data shall be submitted in a

form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(3) QUALITY MEASURES.—

''(A) IN GENERAL.—The quality measures specified under this subparagraph shall be such measures selected by the Secretary from measures that have been endorsed under paragraph (1) of section 1890C(f) or used as a result of a determination under paragraph (2) of such section.

''(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

''(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of

care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))).

(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 (as selected from measures that are endorsed under paragraph (1) of section 1890C(f) or used as a result of a determination under paragraph (2) of such section), to the extent feasible and prac-

ticable, of all dimensions of quality and efficiency in skilled nursing facilities.

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

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

(D) Methods for the public disclosure of information on the performance of skilled nursing facilities.

(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) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Con-

gress a report containing the plan developed under paragraph (1).

(b) HOME HEALTH AGENCIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(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 (as selected from measures that are endorsed under paragraph (1) of section 1890C(f) or used as a result of a determination under paragraph (2) of such section), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

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

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

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate 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) REPORT TO CONGRESS.—Not later than October 1, 2010, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(1), by inserting ''subject to subsection (p),'' after ''1998,''.

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

''(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

''(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the geographic adjustment factors established under subsection (e).

''(2) QUALITY.—

''(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished (as

established by the Secretary under subparagraph (B)).

''(B) MEASURES.—

''(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect health outcomes. Such measures shall be risk adjusted as determined appropriate by the Secretary.

''(ii) The Secretary shall seek endorsement of the measures established under this subparagraph by the entity with a contract under section 1890(a).

''(3) COSTS.—For purposes of paragraph (1), costs shall be evaluated, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (n)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)), and take into account risk factors (such as socio-economic and demographic characteristics, ethnicity, and health status

of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

''(4) IMPLEMENTATION.—

''(A) PUBLICATION OF MEASURES, DATES OF IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2012, the Secretary shall publish the following:

''(i) The measures of quality of care and costs established under paragraphs (2) and (3), respectively.

''(ii) The dates for implementation of the payment modifier (as determined under subparagraph (B)).

''(iii) The initial performance period (as specified under subparagraph (B)(ii)).

''(B) DEADLINES FOR IMPLEMENTATION.—

''(i) INITIAL IMPLEMENTATION.—Subject to the preceding provisions of this subparagraph, the Secretary shall begin implementing the payment modifier established under this subsection through the rulemaking process during 2013 for the physi-

cian fee schedule established under subsection (b).

''(ii) INITIAL PERFORMANCE PERIOD.—

''(I) IN GENERAL.—The Secretary shall specify an initial performance period for application of the payment modifier established under this subsection with respect to 2015.

''(II) PROVISION OF INFORMATION DURING INITIAL PERFORMANCE PERIOD.—During the initial performance period, the Secretary shall, to the extent practicable, provide information to physicians and groups of physicians about the quality of care furnished by the physician or group of physicians to individuals enrolled under this part compared to cost (as determined under paragraphs (2) and (3), respectively) with respect to the performance period.

''(iii) APPLICATION.—The Secretary shall apply the payment modifier estab-

lished under this subsection for items and services furnished—

"(I) beginning on January 1, 2015, with respect to specific physicians and groups of physicians the Secretary determines appropriate; and

"(II) beginning not later than January 1, 2017, with respect to all physicians and groups of physicians.

"(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection shall be implemented in a budget neutral manner.

"(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

"(6) CONSIDERATION OF SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

''(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term 'physician' has the meaning given such term in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) COSTS.—The term 'costs' means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

''(B) PERFORMANCE PERIOD.—The term 'performance period' means a period specified by the Secretary.

''(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier estab-

lished under this subsection with the Physician Feedback Program under subsection (n) and, as the Secretary determines appropriate, other similar provisions of this title.

''(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise or otherwise of—

''(A) the establishment of the value-based payment modifier under this subsection;

''(B) the evaluation of quality of care under paragraph (2), including the establishment of appropriate measures of the quality of care under paragraph (2)(B);

''(C) the evaluation of costs under paragraph (3), including the establishment of appropriate measures of costs under such paragraph;

''(D) the dates for implementation of the value-based payment modifier;

''(E) the specification of the initial performance period and any other performance period under paragraphs (4)(B)(ii) and (8)(B), respectively;

''(F) the application of the value-based payment modifier under paragraph (7); and

''(G) the determination of costs under paragraph (8)(A).''.

SEC. 3008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following new subsection:

''(p) ADJUSTMENT TO HOSPITAL PAYMENTS FOR HOSPITAL ACQUIRED CONDITIONS.—

''(1) IN GENERAL.—In order to provide an incentive for applicable hospitals to reduce hospital acquired conditions under this title, with respect to discharges from an applicable hospital occurring during fiscal year 2015 or a subsequent fiscal year, the amount of payment under this section or section 1814(b)(3), as applicable, for such discharges during the fiscal year shall be equal to 99 percent of the amount of payment that would otherwise apply to such discharges under this section or section 1814(b)(3) (determined after the application of subsections (n), (o), and (q) and section 1814(l)(3) but without regard to this subsection).

''(2) APPLICABLE HOSPITALS.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'applicable hospital' means

a subsection (d) hospital that meets the criteria described in subparagraph (B).

''(B) CRITERIA DESCRIBED.—

''(i) IN GENERAL.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

''(ii) RISK ADJUSTMENT.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

''(3) HOSPITAL ACQUIRED CONDITIONS.—For purposes of this subsection, the term 'hospital acquired condition' means a condition identified for purposes of subsection (d)(4)(D)(iv) that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

''(4) APPLICABLE PERIOD.—In this subsection, the term 'applicable period' means, with respect to a fiscal year, a period specified by the Secretary.

''(5) REPORTING TO HOSPITALS.—Prior to fiscal year 2015 and each subsequent fiscal year, the Secretary shall provide confidential reports to applicable hospitals with respect to hospital acquired conditions of the applicable hospital during the applicable period.

''(6) REPORTING HOSPITAL SPECIFIC INFORMATION.—

''(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

''(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

''(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

''(7) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) The criteria described in paragraph (2)(A).

''(B) The specification of hospital acquired conditions under paragraph (3).

''(C) The specification of the applicable period under paragraph (4).

''(D) The provision of reports to applicable hospitals under paragraph (5) and the information made available to the public under paragraph (6)''.

PART II—STRENGTHENING THE QUALITY INFRASTRUCTURE

SEC. 3011. NATIONAL STRATEGY.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1890 the following new section:

''NATIONAL STRATEGY FOR QUALITY IMPROVEMENT IN HEALTH CARE

''SEC. 1890A. (a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

''(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

''(2) IDENTIFICATION OF PRIORITIES.—

"(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

"(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

"(i) have the greatest potential for improving the health outcomes, efficiency, and patient-centeredness of health care;

"(ii) identify areas in the delivery of health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

"(iii) address gaps in quality , efficiency, and health outcomes measures and data aggregation techniques;

"(iv) improve Federal payment policy to emphasize quality and efficiency;

"(v) enhance the use of health care data to improve quality, efficiency, transparency, and outcomes;

"(vi) address the health care provided to patients with high-cost chronic diseases;

"(vii) improve strategies and best practices to improve patient safety and re-

duce medical errors, preventable admissions and readmissions, and health care-associated infections;

''(viii) reduce health disparities across health disparity populations (as defined by section 485E of the Public Health Service Act) and geographic areas; and

''(ix) address other areas as determined appropriate by the Secretary.

''(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration—

''(i) the recommendations submitted by qualified consensus-based entities as required under section 1890C; and

''(ii) the recommendations of the Interagency Working Group on Health Care Quality established under section 3012 of the America's Healthy Future Act of 2009.

''(b) STRATEGIC PLAN.—

''(1) IN GENERAL.—The national strategy shall include a comprehensive strategic plan to achieve the priorities described in subsection (a).

''(2) REQUIREMENTS.—The strategic plan shall include provisions for addressing, at a minimum, the following:

''(A) Coordination among agencies within the Department, which shall include steps to minimize duplication of efforts and utilization of common quality measures, where available. Such common quality measures shall be measures endorsed under section 1890C.

''(B) Agency-specific strategic plans to achieve national priorities.

''(C) Establishment of annual benchmarks for each relevant agency to achieve national priorities.

''(D) A process for regular reporting by the agencies to the Secretary on the implementation of the strategic plan.

''(E) Strategies to align incentives among public and private payers with regard to quality and patient safety efforts.

''(F) Incorporating quality improvement and measurement in the strategic plan for health information technology required by the American Recovery and Reinvestment Act of 2009 (Public Law 111–5).

"(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—The Secretary shall update the national strategy not less than triennially. Any such update shall include a review of short- and long-term goals.

"(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATES.—

"(1) DEADLINE FOR INITIAL SUBMISSION OF NATIONAL STRATEGY.—Not later than December 31, 2010, the Secretary shall submit to the relevant Committees of Congress the national strategy.

"(2) UPDATES.—

"(A) IN GENERAL.—The Secretary shall submit to the relevant Committees of Congress any updates to such strategy.

"(B) INFORMATION SUBMITTED.—Any update submitted under subparagraph (A) shall include—

"(i) a review of the short and long-term goals of the national strategy; and

"(ii) an analysis of the progress made in meeting those goals.

"(e) HEALTH CARE QUALITY WEBSITE.—The Secretary shall create an Internet website to make public information regarding—

''(1) the national priorities for health care quality improvement established under subsection (a)(2);

''(2) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B); and

''(3) other information, as the Secretary determines to be appropriate.''.

SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

(a) IN GENERAL.—The President shall convene a working group to be known as the Interagency Working Group on Health Care Quality (referred to in this section as the ''Working Group'').

(b) GOALS.—The goals of the Working Group shall be to achieve the following:

(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables that are consistent with the national priorities identified under section 1890A of the Social Security Act (as added by section 3011).

(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where prac-

ticable, and a streamlined process for quality reporting and compliance requirements.

(c) COMPOSITION.—

(1) IN GENERAL.—The Working Group shall be composed of senior level representatives of—

(A) the Department of Health and Human Services;

(B) the Centers for Medicare & Medicaid Services;

(C) the National Institutes of Health;

(D) the Centers for Disease Control and Prevention;

(E) the Food and Drug Administration;

(F) the Health Resources and Services Administration;

(G) the Agency for Healthcare Research and Quality;

(H) the Administration for Children and Families;

(I) the Department of Commerce;

(J) the Office of Management and Budget;

(K) the United States Coast Guard;

(L) the Federal Bureau of Prisons;

(M) the National Highway Traffic Safety Administration;

(N) the Federal Trade Commission;

(O) the Social Security Administration;

(P) the Department of Labor;

(Q) the United States Office of Personnel Management;

(R) the Department of Defense;

(S) the Department of Education;

(T) the Department of Veterans Affairs;

(U) the Veterans Health Administration; and

(V) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

(2) CHAIR AND VICE CHAIR.—

(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

(B) VICE CHAIR.—Members of the Working Group, other than the Secretary of Health and Human Services, shall serve as Vice Chair of the Group on a rotating basis, as determined by the Group.

(d) REPORT TO CONGRESS.—Not later than a date determined appropriate by the Secretary, and annually

thereafter, the Working Group shall submit to the relevant Committees of Congress, and make public on an Internet website, a report describing the progress and recommendations of the Working Group in meeting the goals described in subsection (b).

SEC. 3013. QUALITY MEASURE DEVELOPMENT.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3011, is further amended by inserting after section 1890A the following new section:

''QUALITY MEASURE DEVELOPMENT

''SEC. 1890B. (a) QUALITY MEASURE.—In this section, the term 'quality measure' means a standard for measuring the performance and improvement of population health or of health plans, providers of services, and other clinicians in the delivery of health care services.

''(b) IDENTIFICATION OF QUALITY MEASURES.—

''(1) IDENTIFICATION.—The Secretary shall identify, not less often than triennially, gaps where no quality measures exist, or where existing quality measures need improvement, updating, or expansion, consistent with the national strategy under section 1890A, for use in programs authorized under this Act. In identifying such gaps, the Secretary shall take into consideration the gaps identified by a

qualified consensus-based entity under section 1890C.

''(2) PUBLICATION.—The Secretary shall make available to the public on an Internet website a report on any gaps identified under paragraph (1) and the process used to make such identification.

''(c) GRANTS OR CONTRACTS FOR QUALITY MEASURE DEVELOPMENT.—

''(1) IN GENERAL.—The Secretary shall award grants, contracts, or intergovernmental agreements to eligible entities for purposes of developing, improving, updating, or expanding quality measures identified under subsection (b).

''(2) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

''(A) health outcomes and functional status of patients;

''(B) the coordination of health care across episodes of care and care transitions;

''(C) the meaningful use of health information technology;

"(D) safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

"(E) efficiency of care;

"(F) equity of health services and health disparities across health disparity populations (as defined in section 485E of the Public Health Service Act) and geographic areas;

"(G) patient experience and satisfaction; and

"(H) other areas determined appropriate by the Secretary.

"(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) have demonstrated expertise and capacity in the development and evaluation of quality measures;

"(B) have adopted procedures to include in the quality measure development process—

"(i) the views of those providers or payers whose performance will be assessed by the measure; and

"(ii) the views of other parties who also will use the quality measures (such as

patients, consumers, and health care purchasers);

"(C) collaborate with a qualified consensus-based entity (as defined in section 1890C), as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by such qualified consensus-based entity;

"(D) have transparent policies regarding governance and conflicts of interest; and

"(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

"(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

"(A) Such measures build upon measures required to be reported pursuant to this title, where applicable.

"(B) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

''(C) Each quality measure is free of charge to users of such measure.

''(D) Each quality measure is publicly available on an Internet website.

''(d) OTHER ACTIVITIES BY THE SECRETARY.—The Secretary may use amounts available under this section to update and test, where applicable, quality measures endorsed by a qualified consensus-based entity (as defined in section 1890C) or adopted by the Secretary.

''(e) FUNDING.—There are authorized to be appropriated to carry out this section, $75,000,000 for each of fiscal years 2010 through 2014.''.

SEC. 3014. QUALITY MEASURE ENDORSEMENT.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by sections 3011 and 3013, is further amended by inserting after section 1890B the following new section:

''QUALITY MEASURE ENDORSEMENT

''SEC. 1890C. (a) DEFINITION.—In this section:

''(1) QUALIFIED CONSENSUS-BASED ENTITY.—The term 'qualified consensus-based entity' means an entity with a contract with the Secretary under section 1890.

''(2) QUALITY MEASURE.—The term 'quality measure' means a standard for measuring the performance and improvement of population health or

of health plans, providers of services, and other clinicians in the delivery of health care services.

''(3) MULTI-STAKEHOLDER GROUP.—The term 'multi-stakeholder group' means, with respect to a quality measure, a voluntary collaborative of organizations representing a broad group of stakeholders interested in or affected by the use of such quality measure. Stakeholders would include representatives of hospitals, physicians, post-acute providers, quality alliances, nurses and other health care practitioners, health plans, consumer representatives, life sciences industry, employers and public purchasers, labor organizations, licensing, credentialing and accrediting bodies, relevant government agency representatives; and others deemed appropriate by the Secretary. Such a multi-stakeholder group would operate in an open and transparent process.

''(b) GRANTS AND CONTRACTS.—A qualified consensus-based entity may receive a grant or contract under this section to—

''(1) make recommendations to the Secretary for national priorities for performance improvement in population health and in the delivery of health care services;

''(2) identify gaps in endorsed quality measures, which shall include measures that are within priority areas identified by the Secretary under the national strategy established under section 1890A;

''(3) identify and endorse quality measures;

''(4) update endorsed quality measures at least every 3 years;

''(5) make endorsed quality measures publicly available and have a plan for broad-based dissemination of endorsed measures; and

''(6) transmit endorsed quality measures to the Secretary.

''(c) ANNUAL REPORTS.—

''(1) IN GENERAL.—A qualified consensus-based entity that receives a grant or contract under this section shall provide a report to the Secretary not less than annually—

''(A) of where gaps (as described in subsection (b)(2)) exist and where quality measures are unavailable or inadequate to identify or address such gaps; and

''(B) regarding areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established

under section 1890A and where targeted research may address such gaps.

''(2) IMPACT OF QUALITY MEASURES.—A qualified consensus-based entity that receives a grant or contract under this section shall provide a report to the Secretary not less than annually regarding the economic and quality impact of the use of endorsed measures.

''(d) PRIORITIES FOR PERFORMANCE IMPROVEMENT.—

''(1) RECOMMENDATION FOR NATIONAL PRIORITIES.—A qualified consensus-based entity that receives a grant or contract under this section shall evaluate evidence and convene multi-stakeholder groups to make recommendations to the Secretary for national priorities (as identified in section 1890A(a)(2)) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 1890A. The qualified consensus-based entity shall make such recommendations not less frequently than triennially.

''(2) REQUIREMENTS FOR TRANSPARENCY IN PROCESS.—

"(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (1) with respect to recommendations for national priorities, the qualified consensus-based entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

"(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under subparagraph (A) shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

"(e) PROCESS FOR CONSULTATION OF STAKEHOLDER GROUPS.—

"(1) CONSULTATION OF SELECTION OF ENDORSED QUALITY MEASURES.—A qualified consensus-based entity that receives a grant or contract under this section shall convene multi-stakeholder groups to provide guidance on the selection of individual or composite quality measures, for use in reporting performance information to the public or for use in Federal health programs, from among—

"(A) such measures that have been endorsed by the qualified consensus-based entity (under section 1890(b) or otherwise); and

"(B) such measures that have not been considered for endorsement by the qualified consensus-based entity but are used or proposed to be used by the Secretary under subsection (f)(2) under laws under the jurisdiction of the Secretary that require the collection or reporting of quality measures.

"(2) ESTABLISHMENT OF PRE-RULEMAKING PROCESS.—

"(A) IN GENERAL.—The Secretary shall establish a pre-rulemaking process under which a qualified consensus-based entity that receives a grant or contract under this section and multi-stakeholder groups convened under paragraph (1) provide guidance to the Secretary on the selection of individual or composite quality measures (as described in such paragraph).

"(B) PUBLIC AVAILABILITY OF MEASURES CONSIDERED FOR SELECTION.—Not later than December 1 or each year (beginning with 2011), the Secretary shall make available to the public a list of such measures that the Sec-

retary is considering for selection with respect to quality reporting and payment systems under this title.

''(C) INCLUSION OF MEASURES.—The list made available under subparagraph (B) may include such measures that are described in subparagraphs (A) or (B) of paragraph (1) as the Secretary determines appropriate.

''(D) TRANSMISSION OF MULTI-STAKEHOLDER GUIDANCE.—Not later than February 1 of each year (beginning with 2012), the qualified consensus-based entity shall transmit to the Secretary the guidance of multi-stakeholder groups provided under paragraph (1).

''(3) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—

''(A) IN GENERAL.—In convening multi-stakeholder groups under paragraph (1) with respect to the selection of quality measures, the qualified consensus-based entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

''(B) SELECTION OF ORGANIZATIONS PARTICIPATING IN MULTI-STAKEHOLDER GROUPS.—The process under subparagraph (A)

shall ensure that the selection of representatives comprising such groups provides for public nominations for, and the opportunity for public comment on, such selection.

''(f) COORDINATION OF USE OF QUALITY MEASURES.—

''(1) ENDORSED QUALITY MEASURES.—The Secretary may make a determination under regulation or otherwise to use a quality measure described in subsection (e)(1)(A) only after taking into account the guidance of multi-stakeholder groups under subsection (e)(2).

''(2) USE OF NON-ENDORSED MEASURES.—

''(A) IN GENERAL.—The Secretary may make a determination, by regulation or otherwise, to use a quality measure that has not been endorsed as described in subsection (e)(1)(A), provided that the Secretary—

''(i) in a timely manner, transmits the measure to the qualified consensus-based entity for consideration for endorsement and for the multi-stakeholder consultation process under subsection (e)(1);

"(ii) publishes in the Federal Register the rationale for the use of the measure; and

"(iii) phases out use of the measure upon a decision of the qualified consensus-based entity not to endorse the measure, contingent on availability of an adequate alternative endorsed measure (as determined by the Secretary), taking into account guidance from multi-stakeholder consultation process under subsection (e)(1).

"(B) NO ADEQUATE ALTERNATIVE.—If an adequate alternative endorsed measure is not available, the Secretary shall support the development of such an alternative endorsed measure, as described in section 1890B.

"(3) EFFECTIVE DATE.—This subsection shall apply with respect to determinations or requirements by the Secretary for the use of quality measures made on or after the date of enactment of the America's Health Future Act of 2009.

"(g) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

"(1) IN GENERAL.—Not less than once every 3 years, the Secretary shall review quality measures

used by the Secretary and, with respect to each such measure, shall determine whether to—

"(A) maintain the use of such measure; or

"(B) phase out such measure.

"(2) CONSIDERATIONS.—In conducting the review under paragraph (1), the Secretary shall—

"(A) seek to avoid duplication of measures used; and

"(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by a qualified consensus-based entity since the previous review by the Secretary.

"(h) PROCESS FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

"(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the incorporation of such measures, where applicable, in workforce programs, training curricula, payment programs, and any other means of dissemination determined by the Secretary. The Secretary shall establish a process to disseminate such quality meas-

ures to the Interagency Working Group established in section 3012 of the America's Health Future Act of 2009.

''(2) AUTHORITY TO CONTRACT WITH CERTAIN ORGANIZATIONS FOR DISSEMINATION.—

''(A) IN GENERAL.—The Secretary may contract with 1 or more entities that meet the requirements described in subparagraph (B) to carry out this subsection.

''(B) ENTITIES DESCRIBED.—The requirements described in this subparagraph are the following:

''(i) The entity is a nonprofit entity.

''(ii) The entity has at least 5 years of experience in developing and implementing quality improvement strategies.

''(iii) The entity has operated programs described in paragraph (1) on a statewide or multi-State basis to improve patient safety and the quality of health care delivered in hospitals, including at a minimum such programs in hospital intensive care units, hospital-associated infections, hospital perioperative patient safety, and hospital emergency rooms.

''(iv) The entity has worked with a variety of institutional health care providers, physicians, and other providers of services and suppliers.

''(i) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to providers of services and suppliers required to report on measures under this title. In providing such assistance, the Secretary shall give priority to—

''(1) rural and urban providers of services and suppliers with limited infrastructure and financial resources to implement and support quality improvement activities;

''(2) providers of services and suppliers with poor performance scores; and

''(3) providers of services and suppliers with disparities in care among subgroups of patients.

''(j) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841, in such proportion as the Secretary determines appropriate, of $50,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each

of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall remain available until expended.''.

PART III—ENCOURAGING DEVELOPMENT OF NEW PATIENT CARE MODELS

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by inserting after section 1115 the following new section:

''CENTER FOR MEDICARE AND MEDICAID INNOVATION

''SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION ESTABLISHED.—

''(1) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a Center for Medicare and Medicaid Innovation (in this section referred to as the 'CMI') to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services fur-

nished to applicable individuals defined in paragraph (4)(A).

''(2) DEADLINE.—The Secretary shall ensure that the CMI is carrying out the duties described in this section by not later than January 1, 2011.

''(3) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult representatives of relevant Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

''(4) DEFINITIONS.—In this section:

''(A) APPLICABLE INDIVIDUAL.—The term 'applicable individual' means—

''(i) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of such title;

''(ii) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

''(iii) an individual who meets the criteria of both clauses (i) and (ii).

''(B) APPLICABLE TITLE.—The term 'applicable title' means title XVIII, title XIX, or both.

''(b) TESTING OF MODELS (PHASE I).—

''(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

''(2) SELECTION OF MODELS TO BE TESTED.—

''(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence that the model addresses a defined population for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

''(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

"(i) Promoting broad payment and practice reform in primary care, including patient-centered medical home models for high-need Medicare beneficiaries, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment under title XVIII

"(ii) Contracting directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment or salary-based payment.

"(iii) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based payment.

"(iv) Supporting care coordination for chronically-ill Medicare beneficiaries at high risk of hospitalization, such as individuals with cognitive impairment (including dementia) through a health informa-

tion technology-enabled network that includes a chronic disease registry, home tele-health technology, and care oversight by the Medicare beneficiary's treating physician.

"(v) Varying payment to physicians who order advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)) according to the physician's adherence to appropriateness criteria for the ordering of such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

"(vi) Utilizing medication therapy management services.

"(vii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management activities.

"(viii) Funding physician, nurse practitioner, or physician assistant-led home-based primary care programs with demonstrated experience in serving high-cost

Medicare beneficiaries with multiple chronic illnesses and functional disabilities.

''(ix) Assisting Medicare beneficiaries in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools that improve Medicare beneficiary and caregiver understanding of medical treatment options.

''(x) Allowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight of all funds under the applicable titles with respect to such individuals.

''(xi) Allowing States to test and evaluate systems of all-payer payment reform for the medical care of residents of the State, including dual eligible individuals.

''(xii) Aligning nationally-recognized, evidence-based guidelines of cancer care with payment incentives under title XVIII in the areas of treatment planning and follow-up care planning for Medicare bene-

ficiaries with cancer, including the identification of gaps in applicable quality measures.

''(xiii) Improving post-acute care through continuing care hospitals that offer inpatient rehabilitation, long-term care hospitals, and home health or skilled nursing care during an inpatient stay and the 30 days immediately following discharge.

''(xiv) Funding home health providers who offer chronic care management services to Medicare beneficiaries in cooperation with interdisciplinary teams.

''(xv) Promoting improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

''(I) developing, documenting, and disseminating best practices and proven care methods;

''(II) implementing such best practices and proven care methods within such institutions to dem-

onstrate further improvements in quality and efficiency; and

''(III) providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

''(xvi) Promoting greater efficiencies and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

''(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

''(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is

consistent with the needs and preferences of Medicare beneficiaries.

''(ii) Whether the model places the Medicare beneficiary, including family members and other informal caregivers of the beneficiary, at the center of the care team of the beneficiary.

''(iii) Whether the model provides for in-person contact with Medicare beneficiaries.

''(iv) Whether the model utilizes technology, such as electronic health records and patient-based remote monitoring systems, to coordinate care over time and across settings.

''(v) Whether the model provides for the maintenance of a close relationship between care coordinators, primary care practitioners, specialist physicians, and other providers of services and suppliers.

''(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, and self-management coaching.

"(vii) Whether, under the model, providers of services and suppliers are able to share information with other providers of services and suppliers on a real time basis.

"(3) BUDGET NEUTRALITY.—

"(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

"(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to program spending under the applicable title, certifies), after testing has begun, that the model is expected to—

"(i) improve the quality of care (as determined by the Administrator of the Centers for Medicare & Medicaid Services) without increasing spending under the applicable title;

''(ii) reduce spending under the applicable title without reducing the quality of care; or

''(iii) improve the quality of care and reduce spending.

Such termination may occur at any time after such testing has begun and before completion of the testing.

''(4) EVALUATION.—

''(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

''(i) the quality of care furnished under the model, including the measurement of patient-level outcomes; and

''(ii) the changes in spending under the applicable titles by reason of the model.

''(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish requirements for States and other entities participating in the testing of models under this section to collect

and report information that the Secretary determines is necessary to monitor and evaluate such models.

''(c) EXPANSION OF MODELS (PHASE II).—Taking into account the evaluation under subsection (b)(4), the Secretary may, through rulemaking, expand (including implementation on a nationwide basis) the duration and the scope of a model that is being tested under subsection (b) or a demonstration project under section 1866C, to the extent determined appropriate by the Secretary, if—

''(1) the Secretary determines that such expansion is expected to—

''(A) reduce spending under applicable title without reducing the quality of care; or

''(B) improve the quality of care and reduce spending; and

''(2) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce net program spending under applicable titles.

''(d) IMPLEMENTATION.—

''(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII and of sections 1902(a)(1), 1902(a)(13), and 1903(m)(2)(A)(iii) as may be necessary solely for

purposes of carrying out this section with respect to testing models described in subsection (b).

''(2) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(A) the selection of models for testing or expansion under this section;

''(B) the selection of organizations, sites, or participants to test those models selected;

''(C) the elements, parameters, scope, and duration of such models for testing or dissemination;

''(D) determinations regarding budget neutrality under subsection (b)(3);

''(E) the termination or modification of the design and implementation of a model under subsection (b)(3)(B); and

''(F) determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.

''(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing

and evaluation of models or expansion of such models under this section.

''(e) APPLICATION TO CHIP.—The Center may carry out activities under this section with respect to title XXI in the same manner as provided under this section with respect to the program under the applicable titles.

''(f) FUNDING.—

''(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

''(A) $10,000,000,000 for the activities initiated under this section for the period of fiscal years 2011 through 2019; and

''(B) the amount described in subparagraph (A) for the activities initiated under this section for each subsequent 10-year fiscal period (beginning with the 10-year fiscal period beginning with fiscal year 2020).

Amounts appropriated under the preceding sentence shall remain available until expended.

''(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated under paragraph (1), not less than $25,000,000 shall be made available each such fiscal year to design, implement, and evaluate models under subsection (b).

''(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section. Each such report shall describe the models tested under subsection (b), including the number of individuals described in subsection (a)(4)(A)(i) and of individuals described in subsection (a)(4)(A)(ii) participating in such models and payments made under applicable titles for services on behalf of such individuals, any models chosen for expansion under subsection (c), and the results from evaluations under subsection (b)(4). In addition, each such report shall provide such recommendations as the Secretary determines are appropriate for legislative action to facilitate the development and expansion of successful payment models.''.

(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 5103 and 5105, is amended—

(1) in paragraph (77), by striking ''and'' at the end;

(2) in paragraph (78), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (78) the following new paragraph:

''(79) provide for implementation of the payment models specified by the Secretary under section 1115A(c) for implementation on a nationwide basis unless the State demonstrates to the satisfaction of the Secretary that implementation would not be administratively feasible or appropriate to the health care delivery system of the State.''.

(c) REVISIONS TO HEALTH CARE QUALITY DEMONSTRATION PROGRAM.—Subsections (b) and (f) of section 1866C of the Social Security Act (42 U.S.C. 1395cc–3) are amended by striking ''5-year'' each place it appears.

SEC. 3022. MEDICARE SHARED SAVINGS PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SHARED SAVINGS PROGRAM

''SEC. 1899. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—Not later than January 1, 2012, the Secretary shall establish a shared savings program (in this section referred to as the 'program') that promotes accountability for a patient population and coordinates items and services under parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery. Under such program—

''(A) groups of providers of services and suppliers meeting criteria specified by the Secretary may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (referred to in this section as an 'ACO'); and

''(B) ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings under subsection (d)(2).

''(b) ELIGIBLE ACOS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, as determined appropriate by the Secretary, the following groups of providers of services and suppliers which have established a mechanism for shared governance are eligible to participate as ACOs under the program under this section:

''(A) ACO professionals in group practice arrangements.

''(B) Networks of individual practices of ACO professionals.

"(C) Partnerships or joint venture arrangements between hospitals and ACO professionals.

"(D) Hospitals employing ACO professionals.

"(E) Such other groups of providers of services and suppliers as the Secretary determines appropriate.

"(2) REQUIREMENTS.—An ACO shall meet the following requirements:

"(A) The ACO shall be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.

"(B) The ACO shall enter into an agreement with the Secretary to participate in the program for not less than a 3-year period (referred to in this section as the 'agreement period').

"(C) The ACO shall have a formal legal structure that would allow the organization to receive and distribute payments for shared savings under subsection (d)(2) to participating providers of services and suppliers.

"(D) The ACO shall include the primary care ACO professionals described in subsection (h)(1)(A) of at least 5,000 Medicare fee-for-service beneficiaries assigned to the ACO under subsection (c).

"(E) The ACO shall provide the Secretary with such information regarding ACO professionals participating in the ACO as the Secretary determines necessary to support the assignment of Medicare fee-for-service beneficiaries to an ACO, the implementation of quality and other reporting requirements under paragraph (3), and the determination of payments for shared savings under subsection (d)(2).

"(F) The ACO shall have in place a leadership and management structure that includes clinical and administrative systems.

"(G) The ACO shall define processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.

''(H) The ACO shall demonstrate to the Secretary that it meets patient-centeredness criteria specified by the Secretary, such as the use of patient and caregiver assessments or the use of individualized care plans.

''(3) QUALITY AND OTHER REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by the ACO, such as measures of—

''(i) clinical processes and outcomes;

''(ii) patient perspectives on care; and

''(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).

''(B) REPORTING REQUIREMENTS.—An ACO shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate the quality of care furnished by the ACO. Such data may include care transitions across health care settings, including hospital discharge planning and post hospital

discharge follow-up by ACO professionals, as the Secretary determines appropriate.

''(C) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs. The Secretary shall seek to improve the quality of care furnished by ACOs over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

''(D) OTHER REPORTING REQUIREMENTS.—The Secretary may, as the Secretary determines appropriate, incorporate reporting requirements and incentive payments related to the physician quality reporting initiative (PQRI) under section 1848, including such requirements and such payments related to electronic prescribing, electronic health records, and other similar initiatives under section 1848, and may use alternative criteria than would otherwise apply under such section for determining whether to make such payments. The incentive payments described in the preceding sentence shall not be taken into consideration

when calculating any payments otherwise made under subsection (d).

''(4) NO DUPLICATION IN PARTICIPATION IN SHARED SAVINGS PROGRAMS.—A provider of services or supplier that participates in any of the following shall not be eligible to participate in an ACO under this section:

''(A) A model tested or expanded under section 1115A that involves shared savings under this title, or any other program or demonstration project that involves such shared savings.

''(B) The independence at home medical practice pilot program under section 1866E.

''(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services under this title.

''(d) PAYMENTS AND TREATMENT OF SAVINGS.—

''(1) PAYMENTS.—

''(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the

original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

''(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

''(ii) the ACO meets the requirement under subparagraph (B)(i).

''(B) SAVINGS REQUIREMENT AND BENCHMARK.—

''(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to ac-

count for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

''(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

''(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary

under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO as shared savings and the remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

''(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

''(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

''(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

''(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

''(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

''(1) the specification of criteria under subsection (a)(1)(B);

''(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

''(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

''(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings, including the determination of the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries assigned to the ACO and the average benchmark for the ACO under subsection (d)(1)(B);

''(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit

on the total amount of shared savings established by the Secretary under such subsection; and

''(6) the termination of an ACO under subsection (d)(4).

''(h) DEFINITIONS.—In this section:

''(1) ACO PROFESSIONAL.—The term 'ACO professional' means—

''(A) a physician (as defined in section 1861(r)(1)); and

''(B) a practitioner described in section 1842(b)(18)(C)(i).

''(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

''(3) MEDICARE FEE-FOR-SERVICE BENEFICIARY.—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 and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a PACE program under section 1894.''.

SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3021, is amended by inserting after section 1886C the following new section:

''NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

''SEC. 1866D. (a) IMPLEMENTATION.—

''(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization.

''(2) DEFINITIONS.—In this section:

''(A) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

''(i) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B of such title, but not enrolled under part C; and

''(ii) is admitted to a hospital for an applicable condition.

''(B) APPLICABLE CONDITION.—The term 'applicable condition' means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the

Secretary shall take into consideration the following factors:

''(i) Whether the conditions selected include a mix of chronic and acute conditions.

''(ii) Whether the conditions selected include a mix of surgical and medical conditions.

''(iii) Whether a condition is one for which there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

''(iv) Whether a condition has significant variation in—

''(I) the number of readmissions; and

''(II) the amount of expenditures for post-acute care spending under this title.

''(v) Whether a condition has high-volume and high post-acute care expenditures under this title.

''(vi) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

''(C) APPLICABLE SERVICES.—The term 'applicable services' means the following:

''(i) Acute care inpatient services.

''(ii) Physicians' services delivered in and outside of an acute care hospital setting.

''(iii) Outpatient hospital services, including emergency department services.

''(iv) Services associated with acute care hospital readmissions.

''(v) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

''(vi) Other services the Secretary determines appropriate.

''(D) EPISODE OF CARE.—

''(i) IN GENERAL.—Subject to clause (ii), the term 'episode of care' means, with

respect to an applicable beneficiary, the period that includes—

"(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for an applicable condition;

"(II) the length of stay of the applicable beneficiary in such hospital; and

"(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

"(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

"(E) PHYSICIANS' SERVICES.—The term 'physicians' services' has the meaning given such term in section 1861(q).

"(F) PILOT PROGRAM.—The term 'pilot program' means the pilot program under this section.

''(G) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given such term in section 1861(u).

''(H) READMISSION.—The term 'readmission' has the meaning given such term in section 1886(q)(3)(B).

''(I) SUPPLIER.—The term 'supplier' has the meaning given such term in section 1861(d).

''(3) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program not later than January 1, 2013.

''(b) DEVELOPMENTAL PHASE.—

''(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the applicable condition of an applicable beneficiary for purposes of determining the most clinically-appropriate site for the provision of post-acute care to the applicable beneficiary.

''(2) DEVELOPMENT OF QUALITY MEASURES FOR AN EPISODE OF CARE AND FOR POST-ACUTE CARE.—

''(A) IN GENERAL.—The Secretary, in consultation with the Agency for Healthcare Research and Quality and a qualified consensus-based entity under section 1890C, shall develop quality measures for use in the pilot program—

''(i) for episodes of care; and

''(ii) for post-acute care.

''(B) SITE-NEUTRAL POST-ACUTE CARE QUALITY MEASURES.—Any quality measures developed under subparagraph (A)(ii) shall be site-neutral.

''(C) COORDINATION WITH QUALITY MEASURE DEVELOPMENT AND ENDORSEMENT PROCEDURES.—The Secretary shall ensure that the development of quality measures under subparagraph (A) is done in a manner that is consistent with the measures developed and endorsed under sections 1890B and 1890C that are applicable to all post-acute care settings.

''(3) DETERMINATION OF APPLICATION OF WAIVER AUTHORITY.—The Secretary shall determine which requirements of this title and title XI to waive under subsection (d) to carry out the pilot program .

''(c) DETAILS.—

"(1) DURATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the pilot program shall be conducted for a period of 5 years.

"(B) EXTENSION.—The Secretary may extend the duration of the pilot program for providers of services and suppliers participating in the pilot program as of the day before the end of the 5-year period described in subparagraph (A), for a period determined appropriate by the Secretary, if the Secretary determines that such extension will result in any of the following conditions being met:

"(i) The extension of the pilot program is expected to improve the quality of patient care without increasing expenditures under this title.

"(ii) The extension of the pilot program is expected to reduce expenditures under this title without reducing the quality of patient care.

"(2) PARTICIPATING PROVIDERS OF SERVICES AND SUPPLIERS.—

"(A) IN GENERAL.—Subject to subparagraph (C), any provider of services or supplier,

including a hospital, a physician group, or an entity composed of 2 or more providers of services or suppliers may submit an application to the Secretary to participate in the pilot program.

''(B) REQUIREMENTS.—The Secretary shall develop requirements for providers of services, suppliers, and entities composed of 2 or more providers of services or suppliers to participate in the pilot program. Such requirements shall ensure that applicable beneficiaries have an adequate choice of providers of services and suppliers under the pilot program.

''(C) REQUIREMENTS FOR POST-ACUTE ENTITIES.—An entity composed of 2 or more providers of services or suppliers may only participate in the pilot program if the entity owns, operates, or contracts with an acute care hospital for the furnishing of services for which a bundled payment is made under paragraph (3)(D).

''(3) PAYMENT METHODOLOGY.—

''(A) IN GENERAL.—

''(i) ESTABLISHMENT OF PAYMENT RATES.—The Secretary shall establish pay-

ment rates under the pilot program for providers of services, suppliers, and entities participating in the pilot program at an amount that is equal to the average expected reimbursement under this title of providers of services, suppliers, and entities not participating in the pilot program for applicable services over an episode of care.

''(ii) TESTING OF ALTERNATIVE PAYMENT METHODOLOGIES.—The Secretary shall test alternative payment methodologies under the pilot program, including bundled payments or arrangements in which providers of services, suppliers, and entities continue to receive reimbursement under payment systems that would otherwise apply under this title, in accordance with this paragraph.

''(B) ADJUSTMENT OF PAYMENTS.—Payments to participating providers of services, suppliers, and entities under the pilot program shall be adjusted for—

''(i) severity of illness and other characteristics of applicable beneficiaries, in-

cluding having a major diagnosis of substance abuse or mental illness; and

''(ii) resources needed to provide care, including an adjustment for differences in hospital average hourly wages, physician work, practice expense, malpractice expense, and geographic adjustment factors.

''(C) INCLUSION OF CERTAIN SERVICES.—A payment methodology tested under the pilot program shall include payment for the furnishing of applicable services and other appropriate services, such as care coordination, medication reconciliation, discharge planning, transitional care services, and other patient-centered activities as determined appropriate by the Secretary.

''(D) BUNDLED PAYMENTS.—

''(i) IN GENERAL.—A bundled payment under the pilot program shall—

''(I) be comprehensive, covering the costs of applicable services and other appropriate services furnished to an individual during an episode of care (as determined by the Secretary), including the costs of any readmission

which would otherwise be subject to a payment adjustment under section 1886(q)(5); and

"(II) be made to a provider of services or supplier (or an entity composed of 2 or more providers of services or suppliers) participating in the pilot program.

"(ii) REQUIREMENT FOR PROVISION OF APPLICABLE SERVICES AND OTHER APPROPRIATE SERVICES.—Applicable services and other appropriate services for which payment is made under this subparagraph shall be furnished or directed by a provider of services, supplier, or entity which is participating under this title.

"(iii) BUNDLED PAYMENT FOR APPLICABLE CONDITIONS.—A bundled payment under the pilot program with respect to an applicable condition shall be based on the average of the amount of payment otherwise made under this title to a hospital, a physician, other providers of services, and other suppliers for such services furnished to an applicable beneficiary with respect to

the applicable condition during an episode of care.

''(iv) PAYMENT FOR EACH APPLICABLE BENEFICIARY FURNISHED APPLICABLE SERVICES DURING AN EPISODE OF CARE.—A bundled payment under the pilot program shall be made to a provider of services, supplier, or entity with respect to each applicable beneficiary who is furnished applicable services during an episode of care by the provider of services, supplier, or entity, regardless of whether the applicable beneficiary receives a certain level of physicians' services or post-acute care services.

''(E) EXEMPTION FROM PAYMENT ADJUSTMENT FOR READMISSIONS.—In the case where the Secretary determines there is overlap between an applicable condition under the pilot program and a condition selected under paragraph (2) of section 1886(q) for which there would otherwise be a payment adjustment under paragraph (5) of such section, the applicable condition shall be exempt from such payment adjustment.

"(F) READMISSIONS TO A HOSPITAL OTHER THAN THE HOSPITAL OF THE INITIAL ADMISSION.—

"(i) IN GENERAL.—Under the pilot program, in the case of the readmission of an applicable beneficiary to a hospital other than the hospital of the initial admission, the Secretary shall reimburse the hospital of the readmission the amount of payment that would otherwise be made under this title for the readmission.

"(ii) ADJUSTMENT OF BUNDLED PAYMENT.—In the case described in clause (i), the Secretary shall reduce the amount of the bundled payment under subparagraph (D) for the hospital of the initial admission by an amount equal to the amount paid to the hospital of the readmission under such clause.

"(G) PAYMENT FOR POST-ACUTE CARE SERVICES AFTER THE EPISODE OF CARE.—The Secretary shall establish procedures, in the case where an applicable beneficiary requires continued post-acute care services after the last day of the episode of care, under which the original

Medicare fee-for-service program under parts A and B covers post-acute care services furnished to the applicable beneficiary in an appropriate setting (as determined using the patient assessment instrument under subsection (b)(1)).

''(4) QUALITY MEASURES.—

''(A) IN GENERAL.—The Secretary shall establish quality measures (including quality measures of process, outcome, and structure) related to care provided across all providers of services, suppliers, and entities participating in the pilot program. Quality measures established under the preceding sentence shall include measures of the following:

''(i) An episode of care.

''(ii) Functional status improvement.

''(iii) Rates of readmission.

''(iv) Rates of readmissions described in section 1861(q)(3)(B)(ii).

''(v) Rates of return to the community.

''(vi) Rates of admission to an emergency room after a hospitalization (as distinctly separate from rates described in clauses (iii) and (iv)).

''(vii) Efficiency measures.

''(viii) Measures of patient-centeredness of care.

''(ix) Measures of patient perception of care.

''(x) Measures to monitor and detect the under provision of necessary care.

''(xi) Other measures, including measures of patient outcomes, determined appropriate by the Secretary.

''(B) RISK ADJUSTMENT.—Quality measures established under subparagraph (A) shall be risk-adjusted.

''(C) REVISION OF QUALITY MEASURES.—The Secretary may revise quality measures so established (including adding new quality measures and retiring quality measures that are obsolete) as the Secretary determines appropriate with respect to applicable services and other appropriate services provided to applicable beneficiaries under the pilot program.

''(D) REPORTING ON QUALITY MEASURES.—

''(i) IN GENERAL.—A provider of services, supplier, or entity described in

clause (ii) shall submit data to the Secretary on quality measures established under subparagraph (A) during each year of the pilot program (in a form and manner, subject to clause (iii), specified by the Secretary).

''(ii) PROVIDER OF SERVICES, SUPPLIER, OR ENTITY DESCRIBED.—A provider of services, supplier, or entity described in this clause is a provider of services, supplier, or entity—

''(I) participating in the pilot program; and

''(II) who receives a bundled payment under paragraph (3)(D).

''(iii) SUBMISSION OF DATA THROUGH ELECTRONIC HEALTH RECORD.—To the extent practicable, the Secretary shall specify that data on measures be submitted under clause (i) through the use of an qualified electronic health record (as defined in section 3000(13) of the Public Health Service Act (42 U.S.C. 300jj–11(13)) in a manner specified by the Secretary.

''(d) WAIVER.—The Secretary may waive such provisions of this title and title XI as may be necessary to carry out the pilot program.

''(e) INDEPENDENT EVALUATION AND REPORTS ON PILOT PROGRAM.—

''(1) INDEPENDENT EVALUATION.—

''(A) IN GENERAL.—The Secretary shall enter into a contract with an entity for the conduct of an independent evaluation of the pilot program, including an evaluation of whether and if so, the extent to which, the performance of providers of services, suppliers, and entities composed of 2 or more providers of services or suppliers participating in the pilot program has improved with respect to—

''(i) quality measures established under subsection (c)(4)(A);

''(ii) health outcomes;

''(iii) applicable beneficiary access to care; and

''(iv) financial outcomes.

''(B) SUBMISSION OF REPORTS.—Such contract shall provide for the submission to the Secretary and Congress of the reports described in paragraph (2).

''(2) REPORTS BY ENTITY CONDUCTING INDEPENDENT EVALUATION.—

''(A) INTERIM REPORT.—Not later than 2 years after the implementation of the pilot program, the entity with a contract under paragraph (1) shall submit to the Secretary and to Congress a report on the initial results of the independent evaluation conducted under such paragraph.

''(B) FINAL REPORT.—Not later than 3 years after the implementation of the pilot program, the entity described in subparagraph (A) shall submit to the Secretary and to Congress a report on the final results of such independent evaluation.

''(C) CONTENTS OF REPORT.—Each report submitted under this paragraph shall include an evaluation of—

''(i) whether the performance of providers of services, suppliers, and entities participating in the pilot program has improved with respect to—

''(I) quality measures established under subsection (c)(4)(A);

''(II) health outcomes;

"(III) applicable beneficiary access to care; and

"(IV) financial outcomes; and

"(ii) if the evaluation under clause (i) determines such performance has improved, the extent of such improvement.

"(f) STUDY AND REPORT ON APPLICATION OF PILOT PROGRAM TO SMALL RURAL HOSPITALS.—

"(1) STUDY.—The Secretary, in consultation with representatives of small rural hospitals, including critical access hospitals, shall conduct a study to determine appropriate and effective methods for such hospitals to participate in the pilot program or in a pilot program conducted in a similar manner under this title. Such study shall include consideration of innovative methods of implementing bundled payments in hospitals described in the preceding sentence, taking into consideration any difficulties in doing so as a result of the low volume of services provided by such hospitals.

"(2) REPORT.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation

and administrative action as the Secretary determines appropriate.

''(3) DEFINITION OF SMALL RURAL HOSPITAL.—In this subsection, the term 'small rural hospital' means a hospital located in a rural area (as defined in section 1886(d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds.

''(g) IMPLEMENTATION PLAN.—

''(1) IN GENERAL.—Not later than January 1, 2016, subject to paragraph (2), the Secretary shall submit a plan for the implementation of an expansion of the pilot program by not later than January 1, 2018, to an extent determined appropriate by the Secretary, if the Secretary determines that such expansion will result in any of the following conditions being met:

''(A) The expansion of the pilot program is expected to improve the quality of patient care without increasing expenditures under this title.

''(B) The expansion of the pilot program is expected to reduce expenditures under this title without reducing the quality of patient care.''.

SEC. 3024. INDEPENDENCE AT HOME PILOT PROGRAM.

Title XVIII of the Social Security Act, as amended by section 3023, is amended by inserting after section 1866D the following new section:

''INDEPENDENCE AT HOME MEDICAL PRACTICE PILOT PROGRAM

''SEC. 1866E. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall conduct a pilot program (in this section referred to as the 'pilot program') to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expenditures and improve health outcomes in the provision of items and services under this title to applicable beneficiaries (as defined in subsection (d)).

''(2) REQUIREMENT.—The pilot program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, continuous, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

''(A) reducing preventable hospitalizations;

''(B) preventing hospital readmissions;

''(C) reducing emergency room visits;

''(D) improving health outcomes commensurate with the beneficiaries' stage of chronic illness;

''(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests;

''(F) reducing the cost of health care services covered under this title; and

''(G) achieving beneficiary and family caregiver satisfaction.

''(b) INDEPENDENCE AT HOME MEDICAL PRACTICE.—

''(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

''(A) IN GENERAL.—The term 'independence at home medical practice' means a legal entity that—

''(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home-based pri-

mary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary's chronic conditions and designed to achieve the results in subsection (a) and—

''(ii) is organized at least in part for the purpose of providing physicians' services and has the medical training or experience to fulfill the physician's role in clause (i);

''(iii) has documented experience in providing home-based primary care services to high cost chronically ill beneficiaries, as determined appropriate by the Secretary;

''(iv) has the capacity to provide services covered by this section to at least 200 applicable beneficiaries as defined in subsection (d);

''(v) has entered into an agreement with the Secretary;

''(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

''(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the pilot program.

An agreement described in clause (iv) shall require the entity to report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for providers of services and suppliers, or both) and report to the Secretary (in a form, manner, and frequency as specified by the Secretary) such data as the Secretary determines appropriate to monitor and evaluate the pilot program .

''(B) PHYSICIAN.—The term 'physician' includes, except as the Secretary may otherwise provide, any individual who—

''(i) furnishes services for which payment may be made as physicians' services; and

''(ii) has the medical training or experience to fulfill the physician's role in (1)(A)(i).

''(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team as part of an independence at home medical practice if—

''(A) all the requirements of this section are met;

''(B) the nurse practitioner or physician assistant, as the case may be, is acting consistent with State law; and

''(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role in paragraph (1)(A)(i).

''(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this subsection shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or practitioner participates in the pilot program and shares in any savings under the pilot program.

''(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the pilot program.

''(c) PAYMENT.—

''(1) SHARED SAVINGS PAYMENT METHODOLOGY.—

''(A) ESTABLISHMENT OF TARGET SPENDING LEVELS AND SHARED SAVINGS AMOUNTS.—

''(i) TARGETS.—The Secretary shall establish annual target spending levels in such a manner as to account for normal variation in expenditures for items and services covered under parts A and B for each participating independence at home medical practices based upon the size of the practice, characteristics of the enrolled individuals, and such other factors as the Secretary determines appropriate.

''(ii) DESIGNATION OF SAVINGS.—The Secretary shall designate annually the aggregate amount of savings achieved for beneficiaries enrolled in independence at home medical practices.

"(iii) APPORTIONMENT OF SAVINGS.—The Secretary shall designate how, and to what extent, savings beyond the first 5 percent are to be apportioned among participating independence at home medical practices, taking into account the number of beneficiaries served by each practice, the characteristics of the individuals enrolled in each practice, the independence at home medical practices' performance on quality performance measures, and such other factors as the Secretary determines appropriate.

"(B) MINIMUM 5 PERCENT SAVINGS TO THE MEDICARE PROGRAM.—The Secretary shall limit shared savings payments to each an independence at home medical practice under this paragraph as necessary to ensure that the aggregate expenditures for part A and B services with respect to applicable beneficiaries for such independence at home medical practice (inclusive of shared savings payments) do not exceed the amount that the Secretary estimates, less 5 percent, would be expended for such services for such beneficiaries enrolled in an independence

at home medical practice if the pilot program under this section were not implemented.

''(d) APPLICABLE BENEFICIARIES.—

''(1) DEFINITION.—In this section, the term 'applicable beneficiary' means, with respect to a qualifying independence at home medical practice, an individual who the practice has determined—

''(A) is entitled to, or enrolled for, benefits under part A and enrolled for benefits under part B;

''(B) is not enrolled in a Medicare Advantage plan under part C, a PACE program under section 1894, or an ACO under section 1899 or any other shared savings program under this title;

''(C) has 2 or more chronic illnesses, such as congestive heart failure, diabetes, other dementias designated by the Secretary, chronic obstructive pulmonary disease, ischemic heart disease, stroke, Alzheimer's Disease and neurodegenerative diseases, and other diseases and conditions designated by the Secretary which result in high costs under this title;

''(D) within the past 12 months has had a nonelective hospital admission and received

acute or subacute rehabilitation services or skilled home care services;

''(E) has 2 or more functional dependencies requiring the assistance of another person (such as bathing, dressing, toileting, walking, or feeding); and

''(F) meets such other criteria as the Secretary determines appropriate.

''(2) PATIENT ELECTION TO PARTICIPATE.—The Secretary shall determine an appropriate method of ensuring that applicable beneficiaries have agreed to enroll in an independence at home medical practice. Enrollment in the pilot program shall be voluntary.

''(3) BENEFICIARY ACCESS TO SERVICES.—Nothing in this section shall be construed as encouraging physicians or nurse practitioners to limit applicable beneficiary access to services covered under this title and applicable beneficiaries shall not be required to relinquish access to any benefit under this title as a condition of receiving services from an independence at home medical practice.

''(e) IMPLEMENTATION.—

''(1) STARTING DATE.—The pilot program shall begin not later than January 1, 2012. An agreement

with an independence at home medical practice under the pilot program may cover a 3-year period.

''(2) NO PHYSICIAN DUPLICATION IN PILOT PARTICIPATION.—The Secretary shall not pay an independence at home medical practice under this section that participates in section 1115A or section 1866D.

''(3) PREFERENCE.—In approving an independence at home medical practice, the Secretary shall give preference to practices that are—

''(A) located in high-cost areas of the country;

''(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

''(C) use electronic medical records, health information technology, and individualized plans of care.

''(4) NUMBER OF PRACTICES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall enter into agreements with as many qualified independence at home medial practices as practicable and consistent with this subsection to test the potential of the independence at home medical practice

model under this section in order to achieve the results described in subsection (a)(2) across practices serving varying numbers of applicable beneficiaries.

''(B) LIMITATION.—In selecting qualified independence at home medial practices to participate under the pilot program, the Secretary shall limit the number of applicable beneficiaries that may participate in the pilot program to 10,000.

''(5) WAIVER.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the pilot program.

''(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

''(f) EVALUATION AND MONITORING.—The Secretary shall evaluate each independence at home medical practice under the pilot program to assess whether the practice achieved the results described in subsection (a)(2).

''(g) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the pilot program and submit to Congress an interim and a final report.. Each report shall include an analysis of—

''(1) best practices under the pilot program; and

''(2) the impact of the pilot program on—

''(A) coordination of care;

''(B) expenditures under this title;

''(C) access to services; and

''(D) the quality of health care services provided to applicable beneficiaries; and

''(E) Such other areas determined appropriate by the Secretary.

''(h) EXPANSION TO PROGRAM; IMPLEMENTATION.—

''(1) TESTING AND REFINEMENT OF PAYMENT INCENTIVE AND SERVICE DELIVERY MODELS.—Subject to the evaluation described in subsection (g), the Secretary may enter into agreements under the pilot program with additional qualifying independence at home medical practices to further test and refine models with respect to qualifying independence at home medical practices.

''(2) EXPANDING USE OF SUCCESSFUL MODELS TO PROGRAM IMPLEMENTATION.—Taking into account the results of the evaluations under subsections (f) and (g), the Secretary may issue regulations to implement, on a permanent (and if appropriate, on a nationwide) basis, the independence at

home medical practice model if, and to the extent that—

"(A) such models are beneficial to the program under this title, as determined by the Secretary; and

"(B) the Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such model would result in estimated expenditures for part A and B items and services are at least 5 percent less than the expenditures that would be otherwise be made for such items and services in the absence of such expansion, as estimated by Chief Actuary.

"(i) FUNDING.—For purposes of administering and carrying out the pilot program, other than for payments for items and services furnished under this title and shared savings under subsection (c), in addition to funds otherwise appropriated, 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 $5,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years

2010 through 2015. Amounts appropriated under the preceding sentence shall remain available until expended.''.

SEC. 3025. HOSPITAL READMISSIONS REDUCTION PROGRAM.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001 and 3008, is amended by adding at the end the following new subsection:

''(q) HOSPITAL READMISSIONS REDUCTION PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital readmissions reduction program (in this subsection referred to as the 'Program') under which payments to subsection (d) hospitals are reduced under paragraph (5) for certain readmissions.

''(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

''(C) DEFINITION OF SUBSECTION (D) HOSPITAL.—For purposes of this subsection, the

term 'subsection (d) hospital' has the meaning given such term in subsection (d)(1)(B)).

''(2) SELECTION OF CONDITIONS ASSOCIATED WITH READMISSIONS.—

''(A) INITIAL SET.—Beginning during fiscal year 2012, the Secretary shall select 8 conditions that have a high volume or high rate, or both, of potentially preventable inpatient hospital readmissions, as determined by the Secretary.

''(B) EXPANSION.—For fiscal year 2016 and subsequent fiscal years, the Secretary may expand the list of conditions selected under subparagraph (A). In selecting conditions under the preceding sentence, the Secretary shall take into account whether—

''(i) the condition has a high volume or high rate, or both, of potentially preventable inpatient hospital readmissions; and

''(ii) the condition has high expenditures under this title.

''(3) DETERMINATION OF RISK-ADJUSTED NATIONAL AVERAGE AND HOSPITAL-SPECIFIC READMISSION RATES FOR EACH SELECTED CONDITION.—

"(A) IN GENERAL.—Before the beginning of the fiscal year involved under the Program, the Secretary shall calculate the following:

"(i) A national average readmission rate related to each condition selected under paragraph (2). Such rate shall be a weighted average of all diagnosis-related groups related to the condition. Such rate shall be risk-adjusted for patient severity of illness and other patient characteristics as the Secretary determines appropriate.

"(ii) A hospital-specific hospital readmission rate related to each condition selected under paragraph (2). Such rate shall be risk-adjusted in the same manner as the rate under clause (i) is risk-adjusted.

"(B) READMISSION DEFINED.—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of this subsection, the term 'readmission' means, in the case of an individual who is discharged from a subsection (d) hospital, the admission of the individual to the same or another hospital or a critical access hospital within 30 days from the date of such discharge.

"(ii) EXCLUSIONS.—The term 'readmission' does not include—

"(I) a planned readmission;

"(II) a readmission related to major or metastatic malignancies, burn care, or trauma care;

"(III) a readmission where the original admission was with a discharge status of 'left against medical advice'; and

"(IV) a transfer from another hospital.

"(4) ASSIGNMENT OF HOSPITALS.—With respect to each fiscal year the Secretary shall—

"(A) rank all subsection (d) hospitals based on the national average and hospital-specific readmission rate calculated under paragraph (3) for a period specified by the Secretary for each condition selected under paragraph (2); and

"(B) identify the quartile of such hospitals with the highest readmission rates for each such condition.

"(5) PAYMENT ADJUSTMENT.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), for discharges occurring in a fiscal year beginning on or after October 1, 2013, if an individual is readmitted (as defined in paragraph (3)(B)) and the prior discharge from the subsection (d) hospital is related to a condition selected under paragraph (2) for the fiscal year, the Secretary shall reduce the payment amount for the prior discharge under subsection (d) by an amount equal to the applicable percent (as defined in subparagraph (C)) of the payment amount for the discharge under subsection (d) (determined without regard to the application of this paragraph).

"(B) EXCEPTION.—The payment adjustment under this paragraph for a discharge in a fiscal year shall only apply to a subsection (d) hospital that is identified under paragraph (4)(B) for the fiscal year with respect to the condition that is related to such discharge.

"(C) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The payment reductions under subparagraph (A) shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such payment reductions

in making payments to a subsection (d) hospital under this section in a subsequent fiscal year.

''(D) APPLICABLE PERCENT.—In this paragraph, the term 'applicable percent' means—

''(i) in the case of a readmission that occurs within 7 days of the prior discharge, 20 percent; and

''(ii) in the case of a readmission that occurs within 15 days of the prior discharge, 10 percent.

''(6) REPORTING TO HOSPITALS.—Prior to each fiscal year under the Program (and prior to the fiscal year preceding the first fiscal year under the Program), the Secretary shall provide confidential reports to subsection (d) hospitals with respect to the national average and hospital-specific readmission rates for each condition selected under paragraph (2).

''(7) REPORTING HOSPITAL SPECIFIC INFORMATION.—

''(A) IN GENERAL.—The Secretary shall make information available to the public regarding readmission rates of each subsection (d) hospital under the Program.

"(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a subsection (d) hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

"(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

"(8) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

"(A) The determination of the payment amount for the prior discharge under subsection (d) under paragraph (5)(A).

"(B) The methodology for selecting conditions under paragraph (2), determining rates under paragraph (4), and making adjustments under paragraph (5).

"(C) The provision of reports to subsection (d) hospitals under paragraph (6) and the information made available to the public under paragraph (7).".

SEC. 3026. COMMUNITY-BASED CARE TRANSITIONS PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, such as a hospital-specific hospital readmission rate above the 75th percentile (as calculated under paragraph (3)(A)(ii) of section 1886(q) of the Social Security Act, as added by section 3025) for conditions selected under paragraph (2) of such section 1886(q).

(B) An appropriate community-based organization that is capable of providing care transition services under this section, including the ability to have arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i).

(2) HIGH-RISK MEDICARE BENEFICIARY.—The term ''high-risk Medicare beneficiary'' means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or substandard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(3) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(4) PROGRAM.—The term ''program'' means the program conducted under this section.

(5) READMISSION.—The term ''readmission'' has the meaning given such term in section

1886(q)(3)(B) of the Social Security Act, as added by section 3025.

(6) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(c) REQUIREMENTS.—

(1) DURATION.—

(A) IN GENERAL.—The program shall be conducted for a 5-year period, beginning not later than January 1, 2011.

(B) EXPANSION.—The Secretary may expand the duration and the scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services, with respect to spending under this title, certifies) that such expansion would reduce spending under this title without reducing quality.

(2) APPLICATION; PARTICIPATION.—

(A) IN GENERAL.—

(i) APPLICATION.—An eligible entity seeking to participate in the program shall submit an application to the Secretary at such time, in such manner, and containing

such information as the Secretary may require.

(ii) PARTNERSHIP.—If an eligible entity is a hospital, such hospital shall enter into a partnership with a community-based organization to participate in the program.

(B) INTERVENTION PROPOSAL.—Subject to subparagraph (C), an application submitted under subparagraph (A)(i) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(i) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary from the eligible entity.

(ii) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition.

(iii) Providing the high-risk Medicare beneficiary (and, as appropriate, the pri-

mary caregiver of the beneficiary) with assistance to ensure productive and timely interactions with post-acute and outpatient providers.

(iv) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) through the provision of self-management support and relevant information that is specific to the beneficiary's condition.

(v) Conducting comprehensive medication review and management (including, if appropriate, self-management support).

(C) LIMITATION.—A care transition intervention proposed under subparagraph (B) may not include services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395x(ee)).

(3) SELECTION.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that provide services to medically underserved populations, small communities, and rural areas.

(d) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the program.

(f) FUNDING.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) IN GENERAL.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting ''(or September 30, 2011, in the case of a demonstration project in operation as of October 1, 2008)'' after ''December 31, 2009''.

(b) FUNDING.—

(1) IN GENERAL.—Subsection (f)(1) of such section is amended by inserting ''and for fiscal year 2010, $1,600,000,'' after ''$6,000,000,''.

(2) AVAILABILITY.—Subsection (f)(2) of such section is amended by striking ''2010'' and inserting ''2014 or until expended''.

(c) REPORTS.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking ''December 1, 2008'' and inserting ''March 31, 2011''.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking ''May 1, 2010'' and inserting ''March 31, 2013''.

PART IV—STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS

SEC. 3031. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.

(a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

''(x) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

''(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

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

''(A) PRIMARY CARE PRACTITIONER.—The term 'primary care practitioner' means an individual—

''(i) who—

''(I) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

''(II) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

''(ii) for whom primary care services accounted for at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

''(B) PRIMARY CARE SERVICES.—The term 'primary care services' means services identified, as of January 1, 2009, by the following HCPCS codes (and as subsequently modified by the Secretary):

''(i) 99201 through 99215.

''(ii) 99304 through 99340.

''(iii) 99341 through 99350.

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

''(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care practitioners under this subsection.''.

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following sentence: ''Section 1833(x) shall not be taken into account in determining the amounts that would otherwise be paid pursuant to the preceding sentence.''.

(b) INCENTIVE PAYMENT PROGRAM FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

''(y) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

''(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would

otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

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

''(A) GENERAL SURGEON.—In this subsection, the term 'general surgeon' means a physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02–General Surgery as their primary specialty code in the physician's application granted by the Secretary for a supplier number for the submission of claims for reimbursement under this title.

''(B) MAJOR SURGICAL PROCEDURES.—The term 'major surgical procedures' means physicians' services which are surgical procedures for which a 10-day or 90-day global period is used for payment under the fee schedule under section 1848(b).

''(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (m) shall be determined without regard to any additional

payment for the service under subsection (m) and this subsection, respectively.

''(4) APPLICATION.—The provisions of paragraph (2) and (4) of subsection (m) shall apply to the determination of additional payments under this subsection in the same manner as such provisions apply to the determination of additional payments under subsection (m).''.

(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by subsection (a)(2), is amended by striking ''Section 1833(x)'' and inserting ''Subsections (x) and (y) of section 1833'' in the last sentence.

(c) BUDGET-NEUTRALITY ADJUSTMENT.—Section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by adding at the end the following new clause:

''(vii) ADJUSTMENT FOR CERTAIN PHYSICIAN INCENTIVE PAYMENTS.—Fifty percent of the additional expenditures under this part attributable to subsections (x) and (y) of section 1833 for a year (as estimated by the Secretary) shall be taken into account in applying clause (ii)(II) for

2011 and subsequent years. In lieu of applying the budget-neutrality adjustments required under clause (ii)(II) to relative value units to account for such costs for the year, the Secretary shall apply such budget-neutrality adjustments to the conversion factor otherwise determined for the year. For 2011 and subsequent years, the Secretary shall increase the incentive payment otherwise applicable under section 1833(m) by a percent estimated to be equal to the additional expenditures estimated under the first sentence of this clause for such year that is applicable to physicians who primarily furnish services in areas designated (under section 332(a)(1)(A) of the Public Health Service Act) as health professional shortage areas.''.

SEC. 3031A. MEDICARE FEDERALLY QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.—

(1) IN GENERAL.—Section 1861(aa)(3)(A) of the Social Security Act (42 U.S.C. 1395w (aa)(3)(A)) is amended to read as follows:

"(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and preventive services (as defined in section 1861(ddd)(3)); and".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2011.

(b) ESTABLISHMENT OF A MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—

(1) IN GENERAL.—Paragraph (3) section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended to read as follows:

"(3)(A) in the case of services described in section 1832(a)(2)(D)(i), the costs which are reasonable and related to the furnishing of such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section

1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; and

''(B) in the case of services described in section 1832(a)(2)(D)(ii) furnished by a Federally qualified health center—

''(i) subject to clauses (iii) and (iv), for services furnished on and after January 1, 2012, during the center's fiscal year that ends in 2012, an amount (calculated on a per visit basis) that is equal to 100 percent of the average of the costs of the center of furnishing such services during such center's fiscal years ending during 2010 and 2011 which are reasonable and related to the cost of furnishing such services, or which are based on such other tests of reasonableness as the Secretary prescribes in regulations including those authorized under section 1861(v)(1)(A) (except that in calculating such cost in a center's fiscal years ending during 2010 and 2011 and applying the average of such cost for a center's fiscal year ending during fiscal year 2012, the Secretary shall not apply a per visit payment limit or produc-

tivity screen), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items or services described in section 1861(s)(10)(A)) exceed 80 percent of such average of such costs;

''(ii) subject to clauses (iii) and (iv), for services furnished during the center's fiscal year ending during 2013 or a succeeding fiscal year, an amount (calculated on a per visit basis and without the application of a per visit limit or productivity screen) that is equal to the amount determined under this subparagraph for the center's preceding fiscal year (without regard to any copayment)—

''(I) increased for a center's fiscal year ending during 2013 by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) for 2013 and increased for a center's fiscal year ending during 2014 or any succeeding fiscal year by the percentage increase for such year of a market basket of Federally qualified health center costs as developed

and promulgated through regulations by the Secretary; and

"(II) adjusted to take into account any increase or decrease in the scope of services, including a change in the type, intensity, duration, or amount of services, furnished by the center during the center's fiscal year,

less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items or services described in section 1861(s)(10)(A)) exceed 80 percent of the amount determined under this clause (without regard to any copayment);

"(iii) subject to clause (iv), in the case of an entity that first qualifies as a Federally qualified health center in a center's fiscal year ending after 2011—

"(I) for the first such center's fiscal year, an amount (calculated on a per visit basis and without the application of a per visit payment limit or productivity screen) that is equal to 100 percent of the costs of furnishing such services during such cen-

ter's fiscal year based on the per visit payment rates established under clause (i) or (ii) for a comparable period for other such centers located in the same or adjacent areas with a similar caseload or, in the absence of such a center, in accordance with the regulations and methodology referred to in clause (i) or based on such other tests of reasonableness (without the application of a per visit payment limit or productivity screen) as the Secretary may specify, less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A)) exceed 80 percent of such costs; and

''(II) for each succeeding center's fiscal year, the amount calculated in accordance with clause (ii); and

''(iv) with respect to Federally qualified health center services that are furnished to an individual enrolled with a Medicare Advantage plan under part C pursuant to a written agree-

ment described in section 1853(a)(4) (or, in the case of a Medicare Advantage private fee-for-service plan, without such written agreement) the amount (if any) by which—

"(I) the amount of payment that would have otherwise been provided under clause (i), (ii), or (iii) (calculated as if '100 percent' were substituted for '80 percent' in such clauses) for such services if the individual had not been enrolled; exceeds

"(II) the amount of the payments received under such written agreement (or, in the case of Medicare Advantage private fee-for-service plans, without such written agreement) for such services (not including any financial incentives provided for in such agreement such as risk pool payments, bonuses, or withholds) less the amount the Federally qualified health center may charge as described in section 1857(e)(3)(B);".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after January 1, 2012.

SEC. 3032. DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(F)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)'';

(2) in paragraph (4)(H)(i), by striking ''paragraph (7)'' and inserting ''paragraphs (7) and (8)''; and

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

''(8) DISTRIBUTION OF ADDITIONAL RESIDENCY POSITIONS.—

''(A) REDUCTIONS IN LIMIT BASED ON UNUSED POSITIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), if a hospital's reference resident level (as defined in subparagraph (I)(i)) is less than the otherwise applicable resident limit (as defined in subparagraph (I)(iii)), effective for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit shall be reduced by 65 percent of the difference between such otherwise applica-

ble resident limit and such reference resident level.

''(ii) EXCEPTIONS.—This subparagraph shall not apply to—

''(I) a hospital located in a rural area (as defined in subsection (d)(2)(D)(ii)) with fewer than 250 acute care inpatient beds; or

''(II) a hospital that was part of a qualifying entity which had a voluntary residency reduction plan approved under paragraph (6)(B), if the hospital demonstrates to the Secretary that it has a specified plan in place for filling the unused positions by not later than 2 years after the date of enactment of this paragraph.

''(B) DISTRIBUTION.—

''(i) IN GENERAL.—The Secretary shall increase the otherwise applicable resident limit for each qualifying hospital that submits an application under this subparagraph by such number as the Secretary may approve for portions of cost reporting periods occurring on or after July 1, 2011.

The aggregate number of increases in the otherwise applicable resident limit under this subparagraph shall be equal to the aggregate reduction in such limits attributable to subparagraph (A) (as estimated by the Secretary).

''(ii) REQUIREMENTS.—Subject to clause (iii), a hospital that receives an increase in the otherwise applicable resident limit under this subparagraph shall ensure, during the 5-year period beginning on the date of such increase, that—

''(I) the number of full-time equivalent primary care residents (as determined by the Secretary) is not less than the average number of full-time equivalent primary care residents (as so determined) during the 3 most recent cost reporting periods ending prior to the date of enactment of this paragraph; and

''(II) not less than 75 percent of the positions attributable to such increase are in a primary care or gen-

eral surgery residency (as determined by the Secretary).

The Secretary may determine whether a hospital has met the requirements under this clause during such 5-year period in such manner and at such time as the Secretary determines appropriate, including at the end of such 5-year period.

''(iii) REDISTRIBUTION OF POSITIONS IF HOSPITAL NO LONGER MEETS CERTAIN REQUIREMENTS.—In the case where the Secretary determines that a hospital described in clause (ii) does not meet either of the requirements under subclause (I) or (II) of such clause, the Secretary shall—

''(I) reduce the otherwise applicable resident limit of the hospital by the amount by which such limit was increased under this paragraph; and

''(II) provide for the distribution of positions attributable to such reduction in accordance with the requirements of this paragraph.

''(C) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the

increase in the otherwise applicable resident limit is provided under subparagraph (B), the Secretary shall take into account—

''(i) the demonstration likelihood of the hospital filling the positions made available under this paragraph within the first 3 cost reporting periods beginning on or after July 1, 2011, as determined by the Secretary;

''(ii) whether the hospital is taking part in an innovative delivery model that promotes quality and care coordination; and

''(iii) whether the hospital has an accredited rural training track (as described in paragraph (4)(H)(iv)).

''(D) PRIORITY FOR CERTAIN AREAS.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subparagraph (B), subject to subparagraph (E), the Secretary shall distribute the increase to hospitals based on the following factors:

''(i) Whether the hospital is located in a State with a resident-to-population ratio

in the lowest quartile (as determined by the Secretary).

''(ii) Whether the hospital is located in a State that is among the top 10 States in terms of the ratio of—

''(I) the total population of the State living in an area designated (under such section 332(a)(1)(A)) as a health professional shortage area (as of the date of enactment of this paragraph); to

''(II) the total population of the State (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census).

''(iii) Whether the hospital is located in a rural area (as defined in subsection (d)(2)(D)(ii)).

''(E) RESERVATION OF POSITIONS FOR CERTAIN HOSPITALS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall reserve the positions available for distribution under this paragraph as follows:

"(I) 70 percent of such positions for distribution to hospitals described in clause (i) of subparagraph (D).

"(II) 30 percent of such positions for distribution to hospitals described in clause (ii) and (iii) of such subparagraph.

"(ii) EXCEPTION IF POSITIONS NOT REDISTRIBUTED WITHIN ONE YEAR.—In the case where the Secretary does not distribute positions to hospitals in accordance with clause (i) by not later than 1 year after the date of enactment of this paragraph, the Secretary shall distribute such positions to other hospitals in accordance with the considerations described in subparagraph (C) and the priority described in subparagraph (D).

"(F) LIMITATION.—A hospital may not receive more than 75 full-time equivalent additional residency positions under this paragraph.

"(G) APPLICATION OF PER RESIDENT AMOUNTS FOR PRIMARY CARE AND NONPRIMARY CARE.—With respect to additional residency positions in a hospital attributable to the

increase provided under this paragraph, the approved FTE resident amounts are deemed to be equal to the hospital per resident amounts for primary care and nonprimary care computed under paragraph (2)(D) for that hospital.

''(H) DISTRIBUTION.—The Secretary shall distribute the increase to hospitals under this paragraph not later than 3 years after the date of enactment of this paragraph.

''(I) DEFINITIONS.—In this paragraph:

''(i) REFERENCE RESIDENT LEVEL.—The term 'reference resident level' has the meaning given such term by the Secretary.

''(ii) RESIDENT LEVEL.—The term 'resident level' has the meaning given such term in paragraph (7)(C)(i).

''(iii) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) of paragraph (4) on the resident level for the hospital determined without regard to this paragraph but taking into account paragraph (7)(A).

''(J) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the implementation of this paragraph.''.

(b) IME.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, is amended—

(A) by striking ''subsection (h)(7)'' and inserting ''subsections (h)(7) and (h)(8)''; and

(B) by striking ''it applies'' and inserting ''they apply''.

(2) CONFORMING AMENDMENT.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following clause:

''(x) For discharges occurring on or after the date of enactment of this clause, insofar as an additional payment amount under this subparagraph is attributable to resident positions distributed to a hospital under subsection (h)(8)(B), the indirect teaching adjustment factor shall be computed in the same manner as provided under clause (ii) with respect to such resident positions.''.

SEC. 3033. COUNTING RESIDENT TIME IN OUTPATIENT SETTINGS AND ALLOWING FLEXIBILITY FOR JOINTLY OPERATED RESIDENCY TRAINING PROGRAMS.

(a) GME.—Section 1886(h)(4) of the Social Security Act (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (E)—

(A) by striking ''shall be counted and that all the time'' and inserting ''shall be counted and that—

''(i) effective for cost reporting periods beginning before July 1, 2010, all the time'';

(B) in clause (i), as inserted by paragraph (1), by striking the period at the end and inserting ''; and''; and

(C) by inserting after clause (i), as so inserted, the following new clause:

''(ii) effective for cost reporting periods beginning on or after July 1, 2010, all the time so spent by a resident shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs, or, in the case of a jointly operated residency train-

ing program (as defined in subparagraph (I)(i)), 1 or more hospitals or 1 or more hospitals and 1 or more eligible training sites (as defined in subparagraph(I)(1)) continue to incur the costs of the stipends and fringe benefits of the resident during the time the resident spends in that setting.''; and

(D) by adding at the end the following new subparagraph:

''(I) JOINTLY OPERATED RESIDENCY TRAINING PROGRAMS.—

''(i) DEFINITIONS.—In this subparagraph:

''(I) ELIGIBLE TRAINING SITE.—The term 'eligible training site' means an ambulatory or non-hospital training site at which the training occurs.

''(II) JOINTLY OPERATED RESIDENCY TRAINING PROGRAM.—The term 'jointly operated residency training program' means an approved medical residency training program that is jointly operated by 1 or more hospitals or by 1 or more hospitals and

1 or more eligible training sites under a written agreement which specifies a method for the equitable distribution of time spent by the resident in activities relating to patient care for purposes of determining the number of full-time equivalent residents of the hospitals or of the hospitals and the eligible training sites, as applicable.

''(ii) REQUIRED SUBMISSION OF WRITTEN AGREEMENT.—Each hospital or eligible training site participating in the operation of a jointly operated residency training program shall submit to the Secretary the written agreement described in clause (i)(II) upon request.

''(iii) LIMITATION.—The Secretary shall ensure that, in the case of a jointly operated residency training program, the aggregate direct graduate medical education payments to the hospitals or to the hospitals and eligible training sites with respect to full-time equivalent residents in such jointly operated residency training program do not exceed the aggregate direct

graduate medical education payments which would have been made to the hospitals or to the hospitals and eligible training sites if the hospitals or the hospitals and eligible training sites independently operated an approved medical residency training program for such residents.''.

(b) IME.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended—

(1) in subparagraph (B)(iv)—

(A) by striking ''(iv) Effective for discharges occurring on or after October 1, 1997'' and inserting ''(iv)(A) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010''; and

(B) by inserting after subparagraph (A), as inserted by paragraph (1), the following new subparagraph:

''(B) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs, or, in the case of a jointly operated resi-

dency training program (as defined in subparagraph (M)(i)), 1 or more hospitals or 1 or more hospitals and 1 or more eligible training sites (as defined in subparagraph (M)(i)) continue to incur the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.''; and

(C) by adding at the end the following new subparagraph:

''(M)(i) In this subparagraph:

''(I) The term 'eligible training site' means an ambulatory or non-hospital training site at which the training occurs.

''(II) The term 'jointly operated residency training program' means an approved medical residency training program that is jointly operated by 1 or more hospitals or by 1 or more hospitals and 1 or more eligible training sites under a written agreement which specifies a method for the equitable distribution of time spent by the resident in activities relating to patient care for purposes of determining the number of full-time equivalent residents of the hospitals or of the hospitals and the eligible training sites, as applicable.

''(ii) Each hospital or eligible training site participating in the operation of a jointly operated residency training program shall submit to the Secretary the written agreement described in clause (i)(II) upon request.

''(iii) The Secretary shall ensure that, in the case of a jointly operated residency training program, the aggregate indirect costs of medical education payments to the hospitals or to the hospitals and eligible training sites with respect to full-time equivalent residents in such jointly operated residency training program do not exceed the aggregate indirect costs of medical education payments which would have been made to the hospitals or to the hospitals and eligible training sites if the hospitals or the hospitals and eligible training sites independently operated an approved medical residency training program for such residents.''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical edu-

cation costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 3034. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 3033, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking ''Such rules'' and inserting ''Subject to subparagraphs (J) and (K), such rules''; and

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

''(J) TREATMENT OF CERTAIN NONHOSPITAL AND DIDACTIC ACTIVITIES.—Such rules shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonhospital setting that is primarily engaged in furnishing patient care (as defined in paragraph (5)(K)) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are

defined by the Secretary, shall be counted toward the determination of full-time equivalency.

''(K) TREATMENT OF CERTAIN OTHER ACTIVITIES.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by an intern or resident in an approved medical residency training program on vacation, sick leave, or other approved leave, as such time is defined by the Secretary, and that does not prolong the total time the resident is participating in the approved program beyond the normal duration of the program shall be counted toward the determination of full-time equivalency.''; and

(2) in paragraph (5), by adding at the end the following new subparagraph:

''(K) NONHOSPITAL SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term 'nonhospital setting that is primarily engaged in furnishing patient care' means a nonhospital setting in which the primary activity is the care and treatment of patients, as defined by the Secretary.''.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

"(x)(I) The provisions of subparagraph (K) of subsection (h)(4) shall apply under this subparagraph in the same manner as they apply under such subsection.

"(II) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, that occurs in the hospital shall be counted toward the determination of full-time equivalency if the hospital—

"(aa) is recognized as a subsection (d) hospital;

"(bb) is recognized as a subsection (d) Puerto Rico hospital;

"(cc) is reimbursed under a reimbursement system authorized under section 1814(b)(3); or

''(dd) is a provider-based hospital outpatient department.

''(III) In determining the hospital's number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities that are not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.''.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section apply to cost reporting periods determined appropriate by the Secretary.

(2) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of

the Social Security Act or for direct graduate medical education costs under section 1886(h) of such Act.

SEC. 3035. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED AND ACQUIRED HOSPITALS.

(a) GME.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. Section 1395ww(h)(4)(H)) is amended by adding at the end the following new clauses:

''(vi) REDISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSES.—

''(I) IN GENERAL.—Subject to the succeeding provisions of this clause, the Secretary shall, by regulation, establish a process under which, in the case where a hospital with an approved medical residency program closes on or after the date of enactment of the Balanced Budget Act of 1997, the Secretary shall increase the otherwise applicable resident limit under this paragraph for other hospitals in accordance with this clause.

''(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in

determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distribute the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group (as defined by the Secretary under clause (ii)) as the closed hospital):

"(aa) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.

"(bb) Second, to hospitals located in the same State as the hospital that closed.

"(cc) Third, to hospitals located in the same region of the country as the hospital that closed.

"(dd) Fourth, only if the Secretary is not able to distribute

the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

''(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under this clause within 3 years.

''(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall be equal to the number of resident positions in the approved medical residency programs that closed on or after the date described in subclause (I).

''(vii) SPECIAL RULE FOR ACQUIRED HOSPITALS.—

"(I) IN GENERAL.—In the case of a hospital that is acquired (through any mechanism) by another entity with the approval of a bankruptcy court, during a period determined by the Secretary (but not less than 3 years), the applicable resident limit of the acquired hospital shall, except as provided in subclause (II), be the applicable resident limit of the hospital that was acquired (as of the date immediately before the acquisition), so long as the acquiring entity continues to operate the hospital that was acquired and to furnish services, medical residency programs, and volume of patients similar to the services, medical residency programs, and volume of patients of the hospital that was acquired (as determined by the Secretary) during such period.

"(II) LIMITATION.—Subclause (I) shall only apply in the case where an acquiring entity waives the right as a new provider under the program

under this title to have the otherwise applicable resident limit of the acquired hospital re-established or increased.''.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)), in the second sentence, as amended by section 3032, is amended by striking ''subsections (h)(7) and (h)(8)'' and inserting ''subsections (h)(4)(H)(vi), (h)(4)(H)(vii), (h)(7), and (h)(8)''.

(c) APPLICATION.—The amendments made by this section shall not be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. Section 1395ww(h)).

(d) EFFECT ON TEMPORARY FTE CAP ADJUSTMENTS.—The Secretary of Health and Human Services shall give consideration to the effect of the amendments made by this section on any temporary adjustment to a hospital's FTE cap under section 413.79(h) of title 42,

Code of Federal Regulations (as in effect on the date of enactment of this Act) in order to ensure that there is no duplication of FTE slots. Such amendments shall not affect the application of section 1886(h)(4)(H)(v) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)(v)).

SEC. 3036. WORKFORCE ADVISORY COMMITTEE.

(a) ESTABLISHMENT.—The Secretary shall establish a Workforce Advisory Committee.

(b) MEMBERSHIP.—The Committee shall be composed of members appointed by the Secretary from among—

(1) external stakeholders and representatives of health care professionals;

(2) schools of higher education for health care professionals;

(3) public health experts;

(4) health insurers;

(5) business, labor, State or local workforce investment boards; and

(6) any other health professional organization or practice the Secretary determines appropriate.

(c) DUTIES.—

(1) NATIONAL WORKFORCE STRATEGY.—

(A) IN GENERAL.—Not later than a date determined appropriate by the Secretary, the

Committee shall develop and submit to Congress and the heads of relevant Federal agencies a national workforce strategy that will set the United States on a path toward recruiting, training, and retaining a health care workforce that meets the current and projected health care needs of the United States.

(B) CONSULTATION.—

(i) RELEVANT FEDERAL AGENCIES.—In developing the national workforce strategy under subparagraph (A), the Committee shall consult closely with the heads of relevant Federal agencies, such as the Office of the Administrator of the Health Resources and Services Administration and the Secretary of Veterans Affairs, to avoid duplication of efforts by those agencies and to review Federal health care workforce policies on a government-wide basis.

(ii) STATE AND LOCAL ENTITIES.—The Committee shall consult with State and local entities in developing such national workforce strategy.

(2) STUDY AND BIANNUAL REPORTS ON THE HEALTH CARE WORKFORCE SUPPLY.—

(A) STUDY.—The Committee shall conduct a study on the health care workforce in the United States. Such study shall include an analysis of—

(i) the current and projected health care workforce supply;

(ii) the current and projected demand for health professionals;

(iii) the capacity for education and training of the health care workforce;

(iv) the implications of current and proposed Federal laws and regulations affecting the health care workforce; and

(v) the health care workforce needs of specific populations, including minorities, rural and urban populations, and medically underserved populations.

(B) BIANNUAL REPORTS.—

(i) IN GENERAL.—The Committee shall, on a biannual basis, submit to Congress and the heads of relevant Federal agencies a report containing the results of the study conducted under subparagraph (A), together with recommendations for

such legislation and administrative action as the Committee determines appropriate.

(ii) PUBLIC AVAILABILITY.—The Committee shall make each report submitted under clause (i) available to the public.

(3) STUDIES AND REPORTS ON OTHER HIGH-PRIORITY TOPICS.—

(A) STUDY.—The Committee shall conduct studies on specific high-priority topics, including—

(i) efforts to integrate the health care workforce into a reformed health care delivery system;

(ii) the implications for the health care workforce as a result of greater utilization of health information technology;

(iii) nursing workforce capacity;

(iv) mental and behavioral health care workforce capacity; and

(v) the geographic distribution of health care providers.

(B) REPORTS.—

(i) IN GENERAL.—The Committee shall submit to Congress and the heads of

relevant Federal agencies a report containing the results of each study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Committee determines appropriate.

(ii) PUBLIC AVAILABILITY.—The Committee shall make each report submitted under clause (i) available to the public.

(d) DEFINITIONS.—In this section:

(1) COMMITTEE.—The term ''Committee'' means the Workforce Advisory Committee established under subsection (a).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SEC. 3037. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS; EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1130A, the following new section:

"SEC. 1130B. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

''(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—

''(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that are designed to provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

''(2) REQUIREMENTS.—

''(A) AID AND SUPPORTIVE SERVICES.—

''(i) IN GENERAL.—A demonstration project conducted by an eligible entity awarded a grant under this section shall, if appropriate, provide eligible individuals participating in the project with financial aid, child care, case management, and other supportive services.

''(ii) TREATMENT.—Any aid, services, or incentives provided to an eligible bene-

ficiary participating in a demonstration project under this section shall not be considered income, and shall not be taken into account for purposes of determining the individual's eligibility for, or amount of, benefits under the State TANF program, the State Medicaid plan, the State Supplemental Nutrition Assistance Program (SNAP), and any Housing and Urban Development program.

''(B) CONSULTATION AND COORDINATION.—An eligible entity awarded a grant to carry out a demonstration project under this section shall consult with the State agency responsible for administering the State TANF program in carrying out the project and, if the entity is not a local workforce investment board, also shall consult with the local workforce investment board for the area in which the project is conducted and with the State Workforce Investment Board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821).

''(C) ASSURANCE OF OPPORTUNITIES FOR INDIAN POPULATIONS.—The Secretary shall

award at least 3 grants under this subsection to an eligible entity that is an Indian tribe, tribal organization, or Tribal College or University.

''(3) REPORTS AND EVALUATION.—

''(A) ELIGIBLE ENTITIES.—An eligible entity awarded a grant to conduct a demonstration project under this subsection shall submit interim reports to the Secretary on the activities carried out under the project and a final report on such activities upon the conclusion of the entities' participation in the project. Such reports shall include assessments of the effectiveness of such activities with respect to improving outcomes for the eligible individuals participating in the project and with respect to addressing health professions workforce needs in the areas in which the project is conducted.

''(B) EVALUATION.—The Secretary shall, by grant, contract, or interagency agreement, evaluate the demonstration projects conducted under this subsection. Such evaluation shall include identification of successful activities for creating opportunities for developing and sustaining, particularly with respect to low-income individuals and other entry-level workers, a

health professions workforce that has accessible entry points, that meets high standards for education, training, certification, and professional development, and that provides increased wages and affordable benefits, including health care coverage, that are responsive to the workforce's needs.

''(C) REPORT TO CONGRESS.—The Secretary shall submit interim reports and, based on the evaluation conducted under subparagraph (B), a final report to Congress on the demonstration projects conducted under this subsection.

''(4) DEFINITIONS.—In this subsection:

''(A) ELIGIBLE ENTITY.—The term 'eligible entity' means a State, an Indian tribe or tribal organization, an institution of higher education, a local workforce investment board established under section 117 of the Workforce Investment Act of 1998 (29 U.S.C. 2832), or a community-based organization.

''(B) ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'eligible individual' means a individual receiving assistance under the State TANF program.

"(ii) OTHER LOW-INCOME INDIVIDUALS.—Such term may include other low-income individuals described by the eligible entity in its application for a grant under this section.

"(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms 'Indian tribe' and 'tribal organization' have the meaning given such terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

"(D) INSTITUTION OF HIGHER EDUCATION.—The term 'institution of higher education' has the meaning given that term in section 101 of the Higher Education Act of 1965 (20 U.S.C. 1001).

"(E) STATE.—The term 'State' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

"(F) STATE TANF PROGRAM.—The term 'State TANF program' means the temporary assistance for needy families program funded under part A of title IV.

''(G) TRIBAL COLLEGE OR UNIVERSITY.—The term 'Tribal College or University' has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1059c(b)).

''(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

''(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this Act, the Secretary shall award grants to eligible entities that are States to conduct demonstration projects for purposes of developing core training competencies and certification programs for personal or home care aides. The Secretary shall—

''(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

''(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the

number of hours of training required under any applicable State or Federal law or regulation.

''(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

''(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

''(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include competencies with respect to the following areas:

''(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

''(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

''(iii) Communication, cultural and linguistic competence and sensitivity, prob-

lem solving, behavior management, and relationship skills.

"(iv) Personal care skills.

"(v) Health care support.

"(vi) Nutritional support.

"(vii) Infection control.

"(viii) Safety and emergency training.

"(ix) Training specific to an individual consumer's needs (including older individuals, younger individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

"(x) Self-Care.

"(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

"(i) The length of the training.

"(ii) The appropriate trainer to student ratio.

"(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

"(iv) Trainer qualifications.

''(v) Content for a 'hands-on' and written certification exam.

''(vi) Continuing education requirements.

''(4) APPLICATION AND SELECTION CRITERIA.—

''(A) IN GENERAL.—

''(i) NUMBER OF STATES.—The Secretary shall enter into agreements with not more than 6 States to conduct demonstration projects under this subsection.

''(ii) REQUIREMENTS FOR STATES.—An agreement entered into under clause (i) shall require that a participating State—

''(I) implement the core training competencies described in paragraph (3)(A); and

''(II) develop written materials and protocols for such core training competencies, including the development of a certification test for personal or home care aides who have completed such training competencies.

''(iii) CONSULTATION AND COLLABORATION WITH COMMUNITY AND VOCA-

TIONAL COLLEGES.—The Secretary shall encourage participating States to consult with community and vocational colleges regarding the development of curricula to implement the project with respect to activities, as applicable, which may include consideration of such colleges as partners in such implementation.

''(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

''(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

''(ii) meet the selection criteria established under subparagraph (C); and

''(iii) meet such additional criteria as the Secretary may specify.

''(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved)—

''(i) geographic and demographic diversity;

"(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

"(iii) that the existing training standards for personal or home care aides in each participating State—

"(I) are different from such standards in the other participating States; and

"(II) are different from the core training competencies described in paragraph (3)(A);

"(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

"(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

"(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

"(5) EVALUATION AND REPORT.—

"(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

"(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

"(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

"(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so,

what minimum number of hours should be required.

''(B) REPORTS.—

''(i) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to such activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(ii) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

''(6) DEFINITIONS.—In this subsection:

"(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term 'eligible health and long-term care provider' means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(o)), or any other health care provider the Secretary determines appropriate which—

"(i) is licensed or authorized to provide services in a participating State; and

"(ii) receives payment for services under title XIX.

"(B) PERSONAL CARE SERVICES.—The term 'personal care services' has the meaning given such term for purposes of title XIX.

"(C) PERSONAL OR HOME CARE AIDE.—The term 'personal or home care aide' means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer's disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by

providing routine personal care services and other appropriate services to the individual.

''(D) STATE.—The term 'State' has the meaning given that term for purposes of title XIX.

''(c) FUNDING.—

''(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b), $85,000,000 for each of fiscal years 2010 through 2014.

''(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such projects. No funds appropriated under paragraph (1) shall be used to carry out demonstration projects under subsection (b) after fiscal year 2012.''.

(b) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—Section 501(c)(1)(A)(iii) of the Social Security Act (42 U.S.C. 701(c)(1)(A)(iii)) is amended by striking ''fiscal year 2009'' and inserting ''each of fiscal years 2009 through 2012''.

SEC. 3038. INCREASING TEACHING CAPACITY.

(a) TEACHING HEALTH CENTERS TRAINING AND ENHANCEMENT.—Part C of title VII of the Public Health Service Act (42 U.S.C. 293k et. seq.) is amended by inserting after section 748 the following:

"SEC. 749. TEACHING HEALTH CENTERS DEVELOPMENT GRANTS.

''(a) PROGRAM AUTHORIZED.—The Secretary may award grants under this section to teaching health centers for the purpose of establishing newly accredited or expanded primary care residency programs.

''(b) AMOUNT AND DURATION.—Grants awarded under this section shall be for a term of not more than 2 years and the maximum award may not be more than $500,000.

''(c) USE OF FUNDS.—Amounts provided under a grant under this section shall be used to cover the costs of—

''(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

''(A) curriculum development;

''(B) recruitment, training and retention of residents and faculty:

''(C) accreditation by the Accreditation Council for Graduate Medical Education

(ACGME) or the American Osteopathic Association (AOA); and

"(D) faculty salaries during the development phase; and

"(2) technical assistance provided by an eligible entity, including costs associated with—

"(A) materials development;

"(B) staff salaries;

"(C) travel; and

"(D) administrative costs.

"(d) APPLICATION.—A teaching health center seeking a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

"(e) PRIORITY.—In selecting recipients for grants under this section, the Secretary shall give priority to funding residency training programs in Federally qualified health centers, rural health centers, Indian health centers, newly established residency programs, and integrated rural training tracks and rural training tracks and residencies with a mission to train physicians for rural and underserved practice.

"(f) FURTHER PRIORITY FOR CERTAIN APPLICATIONS.—With respect to applications for grants under this section that are receiving priority under subsection (e), the

Secretary shall give further preference to any such application that documents an existing affiliation agreement with an area health education center program as defined in sections 751 and 799B.

''(g) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education center program as defined in sections 751 and 799B.

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' means an approved medical residency program under section 1886(h)(5)(A) of the Social Security Act in family medicine, general pediatrics, general internal medicine, or obstetrics and gynecology.

''(3) TEACHING HEALTH CENTER.—The term 'teaching health center'—

''(A) means a facility which—

''(i) is a community-based, ambulatory patient care center; and

''(ii) is establishing a new or expanding an existing primary care residency program under section 1886(h)(5)(A) of the

Social Security Act in a specialty which the Secretary determines is in high-need;

''(B) includes Federally qualified health centers, community health centers, health care for the homeless centers, rural health centers, migrant health centers, Native American health centers operated by the Indian Health Service, Indian tribes and tribal organizations, and other not-for-profit community-based clinical entities.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.''.

(b) NATIONAL HEALTH SERVICE CORPS TEACHING CAPACITY.—Section 338C(a) of the Public Health Service Act (42 U.S.C. 254m(a)) is amended to read as follows:

''(a) SERVICE IN FULL-TIME CLINICAL PRACTICE.—Except as provided in section 338D, each individual who has entered into a written contract with the Secretary under section 338A or 338B shall provide service in the full-time clinical practice of such individual's profession as

a member of the Corps for the period of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.''.

(c) PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by sections 3023 and 3024, is amended by inserting after section 1866E the following new section:

''PAYMENTS TO QUALIFIED TEACHING HEALTH CENTERS FOR DIRECT GRADUATE MEDICAL EDUCATION EXPENSES AND OTHER INDIRECT EXPENSES ASSOCIATED WITH OPERATING APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAMS

''SEC. 1866F. (a) IN GENERAL.—The Secretary shall, for purposes of increasing training and improving access to primary care services, make payments to qualified teaching health centers for direct graduate medical education costs and other indirect costs associated with operating approved graduate medical residency training programs.

''(b) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAMS.—An approved medical residency training program operated by a qualified teaching health

center shall meet criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association).

''(c) DETERMINATION OF PAYMENT AND FUNDING CALCULATIONS.—The Secretary shall determine the basis of payment and any funding calculations necessary with respect to payments for direct graduate medical education expenses and other indirect expenses associated with operating approved graduate medical residency training programs.

''(d) CLARIFICATION REGARDING RELATIONSHIP TO OTHER PAYMENTS FOR GRADUATE MEDICAL EDUCATION.—Payments under this section—

''(1) shall be in addition to any payments—

''(A) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(B) for direct graduate medical education costs under section 1886(h); and

''(2) shall not be taken into account in applying the limitation on the number of total full time equivalent residents under section 1886(h)(4)(F) and clauses (v) and (vi)(I) of section 1886(d)(5)(B).

''(e) REGULATIONS.—The Secretary shall promulgate regulations to carry out this section.

''(f) FUNDING.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817, of $230,000,000,000, for payments under this section for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

''(g) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved medical residency training program' has the meaning given such term in section 1886(h)(5)(A).

''(2) PRIMARY CARE RESIDENCY PROGRAM.—The term 'primary care residency program' means an approved medical residency training program in family medicine, internal medicine, pediatrics, medicine-pediatrics, obstetrics and gynecology, psychiatry, and geriatrics.

''(3) QUALIFIED TEACHING HEALTH CENTER.—

''(A) IN GENERAL.—The term 'qualified teaching health center' means an entity that—

''(i) is a community based, ambulatory patient care center; and

''(ii) operates a primary care residency program.

''(B) INCLUSION OF CERTAIN ENTITIES.—Such term includes the following:

''(i) A Federally qualified health center (as defined in section 1861(aa)(4)).

''(ii) A community mental health center (as defined in section 1861(ff)(3)(B)).

''(iii) A community health center.

''(iv) A health care for the homeless center.

''(v) A rural health center.

''(vi) A migrant health center.

''(vii) A health center operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act).

''(viii) An entity receiving funds under title X of the Public Health Service Act.''.

SEC. 3039. GRADUATE NURSE EDUCATION DEMONSTRATION PROGRAM.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—The Secretary shall establish a graduate nurse education demonstration program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which eligible hos-

pitals are reimbursed for costs described in paragraph (2).

(2) COSTS DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B), the costs described in this paragraph are educational costs, clinical instruction costs, and other direct and indirect costs of the eligible hospital which are attributable to providing advanced practice nurses with qualified training.

(B) LIMITATION.—With respect to a year, the amount reimbursed under the program may not exceed the amount of costs described in subparagraph (A) that are attributable to an increase in the number of advanced practice nurses enrolled in a program that provides qualified training during the year, as compared to the average number of advanced practice nurses who graduated from a program that provides qualified training in each year during the period beginning on January 1, 2006 and ending on December 31, 2010 (as determined by the Secretary).

(b) DEFINITIONS.—In this section:

(1) ADVANCED PRACTICE NURSE.—The term ''advanced practice nurse'' includes the following:

(A) A clinical nurse specialist (as defined in subsection (aa)(5) of section 1861 of the Social Security Act (42 U.S.C. 1395x)).

(B) A nurse practitioner (as defined in such subsection).

(C) A certified registered nurse anesthetist (as defined in subsection (bb)(2) of such section).

(D) A certified nurse midwife.

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term ''applicable non-hospital community-based care setting'' means a non-hospital community-based care setting which has entered into an agreement with the eligible hospital under which the non-hospital community-based care setting is responsible for its share of costs described in subsection (a).

(3) APPLICABLE SCHOOL OF NURSING.—The term ''applicable school of nursing'' means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into an agreement with the eligible hospital under

which the school of nursing is responsible for its share of costs described in subsection (a).

(4) ELIGIBLE HOSPITAL.—The term ''eligible hospital'' means a subsection (d) hospital (as defined in section 1861(d)(1)(B) of the Social Security Act (42 U.S.C. 1395x(d)(1)(B))) that—

(A) is affiliated with 1 or more applicable schools of nursing; and

(B) is partnered with 2 or more applicable non-hospital community-based care settings.

(5) PROGRAM.—The term ''program'' means the graduate nurse education demonstration program established under subsection (a).

(6) QUALIFIED TRAINING.—

(A) IN GENERAL.—The term ''qualified training'' means training—

(i) that provides an advanced practice nurse with the skills necessary to provide primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title; and

(ii) subject to subparagraph (B), at least half of which is provided in a non-hospital community-based care setting.

(B) WAIVER OF REQUIREMENT HALF OF TRAINING BE PROVIDED IN NON-HOSPITAL COMMUNITY-BASED CARE SETTING IN CERTAIN AREAS.—The Secretary may waive the requirement under subparagraph (A)(ii) with respect to eligible hospitals located in rural and medically underserved areas.

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(c) FUNDING.—There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section. Such amounts shall remain available without fiscal year limitation.

PART V—HEALTH INFORMATION TECHNOLOGY

SEC. 3041. FREE CLINICS AND CERTIFIED EHR TECHNOLOGY.

(a) MEDICARE.—

(1) PAYMENT INCENTIVE.—Section 1848(o)(5) of the Social Security Act (42 U.S.C. 1395w–4(o)(5)) is amended—

(A) in subparagraph (C), by striking ''PROFESSIONAL.—The term'' and inserting ''PROFESSIONAL.—

''(i) IN GENERAL.—The term''; and

(i) by adding at the end the following new clause:

''(ii) CLARIFICATION.—Nothing in this subsection shall prevent a physician from being considered an eligible professional for purposes of this subsection as a result of the physician furnishing items and services in a free clinic.''; and

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

''(D) FREE CLINIC.—

''(i) IN GENERAL.—The term 'free clinic' means a safety-net health care organization that—

''(I) uses volunteers to provide a range of medical, dental, pharmacy, or behavioral health services to economically disadvantaged individuals, the majority of whom are uninsured or underinsured; and

''(II) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code or operates as a program or affiliate of an organization so described and exempt.

''(ii) INCLUSION OF CERTAIN OTHER ORGANIZATIONS.—An organization that otherwise meets the definition under clause (i), except that it charges a nominal fee to patients, may still be considered a free clinic for purposes of subparagraph (C)(ii) if the organization provides essential services regardless of the patient's ability to pay for such essential services.''.

(2) PAYMENT ADJUSTMENT.—Section 1848(a)(7)(E)(iii) of the Social Security Act (42 U.S.C. 1395w–4(a)(7)(E)(iii)) is amended—

(A) by striking ''PROFESSIONAL.—The term'' and inserting ''PROFESSIONAL.—The term

''(I) IN GENERAL.—The term''; and

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

"(II) CLARIFICATION.—Nothing in this paragraph shall prevent a physician from being considered an eligible professional for purposes of this paragraph as a result of the physician furnishing items and services in a free clinic (as defined in subsection (o)(5)(D)).".

(b) MEDICAID.—Section 1903(t)(3)(B) of the Social Security Act (42 U.S.C. 1396b(t)(3)(B)) is amended by adding at the end the following flush sentence:

"Nothing in this subsection or subsection (a)(3)(F) shall prevent a Medicaid provider described in clauses (i) through (v) from being considered an eligible professional for purposes of this subsection or subsection (a)(3)(F) as a result of the Medicaid provider furnishing items and services in a free clinic (as defined in section 1848(o)(5)(D)).".

Subtitle B—Improving Medicare for Patients and Providers

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

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(10) UPDATE FOR 2010.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B), (8)(B), and (9)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2010, the update to the single conversion factor shall be 0.5 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.''.

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) EXTENSION OF WORK GPCI FLOOR.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''before January 1, 2010'' and inserting ''before January 1, 2013''.

(b) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''and (G)'' and inserting ''(G), and (H)''; and

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

''(H) PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT FOR 2010 AND SUBSEQUENT YEARS.—

''(i) FOR 2010.—Subject to clause (iii), for services furnished during 2010, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ¾ of the difference between the relative costs of employee wages and rents in each of the dif-

ferent fee schedule areas and the national average of such employee wages and rents.

''(ii) FOR 2011.—Subject to clause (iii), for services furnished during 2011, the employee wage and rent portions of the practice expense geographic index described in subparagraph (A)(i) shall reflect ½ of the difference between the relative costs of employee wages and rents in each of the different fee schedule areas and the national average of such employee wages and rents.

''(iii) HOLD HARMLESS.—The practice expense portion of the geographic adjustment factor applied in a fee schedule area for services furnished in 2010 or 2011 shall not, as a result of the application of clause (i) or (ii), be reduced below the practice expense portion of the geographic adjustment factor under subparagraph (A)(i) (as calculated prior to the application of such clause (i) or (ii), respectively) for such area for such year.

''(iv) ANALYSIS.—The Secretary shall analyze current methods of establishing

practice expense geographic adjustments under subparagraph (A)(i) and evaluate data that fairly and reliably establishes distinctions in the costs of operating a medical practice in the different fee schedule areas. Such analysis shall include an evaluation of the following:

''(I) The feasibility of using actual data or reliable survey data developed by medical organizations on the costs of operating a medical practice, including office rents and non-physician staff wages, in different fee schedule areas.

''(II) The office expense portion of the practice expense geographic adjustment described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

''(III) The weights assigned to each of the categories within the practice expense geographic adjustment described in subparagraph (A)(i).

''(v) REVISION FOR 2012 AND SUBSEQUENT YEARS.—As a result of the analysis described in clause (iv), the Secretary shall, not later than January 1, 2012, make appropriate adjustments to the practice expense geographic adjustment described in subparagraph (A)(i) to ensure accurate geographic adjustments across fee schedule areas, including—

''(I) basing the office rents component and its weight on office expenses that vary among fee schedule areas; and

''(II) considering a representative range of professional and non-professional personnel employed in a medical office based on the use of the American Community Survey data or other reliable data for wage adjustments.

Such adjustments shall be made without regard to adjustments made pursuant to clauses (i) and (ii) and shall be made in a budget neutral manner.

''(vi) SPECIAL RULE.—If the Secretary does not complete the analysis described in clause (iv) and make any adjustments the Secretary determines appropriate for 2012 or a subsequent year under clause (v), the Secretary shall apply clauses (ii) and (iii) for services furnished during 2012 or a subsequent year in the same manner as such clauses apply for services furnished during 2011.''.

SEC. 3103. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 3104. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C.

1395w–4 note), section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), and section 136 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''and 2009'' and inserting ''2009, 2010, and 2011''.

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) GROUND AMBULANCE.—Section 1834(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''; and

(2) in each of clauses (i) and (ii), by striking ''before January 1, 2010'' and inserting ''before January 1, 2012''.

(b) AIR AMBULANCE.—Section 146(b)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''ending on December 31, 2009'' and inserting ''ending on December 31, 2011''.

(c) SUPER RURAL AMBULANCE.—Section 1834(l)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking ''2010'' and inserting ''2012''.

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITAL SERVICES AND OF MORATORIUM ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) EXTENSION OF CERTAIN PAYMENT RULES.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note) is amended by striking ''3-year period'' each place it appears and inserting ''5-year period''.

(b) EXTENSION OF MORATORIUM.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking ''3-year period'' and inserting ''5-year period''.

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE MENTAL HEALTH ADD-ON.

Section 138(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2009'' and inserting ''December 31, 2011''.

SEC. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES AND TO PROVIDE FOR RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) ORDERING POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) IN GENERAL.—Section 1814(a)(2) of the Social Security Act (42 U.S.C. 1395f(a)(2)), in the matter preceding subparagraph (A), is amended by striking ''nurse practitioner or clinical nurse specialist'' and inserting ''nurse practitioner, a clinical nurse specialist, or a physician assistant (as those terms are defined in section 1861(aa)(5))''.

(2) CONFORMING AMENDMENT.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended, in the second sentence, by striking ''or clinical nurse specialist'' and inserting ''clinical nurse specialist, or physician assistant''.

(b) RECOGNITION OF ATTENDING PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.—

(1) IN GENERAL.—Section 1861(dd)(3)(B) of the Social Security Act (42 U.S.C. 1395x(dd)(3)(B)) is amended—

(A) by striking ''or nurse'' and inserting '', the nurse''; and

(B) by inserting '', or the physician assistant (as defined in such subsection)'' after ''subsection (aa)(5))''.

(2) CLARIFICATION OF HOSPICE ROLE OF PHYSICIAN ASSISTANTS.—Section 1814(a)(7)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting ''or a physician assistant'' after ''a nurse practitioner''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. RECOGNITION OF CERTIFIED DIABETES EDUCATORS AS CERTIFIED PROVIDERS FOR PURPOSES OF MEDICARE DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.

(a) IN GENERAL.—Section 1861(qq) of the Social Security Act (42 U.S.C. 1395x(qq)) is amended—

(1) in paragraph (1), by inserting ''or by a certified diabetes educator (as defined in paragraph (3))'' after ''paragraph (2)(B)''; and

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

''(3) For purposes of paragraph (1), the term 'certified diabetes educator' means an individual who—

''(A) is licensed or registered by the State in which the services are performed as a health care professional;

''(B) specializes in teaching individuals with diabetes to develop the necessary skills and knowledge to manage the individual's diabetic condition; and

''(C) is certified as a diabetes educator by a recognized certifying body (as defined in paragraph (4)).

''(4)(A) For purposes of paragraph (3)(C), the term 'recognized certifying body' means—

''(i) the National Certification Board for Diabetes Educators, or

''(ii) a certifying body for diabetes educators, which is recognized by the Secretary as authorized to grant certification of diabetes educators for purposes of this subsection pursuant to standards established by the Secretary,

if the Secretary determines such Board or body, respectively, meets the requirement of subparagraph (B).

''(B) The National Certification Board for Diabetes Educators or a certifying body for diabetes educators meets the requirement of this subparagraph, with respect to the certification of an individual, if the Board or body, respectively, is incorporated and registered to do business in the United States and requires as a condition of such certification each of the following:

''(i) The individual has a qualifying credential in a specified health care profession.

''(ii) The individual has professional practice experience in diabetes self-management training that includes a minimum number of hours and years of experience in such training.

''(iii) The individual has successfully completed a national certification examination offered by such entity.

''(iv) The individual periodically renews certification status following initial certification.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to diabetes outpatient self-management training services furnished on or after January 1, 2011.

SEC. 3110. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) IN GENERAL.—Section 1834(a)(20) of the Social Security Act (42 U.S.C. 1395m(a)(20)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 100–275), is amended—

(1) in subparagraph (F)(i), by inserting ''and subparagraph (G)'' after ''clause (ii)''; and

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

''(G) APPLICATION OF ACCREDITATION REQUIREMENT TO CERTAIN PHARMACIES.—

''(i) IN GENERAL.—In implementing quality standards under this paragraph—

''(I) subject to subclause (II), in applying such standards and the accreditation requirement of subpara-

graph (F)(i) with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirement shall not apply to such pharmacies; and

''(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the Secretary determines such alternative accreditation requirement is more appropriate for such pharmacies.

''(ii) PHARMACIES DESCRIBED.—A pharmacy described in this clause is a pharmacy that meets each of the following criteria:

''(I) The total billings by the pharmacy for such items and services under this title are less than 5 percent of total pharmacy sales, as determined based on the average total pharmacy sales for the previous 3 calendar years, 3 fiscal years, or other yearly period specified by the Secretary.

''(II) The pharmacy has been enrolled under section 1866(j) as a supplier of durable medical equipment, prosthetics, orthotics, and supplies, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 424.57(a) of title 42, Code of Federal Regulations) has not been imposed in the past 5 years.

''(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subclauses (I) and (II). Such attestation shall be subject to section 1001 of title 18, United States Code.

''(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the

criteria described in subclauses (I) and (II). Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy during the relevant periods, as requested by the Secretary.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to items or services furnished on or after January 1, 2010.

(2) ADMINISTRATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

SEC. 3111. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) IN GENERAL.—

(1) IN GENERAL.—Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(l)(1) In the case of any individual who is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code) at the time the individual is entitled

to part A under section 226(b) or section 226A and who is eligible to enroll but who has elected not to enroll (or to be deemed enrolled) during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period described in this paragraph, with respect to an individual, is the 12-month period beginning on the day after the last day of the initial enrollment period of the individual or, if later, the 12-month period beginning with the month the individual is notified of enrollment under this section.

''(3) In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under this part shall begin on the first day of the month in which the individual enrolls, or, at the option of the individual, the first month after the end of the individual's initial enrollment period.

''(4) An individual may only enroll during the special enrollment period provided under paragraph (1) one time during the individual's lifetime.

''(5) The Secretary shall ensure that the materials relating to coverage under this part that are provided to an individual described in paragraph (1) prior to the individual's initial enrollment period contain information concerning the impact of not enrolling under this part, includ-

ing the impact on health care benefits under the TRICARE program under chapter 55 of title 10, United States Code.

''(6) The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to provide for the accurate identification of individuals described in paragraph (1). The Secretary of Defense shall provide such individuals with notification with respect to this subsection. The Secretary of Defense shall collaborate with the Secretary of Health and Human Services and the Commissioner of Social Security to ensure appropriate follow up pursuant to any notification provided under the preceding sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to elections made with respect to initial enrollment periods that end after the date of the enactment of this Act.

(b) WAIVER OF INCREASE OF PREMIUM.—Section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)) is amended by striking ''section 1837(i)(4)'' and inserting ''subsection (i)(4) or (l) of section 1837''.

SEC. 3112. PAYMENT FOR BONE DENSITY TESTS.

(a) PAYMENT.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(A) in subsection (b)—

(i) in paragraph (4)(B), by inserting ", and for 2010 and 2011, dual-energy x-ray absorptiometry services (as described in paragraph (6))" before the period at the end; and

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

"(6) TREATMENT OF BONE MASS SCANS.—For dual-energy x-ray absorptiometry services (identified in 2006 by HCPCS codes 76075 and 76077 (and any succeeding codes)) furnished during 2010 and 2011, instead of the payment amount that would otherwise be determined under this section for such years, the payment amount shall be equal to 70 percent of the product of—

"(A) the relative value for the service (as determined in subsection (c)(2)) for 2006;

"(B) the conversion factor (established under subsection (d)) for 2006; and

"(C) the geographic adjustment factor (established under subsection (e)(2)) for the serv-

ice for the fee schedule area for 2010 and 2011, respectively.''; and

(B) in subsection (c)(2)(B)(iv)—

(i) in subclause (II), by striking ''and'' at the end;

(ii) in subclause (III), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(IV) subsection (b)(6) shall not be taken into account in applying clause (ii)(II) for 2010 or 2011.''.

(2) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by paragraph (1) by program instruction or otherwise.

(b) STUDY AND REPORT BY THE INSTITUTE OF MEDICINE.—

(1) IN GENERAL.—The Secretary of Health and Human Services is authorized to enter into an agreement with the Institute of Medicine of the National Academies to conduct a study on the ramifications of Medicare payment reductions for dual-energy x-ray absorptiometry (as described in section

1848(b)(6) of the Social Security Act, as added by subsection (a)(1)) during 2007, 2008, and 2009 on beneficiary access to bone mass density tests.

(2) REPORT.—An agreement entered into under paragraph (1) shall provide for the Institute of Medicine to submit to the Secretary and to Congress a report containing the results of the study conducted under such paragraph.

SEC. 3113. REVISION TO THE MEDICARE IMPROVEMENT FUND.

Section 1898(b)(1)(A) of the Social Security Act (42 U.S.C. 1395iii) is amended by striking ''$22,290,000,000'' and inserting ''$0''.

SEC. 3114. TREATMENT OF CERTAIN COMPLEX DIAGNOSTIC LABORATORY TESTS.

(a) TREATMENT.—

(1) IN GENERAL.—Notwithstanding sections 1862(a)(14) and 1866(a)(1)(H)(i) of the Social Security Act (42 U.S.C. 1395y(a)(14) and 1395cc(a)(1)(H)(i)), in the case that a laboratory performs a covered complex diagnostic laboratory test, with respect to a specimen collected from an individual during a period in which the individual is a patient of a hospital, if the test is performed after such period the Secretary of Health and Human

Services shall treat such test, for purposes of providing direct payment to the laboratory under section 1833(h) or 1848 of such Act (42 U.S.C. 1395l(h) or 1395w–4), as if such specimen had been collected directly by the laboratory.

(2) COVERED COMPLEX DIAGNOSTIC LABORATORY TEST DEFINED.—For purposes of paragraph (1), the term ''covered complex diagnostic laboratory test'' means a diagnostic laboratory test that—

(A) is an analysis of gene or protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay;

(B) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3));

(C) is performed only by the laboratory offering the test; and

(D) is not furnished by the hospital where the specimen was collected to a patient of such hospital, directly or under arrangements (as defined in section 1861(w)(1) of such Act (42 U.S.C. 1395x(w)(1))) made by such hospital.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The provisions of subsection (a) shall apply to tests furnished on or after July 1, 2011, and before the earlier of—

(A) July 1, 2013; and

(B) the date that the Chief Actuary of the Centers for Medicare & Medicaid Services submits a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate and to the Secretary of Health and Human Services pursuant to paragraph (2).

(2) REPORT IF SPENDING LIMIT REACHED.—

(A) IN GENERAL.—The Chief Actuary of the Centers for Medicare & Medicaid Services shall monitor expenditures under title XVIII of the Social Security Act during the 2-year period beginning on July 1, 2011 by reason of the provisions of subsection (a). If the Chief Actuary determines that either of the conditions described in subparagraph (B) have been met with respect to such 2-year period, the Chief Actuary shall submit a report to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Represent-

atives and the Committee on Finance of the Senate and to the Secretary of Health and Human Services that includes a statement regarding such determination.

(B) CONDITIONS.—The conditions described in this subparagraph are, with respect to the 2-year period described in subparagraph (A), the following conditions:

(i) That expenditures under title XVIII of the Social Security Act during such period by reason of the provisions of subsection (a) have reached $100,000,000.

(ii) That payments to laboratories under such title during such period by reason of such provisions have reached $100,000,000.

SEC. 3115. IMPROVED ACCESS FOR CERTIFIED-MIDWIFE SERVICES.

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting ''(or 100 percent for services furnished on or after January 1, 2011)'' after ''1992, 65 percent''.

SEC. 3116. WORKING GROUP ON ACCESS TO EMERGENCY MEDICAL CARE.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish a Working Group on Access to Emergency Medical Care (referred to in this section as the ''working group'').

(b) MEMBERSHIP.—The membership of the working group shall include not less than 2 individuals from each of the following:

(1) Representatives of emergency room physicians, emergency room nurses, and other health care professionals who provide emergency medical services.

(2) Elected or appointed officials (at the Federal, State, and local levels) who are involved in programs and issues relating to the provision of emergency medical services.

(3) Health care consumer advocates.

(4) Representatives of hospitals and health systems that provide emergency medical services.

(c) COMPENSATION.—The members shall serve without compensation.

(d) ADMINISTRATIVE SUPPORT.—The Department of Health and Human Services shall provide appropriate ad-

ministrative support and technical assistance to the working group. The working group may use the facilities of the Department of Health and Human Services, with or without reimbursement (as determined by the Secretary).

(e) DUTIES.—

(1) STUDY.—The working group shall identify and examine—

(A) barriers contributing to delays in timely processing of patients requiring admission as an inpatient of a hospital who initially sought care through the emergency department of such hospital;

(B) factors in the health care delivery, financing, and legal systems that impede or prevent effective delivery of screening and stabilization services furnished in hospitals that have emergency departments pursuant to the requirements under section 1867 of the Social Security Act (42 U.S.C. 1395dd) (commonly referred to as the ''Emergency Medical Treatment and Labor Act'' or ''EMTALA''); and

(C) best practices to improve patient flow within hospitals.

(2) RECOMMENDATIONS.—The working group shall develop recommendations for admission, board-

ing, and diversion standards for hospitals to follow in the delivery of emergency care to patients, as well as relevant guidelines, measures, and incentives to ensure proper implementation, monitoring, and enforcement of such standards.

(f) REPORT.—Not later than 18 months after establishment of the working group under subsection (a), the working group shall submit to Congress and the Secretary a report containing a detailed description of the recommended standards, guidelines, measures, and incentives developed under subsection (e)(2), any best practices identified under subsection (e)(1)(C), and recommendations for such legislative and administrative actions as the working group considers appropriate, including recommendations regarding—

(1) Federal programs, policies, and financing needed to assure the availability of screening and stabilization services furnished in hospitals that have emergency departments pursuant to EMTALA (as described under subsection (e)(1)(B)); and

(2) coordination of Federal, State, and local programs for responding to disasters and emergencies.

(g) TERMINATION.—The working group shall terminate upon submission of the report described under subsection (f).

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking ''2010''and inserting ''2012''; and

(B) in the second sentence, by striking ''or 2009'' and inserting '', 2009, 2010, or 2011''; and

(2) in subclause (III), by striking ''January 1, 2010'' and inserting ''January 1, 2012''.

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HOLD HARMLESS.—Section 1833(t)(7)(D)(i)(III) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)(III)) is amended by adding at the end the following new sentence: ''In the case of covered OPD services furnished on or after January 1, 2010, and before January 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.''.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l–4), as amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting ''or during the 2-year period beginning on July 1, 2010'' before the period at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) TWO-YEAR EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

''(g) TWO-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 2-year period (in this section re-

ferred to as the '2-year extension period') that begins on the date immediately following the last day of the initial 5-year period under subsection (a)(5).

''(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 2-year extension period, the program shall be conducted in rural areas in any State.

''(3) INCREASE IN MAXIMUM NUMBER OF HOSPITALS PARTICIPATING IN THE DEMONSTRATION PROGRAM.—Notwithstanding subsection (a)(4), during the 2-year extension period, not more than 30 rural community hospitals may participate in the demonstration program under this section.

''(4) NO AFFECT ON 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 shall provide for the continued participation of such rural community hospital in the demonstration program during the 2-year extension period unless the rural community hospital makes an election, in such form and manner as the Secretary may specify, to discontinue such participation.''.

(b) CONFORMING AMENDMENTS.—Subsection (a)(5) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by inserting ''(in this section referred to as the 'initial 5-year period') and, as provided in subsection (g), for the 2-year extension period'' after ''5-year period''.

(c) TECHNICAL AMENDMENTS.—

(1) Subsection (b) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in paragraph (1)(B)(ii), by striking ''2)'' and inserting ''2))''; and

(B) in paragraph (2), by inserting ''cost'' before ''reporting period'' the first place such term appears in each of subparagraphs (A) and (B).

(2) Subsection (f)(1) of section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended—

(A) in subparagraph (A)(ii), by striking ''paragraph (2)'' and inserting ''subparagraph (B)''; and

(B) in subparagraph (B), by striking ''paragraph (1)(B)'' and inserting ''subparagraph (A)(ii)''.

SEC. 3124. EXTENSION OF THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(1) in clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2013''; and

(2) in clause (ii)(II), by striking ''October 1, 2011'' and inserting ''October 1, 2013''.

(b) CONFORMING AMENDMENTS.—

(1) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''October 1, 2011'' and inserting ''October 1, 2013''; and

(B) in clause (iv), by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2013''.

(2) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C.

1395ww note) is amended by striking ''through fiscal year 2011'' and inserting ''through fiscal year 2013''.

SEC. 3125. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

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

(1) in subparagraph (A), by inserting ''or (D)'' after ''subparagraph (B)'';

(2) in subparagraph (B), in the matter preceding clause (i), by striking ''The Secretary'' and inserting ''For discharges occurring in fiscal years 2005 through 2010 and for discharges occurring in fiscal year 2013 and subsequent fiscal years, the Secretary'';

(3) in subparagraph (C)(i)—

(A) by inserting ''(or, with respect to fiscal years 2011 and 2012, 15 road miles)'' after ''25 road miles''; and

(B) by inserting ''(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)'' after ''800 discharges''; and

(4) by adding at the end the following new subparagraph:

"(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2011 and 2012, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with 200 or fewer discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than 1,500 discharges of such individuals in the fiscal year.".

SEC. 3126. IMPROVEMENTS TO THE DEMONSTRATION PROJECT ON COMMUNITY HEALTH INTEGRATION MODELS IN CERTAIN RURAL COUNTIES.

(a) REMOVAL OF LIMITATION ON NUMBER OF ELIGIBLE COUNTIES SELECTED.—Subsection (d)(3) of section 123 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395i–4 note) is amended by striking "not more than 6".

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIANS' SERV-

ICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(i)(3), by striking subclause (III); and

(2) in subsection (j)—

(A) in paragraph (8), by striking subparagraph (B) and inserting the following:

''(B) Physicians' services (as defined in section 1861(q) of the Social Security Act (42 U.S.C. 1395x(q)).'';

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDPAC STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH CARE PROVIDERS SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payments for items and services furnished by providers of services and suppliers in rural areas under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall include an analysis of—

(1) any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas;

(2) access by Medicare beneficiaries to items and services in rural areas;

(3) the adequacy of payments to providers of services and suppliers that furnish items and services in rural areas; and

(4) the quality of care furnished in rural areas.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative action as the Medicare Payment Advisory Commission determines appropriate.

SEC. 3128. TECHNICAL CORRECTION RELATED TO CRITICAL ACCESS HOSPITAL SERVICES.

(a) IN GENERAL.—Subsections (g)(2)(A) and (l)(8) of section 1834 of the Social Security Act (42 U.S.C. 1395m) are each amended by inserting ''101 percent of'' before ''the reasonable costs''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2266).

SEC. 3129. EXTENSION OF AND REVISIONS TO MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) AUTHORIZATION.—Section 1820(j) of the Social Security Act (42 U.S.C. 1395i–4(j)) is amended—

(1) by striking ''2010, and for'' and inserting ''2010, for''; and

(2) by inserting ''and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended'' before the period at the end.

(b) USE OF FUNDS.—Section 1820(g)(3) of the Social Security Act (42 U.S.C. 1395i–4(g)(3)) is amended—

(1) in subparagraph (A), by inserting ''and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the America's Healthy Future Act of 2009, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under

section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end; and

(2) in subparagraph (E)—

(A) by striking '', and to offset'' and inserting '', to offset''; and

(B) by inserting ''and to participate in delivery system reforms under the provisions of and amendments made by the America's Healthy Future Act of 2009, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary'' before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to grants made on or after January 1, 2010.

PART III—IMPROVING PAYMENT ACCURACY

SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) REBASING HOME HEALTH PROSPECTIVE PAYMENT AMOUNT.—

(1) IN GENERAL.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking ''For periods'' and inserting ''Subject to clause (iii), for periods''; and

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

''(iii) ADJUSTMENT FOR 2013 AND SUBSEQUENT YEARS.—

''(I) IN GENERAL.—Subject to subclause (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be applicable under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the mix of services in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the pre-

ceding sentence, the Secretary shall consider differences between hospital-based and freestanding agencies, between for-profit and nonprofit agencies, and between the resource costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

"(II) TRANSITION.—The Secretary shall provide for a 4-year phase-in (in equal increments) of the adjustment under subclause (I), with such adjustment being fully implemented for 2016. During each year of such phase-in, the amount of any adjustment under subclause (I) for the year may not exceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the America's Healthy Future Act of 2009.".

(2) MEDPAC STUDY AND REPORT.—

(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the

implementation of the amendments made by paragraph (1). Such study shall include an analysis of the impact of such amendments on—

(i) access to care;

(ii) quality outcomes;

(iii) the number of home health agencies; and

(iv) rural agencies, urban agencies, for-profit agencies, and nonprofit agencies.

(B) REPORT.—Not later than January 1, 2015, the Medicare Payment Advisory Commission shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

(b) PROGRAM-SPECIFIC OUTLIER CAP.—Section 1895(b) of the Social Security Act (42 U.S.C. 1395fff(b)) is amended—

(1) in paragraph (3)(C), by striking ''the aggregate'' and all that follows through the period at the end and inserting ''5 percent of the total payments estimated to be made based on the prospective pay-

ment system under this subsection for the period.''; and

(2) in paragraph (5)—

(A) by striking ''OUTLIER.—The Secretary'' and inserting the following: ''OUTLIER.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary'';

(B) in subparagraph (A), as added by subparagraph (A), by striking ''5 percent'' and inserting ''2.5 percent''; and

(C) by adding at the end the following new subparagraph:

''(B) PROGRAM SPECIFIC OUTLIER CAP.—The estimated total amount of additional payments or payment adjustments made under subparagraph (A) with respect to a home health agency for a year (beginning with 2011) may not exceed an amount equal to 10 percent of the estimated total amount of payments made under this section (without regard to this paragraph) with respect to the home health agency for the year.''.

(c) APPLICATION OF THE MEDICARE RURAL HOME HEALTH ADD-ON POLICY.—Section 421 of the Medicare

Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283), as amended by section 5201(b) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 46), is amended—

(1) in the section heading, by striking ''**ONE-YEAR**'' and inserting ''**TEMPORARY**''; and

(2) in subsection (a)—

(A) by striking '', and episodes'' and inserting '', episodes'';

(B) by inserting ''and episodes and visits ending on or after January 1, 2010, and before January 1, 2016,'' after ''January 1, 2007,''; and

(C) by inserting ''(or, in the case of episodes and visits ending on or after January 1, 2010, and before January 1, 2016, 3 percent)'' before the period at the end.

(d) STUDY AND REPORT ON THE DEVELOPMENT OF HOME HEALTH PAYMENT REFORMS IN ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study to evaluate the costs and quality of care among efficient home

health agencies relative to other such agencies in providing ongoing access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to more accurately account for the costs related to patient severity of illness or to improving beneficiary access to care, including—

(i) payment adjustments for services that may be under- or over-valued;

(ii) necessary changes to reflect the resource use relative to providing home health services to low-income Medicare beneficiaries or Medicare beneficiaries living in medically underserved areas;

(iii) ways the outlier payment may be improved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;

(iv) the role of quality of care incentives and penalties in driving provider and patient behavior;

(v) improvements in the application of a wage index; and

(vi) other areas determined appropriate by the Secretary.

(B) The validity and reliability of responses on the OASIS instrument with particular emphasis on questions that relate to higher payment under the home health prospective payment system and higher outcome scores under Home Care Compare.

(C) Additional research or payment revisions under the home health prospective payment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medicare beneficiary access to care.

(D) A timetable for implementation of any appropriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C).

(E) Other areas determined appropriate by the Secretary.

(2) CONSIDERATIONS.—In conducting the study under paragraph (1), the Secretary shall consider

whether certain factors should be used to measure patient severity of illness and access to care, such as—

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

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

(C) the presence of severe or chronic diseases, as evidenced by multiple, discontinuous home health episodes;

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

(E) the absence of caregivers;

(F) language barriers;

(G) atypical transportation costs;

(H) security costs; and

(I) other factors determined appropriate by the Secretary.

(3) REPORT.—Not later than March 1, 2011, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations for such legislation and ad-

ministrative action as the Secretary determines appropriate.

(4) CONSULTATIONS.—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

(A) stakeholders representing home health agencies;

(B) groups representing Medicare beneficiaries;

(C) the Medicare Payment Advisory Commission;

(D) the Inspector General of the Department of Health and Human Services; and

(E) the Comptroller General of the United States.

(5) TEMPORARY MEDICARE ADD-ON PAYMENT BASED ON THE RESULTS OF THE STUDY.—

(A) IN GENERAL.—Subject to subparagraph (D), taking into account the results of the study conducted under paragraph (1), the Secretary may, as determined appropriate, provide for a temporary add-on payment for home health services furnished under the Medicare program during the period beginning on January 1, 2012 and ending on December 31, 2018.

Such add-on payment shall be targeted toward ensuring access to care for Medicare beneficiaries with high severity of levels of illness or improving access to care for low-income or underserved Medicare beneficiaries. Such add-on payment, with respect to a home health service, shall not exceed an amount equal to three percent of the payment amount that would otherwise be made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for the service.

(B) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under such section 1895 applicable to home health services furnished during a period to offset any increase in payments during such period resulting from the application of subparagraph (A).

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

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

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

(D) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines appropriate, of $500,000,000 for the period of fiscal years 2012 through 2019 for the purpose of making add-on payments under subparagraph (A).

(E) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation of this paragraph.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(1) IN GENERAL.—Section 1814(i) of the Social Security Act (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(6)(A) The Secretary shall collect additional data and information as the Secretary determines

appropriate to revise payments for hospice care under this subsection pursuant to subparagraph (D) and for other purposes as determined appropriate by the Secretary. The Secretary shall begin to collect this data by not later than January 1, 2011.

''(B) The additional data and information to be collected under subparagraph (A) may include data and information on—

''(i) charges and payments;

''(ii) the number of days of hospice care which are attributable to individuals who are entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B; and

''(iii) with respect to each type of service included in hospice care—

''(I) the number of days of hospice care attributable to the type of service;

''(II) the cost of the type of service; and

''(III) the amount of payment for the type of service;

''(iv) charitable contributions and other revenue of the hospice program;

''(v) the number of hospice visits;

''(vi) the type of practitioner providing the visit; and

''(vii) the length of the visit and other basic information with respect to the visit.

''(C) The Secretary may collect the additional data and information under subparagraph (A) on cost reports, claims, or other mechanisms as the Secretary determines to be appropriate.

''(D)(i) Notwithstanding the preceding paragraphs of this subsection, not later than October 1, 2013, the Secretary shall, by regulation, implement revisions to the methodology for determining the payment rates for routine home care and other services included in hospice care under this part, as the Secretary determines to be appropriate. Such revisions may be based on an analysis of data and information collected under subparagraph (A). Such revisions may include adjustments to per diem payments that reflect changes in resource intensity in providing such care and services during the course of the entire episode of hospice care.

''(ii) Revisions in payment implemented pursuant to subparagraph (D) shall result in the same estimated amount of aggregate expenditures under this title for hospice care furnished in the fiscal year

in which such revisions in payment are implemented as would have been made under this title for such care if such revisions had not been implemented.

''(E) The Secretary shall consult with hospice programs and the Medicare Payment Advisory Commission regarding the additional data and information to be collected under subparagraph (A) and the payment revisions under subparagraph (D).''.

(2) CONFORMING AMENDMENTS.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)) is amended—

(A) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''(before 2014)'' after ''subsequent fiscal year''; and

(ii) in subclause (VII), by inserting ''(before 2014)'' after ''subsequent fiscal year''; and

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

''(iii) With respect to routine home care and other services included in hospice care furnished on or after October 1, 2013, the payment rates for such care and services shall be—

''(I) for fiscal year 2014, the payment rates determined under the methodology implemented under paragraph (6)(D); and

''(II) for a subsequent fiscal year, the payment rates in effect under this clause during the preceding fiscal year increased by the market basket percentage increase for the fiscal year.''.

(b) ADOPTION OF MEDPAC HOSPICE PROGRAM ELIGIBILITY RECERTIFICATION RECOMMENDATIONS.—Section 1814(a)(7) of the Social Security Act (42 U.S.C. 1395f(a)(7)) is amended—

(1) in subparagraph (B), by striking ''and'' at the end; and

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

''(D) on and after January 1, 2011—

''(i) a hospice physician or advance practice nurse of the individual has a face-to-face encounter with the individual to determine continued eligibility of the individual for hospice care prior to the 180th-day recertification and each subsequent recertification under subparagraph (A)(ii)

and attests that such visit took place (in accordance with procedures established by the Secretary); and

''(ii) in the case of hospice care provided an individual for more than 180 days by a hospice program for which the number of such cases for such program comprises more than a percent (specified by the Secretary) of the total number of such cases for all programs under this title, the hospice care provided to such individual is medically reviewed (in accordance with procedures established by the Secretary).''.

SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subsection (d)(5)(F)(i), by striking ''For'' and inserting ''Subject to subsection (r), for''; and

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

''(r) ADJUSTMENTS TO MEDICARE DSH PAYMENTS.—

''(1) EMPIRICALLY JUSTIFIED DSH PAYMENTS.—For fiscal year 2015 and each subsequent fiscal year, instead of the amount of disproportionate share hospital payment that would otherwise be made under subsection (d)(5)(F) to a subsection (d) hospital for the fiscal year, the Secretary shall pay to the subsection (d) hospital 25 percent of such amount (which is an amount that represents the empirically justified amount for such payment, as determined by the Medicare Payment Advisory Commission in its March 2007 Report to the Congress).

''(2) ADDITIONAL PAYMENT.—In addition to the payment made to a subsection (d) hospital under paragraph (1), for fiscal year 2015 and each subsequent fiscal year, the Secretary shall pay to such subsection (d) hospitals an additional amount equal to the product of the following factors:

''(A) FACTOR ONE.—A factor equal to the difference between—

''(i) the aggregate amount of payments that would be made to the subsection (d) hospital under subsection (d)(5)(F) if this subsection did not apply for such fiscal year (as estimated by the Secretary); and

"(ii) the aggregate amount of payments that are made to the subsection (d) hospital under paragraph (1) for such fiscal year (as so estimated).

"(B) FACTOR TWO.—

"(i) FISCAL YEARS 2015, 2016, AND 2017.—For each of fiscal years 2015, 2016, and 2017, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals under the age of 65 who are uninsured, as determined by comparing the percent of such individuals—

"(I) who are uninsured in 2012, the last year before coverage expansion under the America's Healthy Future Act of 2009 (as calculated by the Secretary based on the most recent estimates available from the Director of the Congressional Budget Office prior to the date of enactment of such Act); and

"(II) who are uninsured in the most recent period for which data is available (as so calculated).

''(ii) 2018 AND SUBSEQUENT YEARS.—For fiscal year 2018 and each subsequent fiscal year, a factor equal to 1 minus the percent change (divided by 100) in the percent of individuals who are uninsured, as determined by comparing the percent of individuals—

''(I) who are uninsured in 2012 (as estimated by the Secretary, based on data from the Census Bureau or other sources the Secretary determines appropriate, and certified by the Chief Actuary of the Centers for Medicare & Medicaid Services); and

''(II) who are uninsured in the most recent period for which data is available (as so estimated and certified).

''(C) FACTOR THREE.—A factor equal to the percent, for each subsection (d) hospital, that represents the quotient of—

''(i) the amount of uncompensated care for such hospital for a period selected by the Secretary (as estimated by Secretary, based on appropriate data (includ-

ing, in the case where the Secretary determines that alternative data is available which is a better proxy for the costs of subsection (d) hospitals for treating the uninsured, the use of such alternative data)); and

''(ii) the aggregate amount of uncompensated care for all subsection (d) hospitals that receive a payment under this subsection for such period (as so estimated, based on such data).

''(3) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

''(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).

''(B) Any period selected by the Secretary for such purposes.

''(C) Any determination by the Secretary to use an alternative percent under paragraph (1)(B).''.

SEC. 3134. MISVALUED CODES UNDER THE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraphs:

''(K) POTENTIALLY MISVALUED CODES.—

''(i) IN GENERAL.—The Secretary shall—

''(I) periodically identify services as being potentially misvalued using criteria specified in clause (ii); and

''(II) review and make appropriate adjustments to the relative values established under this paragraph for services identified as being potentially misvalued under subclause (I).

''(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (as the Secretary determines to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) that have experienced substantial changes in practice

expenses; codes for new technologies or services within an appropriate period (such as 3 years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of the RBRVS (the so-called 'Harvard-valued codes'); and such other codes determined to be appropriate by the Secretary.

''(iii) REVIEW AND ADJUSTMENTS.—

''(I) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

''(II) The Secretary may conduct surveys, other data collection activities, studies, or other analyses as the Secretary determines to be appro-

priate to facilitate the review and appropriate adjustment described in clause (i)(II).

''(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

''(IV) The Secretary may coordinate the review and appropriate adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

''(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual

services into bundled codes for payment under the fee schedule under subsection (b).

''(VI) The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).

''(L) VALIDATING RELATIVE VALUE UNITS.—

''(i) IN GENERAL.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (b).

''(ii) COMPONENTS AND ELEMENTS OF WORK.—The process described in clause (i) may include validation of work elements (such as time, mental effort and professional judgment, technical skill and physical effort, and stress due to risk) involved with furnishing a service and may include validation of the pre-, post-, and intra-service components of work.

''(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(ii).

''(iv) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

''(v) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).''.

(b) IMPLEMENTATION.—

(1) ADMINISTRATION.—

(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory

Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c)(2) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

(C) Section 4505(d) of the Balanced Budget Act of 1997 is repealed.

(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

(2) FOCUSING CMS RESOURCES ON POTENTIALLY OVERVALUED CODES.—Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)) is repealed.

SEC. 3135. MODIFICATION OF EQUIPMENT UTILIZATION FACTOR FOR ADVANCED IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B)), the Secretary shall adjust such number of units so it reflects—

''(i) in the case of services furnished on or after January 1, 2010, and before January 1, 2013, a 65 (rather than 50 percent) presumed rate of utilization of imaging equipment; and

''(ii) in the case of services furnished on or after January 1, 2013, a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''; and

(2) in subsection (c)(2)(B)(v)(II), by inserting ''AND OTHER PROVISIONS'' after ''OPD PAYMENT CAP''.

(b) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—In the case of services furnished on or after January 1, 2010, the Secretary shall increase the reduction in payments attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part 405 of title 42, Code of Federal Regulations) from 25 percent to 50 percent.''.

(c) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study on the estimated impact of the adjustment in practice ex-

pense to reflect higher presumed utilization under the amendments made by subsection (a) on the following:

(A) Medicare beneficiary access to advanced diagnostic imaging services (as defined in section 1834(e)(1)(B) of the Social Security Act (42 U.S.C. 1395m(e)(1)(B)), including such access in rural areas.

(B) Utilization of advanced diagnostic imaging services (as so defined).

(C) The estimated savings to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) during the period of 2010 through 2019 as a result of such adjustment.

(2) REPORT.—Not later than January 1, 2013, the Comptroller General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 3136. REVISION OF PAYMENT FOR POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by inserting ''subclause (III) and'' after ''Subject to''; and

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

''(III) SPECIAL RULE FOR POWER-DRIVEN WHEELCHAIRS.—For purposes of payment for power-driven wheelchairs, subclause (II) shall be applied by substituting '15 percent' and '6 percent' for '10 percent' and '7.5 percent', respectively.''; and

(2) in clause (iii)—

(A) in the heading, by inserting ''COMPLEX, REHABILITATIVE'' before ''POWER-DRIVEN''; and

(B) by inserting ''complex, rehabilitative'' before ''power-driven''.

(b) TECHNICAL AMENDMENT.—Section 1834(a)(7)(C)(ii)(II) of the Social Security Act (42 U.S.C.

1395m(a)(7)(C)(ii)(II)) is amended by striking ''(A)(ii) or''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by subsection (a) shall take effect on January 1, 2011, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE BIDDING.—The amendments made by subsection (a) shall not apply to payment made for items and services furnished pursuant to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3137. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) and section 124 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–

275), is amended by striking ''September 30, 2009'' and inserting ''September 30, 2011''.

(2) USE OF PARTICULAR WAGE INDEX.—For purposes of implementation of the amendment made by this subsection, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(b) PLAN FOR REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled ''Report to Congress: Promoting Greater Efficiency in Medicare'', including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) CONSULTATION.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

(c) USE OF PARTICULAR RATIOS FOR DETERMINING RECLASSIFICATIONS.—Section 1886(d)(10)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)) is amended by adding at the end the following clause:

''(vii) Notwithstanding any other provision of law, in making decisions on applications for reclassification of a subsection (d) hospital for the purposes described in clause (v) for fiscal year 2011 and each subsequent fiscal year (before the first fiscal year beginning on or after the date that is 1 year after the Secretary submits the report to Congress under section 3137(b) of the America's Healthy Future Act of 2009), the Board shall use the ratios used in making such decisions as of September 30, 2008. This clause shall be effected in a budget neutral manner.''.

SEC. 3138. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended by adding at the end the following new paragraph:

''(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

''(A) STUDY.—The Secretary shall conduct a study to determine if, under the system under this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups ex-

ceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

''(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by hospitals described in section 1886(d)(1)(B)(v) exceed those costs incurred by other hospitals furnishing services under this subsection, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those higher costs effective for services furnished on or after January 1, 2011.''.

SEC. 3139. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking ''or'' at the end;

(ii) in subparagraph (B), by striking the period at the end and inserting ''; or''; and

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

"(C) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the amount determined under paragraph (8).";

and

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

"(8) BIOSIMILAR BIOLOGICAL PRODUCT.—The amount specified in this paragraph for a biosimilar biological product described in paragraph (1)(C) is the sum of—

"(A) the average sales price as determined using the methodology described under paragraph (6) applied to a biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph is applied to drugs described in such paragraph; and

"(B) 6 percent of the amount determined under paragraph (4) for the reference biological product (as defined in subsection (c)(6)(I)).";

and

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

''(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term 'biosimilar biological product' means a biological product approved under an abbreviated application for a license of a biological product that relies in part on data or information in an application for another biological product licensed under section 351 of the Public Health Service Act.

''(I) REFERENCE BIOLOGICAL PRODUCT.—The term 'reference biological product' means the biological product licensed under such section 351 that is referred to in the application described in subparagraph (H) of the biosimilar biological product.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. PUBLIC MEETING AND REPORT ON PAYMENT SYSTEMS FOR NEW CLINICAL LABORATORY DIAGNOSTIC TESTS.

(a) PUBLIC MEETING.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall convene a public meeting on mechanisms of

payment for new clinical laboratory diagnostic tests under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such public meeting shall include a discussion of how to reform such mechanisms of payment for such tests under such title.

(b) REPORT.—The Secretary shall submit to Congress a report containing a summary of the public meeting convened under subsection (a), together with recommendations for such legislation and administrative action the Secretary determines appropriate.

SEC. 3141. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries are furnished, during the same period, hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(3) SITES.—The Secretary shall establish a total of 26 sites in the United States at which the demonstration program under this section shall be conducted. Such sites shall be located in urban and rural areas.

(b) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for the conduct of an independent evaluation of the demonstration program under this section. Such independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expend-

itures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been implemented.

SEC. 3142. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPITAL WAGE INDEX FLOOR FOR EACH ALL-URBAN AND RURAL STATE.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (h)(4) of section 412.64 of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (e) of such section 412.64 in the same manner as the Secretary administered such subsection (b) and paragraph (e) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3143. HHS STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study on the need for

an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as compared to other hospitals which receive 1 or more additional payments or adjustments under such section (including those payments or adjustments described in paragraph (2)(A)); and

(B) whether payments to medicare-dependent, small rural hospitals under subsection (d)(5)(G) of such section should be applied to urban Medicare-dependent hospitals.

(2) URBAN MEDICARE-DEPENDENT HOSPITAL DEFINED.—For purposes of this section, the term ''urban Medicare-dependent hospital'' means a subsection (d) hospital (as defined in subsection (d)(1)(B) of such section) that—

(A) does not receive any additional payment or adjustment under such section, such as payments for indirect medical education costs under subsection (d)(5)(B) of such section, disproportionate share payments under subsection (d)(5)(A) of such section, payments to a rural

referral center under subsection (d)(5)(C) of such section, payments to a critical access hospital under section 1814(l) of such Act (42 U.S.C. 1395f(l)), payments to a sole community hospital under subsection (d)(5)(D) of such section 1886, or payments to a medicare-dependent, small rural hospital under subsection (d)(5)(G) of such section 1886; and

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients entitled to benefits under part A of title XVIII of such Act.

(b) REPORT.—Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Subtitle C—Provisions Relating to Part C

SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA BENCHMARK BASED ON PLAN'S COMPETITIVE BIDS.—

(1) IN GENERAL.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–23(j)) is amended—

(A) by striking ''AMOUNTS.—For purposes'' and inserting ''AMOUNTS.—

''(1) IN GENERAL.—For purposes'';

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B)—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and indenting the clauses appropriately; and

(ii) in clause (i), as redesignated by clause (i), by striking ''an amount equal to'' and all that follows through the end and inserting ''an amount equal to—

''(I) for years before 2007, 1/12 of the annual MA capitation rate under section 1853(c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

''(II) for 2007 through 2011, 1/12 of the applicable amount determined

under subsection (k)(1) for the area for the year;

"(III) for 2012, the sum of—

"(aa) ⅔ of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) ⅓ of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

"(IV) for 2013, the sum of—

"(aa) ⅓ of the quotient of—

"(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

"(BB) 12; and

"(bb) ⅔ of the MA competitive benchmark amount (as so

determined) for the area for the month;

''(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

''(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or'';

(iii) in clause (ii), as redesignated by clause (i), by striking ''subparagraph (A)'' and inserting ''clause (i)'';

(D) by adding at the end the following new paragraphs:

''(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in

each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E)) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1858(f)(4), except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1853(j)(2)' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

''(B) WEIGHTING RULES.—

''(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

''(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA

payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

''(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.''; and

(E) in subsection (k)(2)(B)(ii)(III), by striking ''(j)(1)(A)'' and inserting ''(j)(1)(A)(i)''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1853(k)(2) of the Social Security Act (42 U.S.C. 1395w–23(k)(2)) is amended—

(i) in subparagraph (A), by striking ''through 2010'' and inserting ''and subsequent years''; and

(ii) in subparagraph (C)—

(I) in clause (iii), by striking ''and'' at the end;

(II) in clause (iv), by striking the period at the end and inserting ''; and''; and

(III) by adding at the end the following new clause:

''(v) for 2011 and subsequent years, 0.00.''.

(B) Section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)) is amended—

(i) in paragraph (3)(B)(i), by striking ''1853(j)(1)'' and inserting ''1853(j)(1)(A)''; and

(ii) in paragraph (4)(B)(i), by striking ''1853(j)(2)'' and inserting ''1853(j)(1)(B)''.

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(i) in paragraph (1), by striking ''1853(j)(2)'' and inserting ''1853(j)(1)(B)''; and

(ii) in paragraph (3)(A), by striking ''1853(j)(1)(A)'' and inserting ''1853(j)(1)(A)(i)''.

(D) Section 1860C–1(d)(1)(A) of the Social Security Act (42 U.S.C. 1395w–29(d)(1)(A)) is amended by striking ''1853(j)(1)(A)'' and inserting ''1853(j)(1)(A)(i)''.

(b) REDUCTION OF NATIONAL PER CAPITA GROWTH PERCENTAGE FOR 2011.—Section 1853(c)(6) of the Social Security Act (42 U.S.C. 1395w–23(c)(6)) is amended—

(1) in clause (v), by striking ''and'' at the end;

(2) in clause (vi)—

(A) by striking ''for a year after 2002'' and inserting ''for 2003 through 2010''; and

(B) by striking the period at the end and inserting a comma; and

(C) by adding at the end the following new clauses:

''(vii) for 2011, 3 percentage points; and

''(viii) for a year after 2011, 0 percentage points.''.

(c) ENHANCEMENT OF BENEFICIARY REBATES.—Section 1854(b)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)(i)) is amended by inserting ''(or 100 percent in the case of plan years beginning on or after January 1, 2014)'' after ''75 percent''.

(d) BIDDING RULES.—

(1) REQUIREMENTS FOR INFORMATION SUBMITTED.—Section 1854(a)(6)(A) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(A)) is amended, in the flush matter following clause (v), by adding at the end the following sentence: ''Information to be submitted under this paragraph shall be certified by a qualified member of the American Academy of Actuaries and shall meet actuarial guidelines and rules established by the Secretary under subparagraph (B)(v).''.

(2) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—Section 1854(a)(6)(B) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(A) in clause (i), by striking ''(iii) and (iv)'' and inserting ''(iii), (iv), and (v)''; and

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

"(v) ESTABLISHMENT OF ACTUARIAL GUIDELINES.—

"(I) IN GENERAL.—In order to establish fair MA competitive benchmarks under section 1853(j)(1)(A)(i), the Secretary, acting through the Chief Actuary of the Centers for Medicare & Medicaid Services (in this clause referred to as the 'Chief Actuary'), shall establish—

"(aa) actuarial guidelines for the submission of bid information under this paragraph; and

"(bb) bidding rules that are appropriate to ensure accurate bids and fair competition among MA plans.

"(II) DENIAL OF BID AMOUNTS.—The Secretary shall deny monthly bid amounts submitted under subparagraph (A) that do not meet

the actuarial guidelines and rules established under subclause (I).

''(III) REFUSAL TO ACCEPT CERTAIN BIDS DUE TO MISREPRESENTATIONS AND FAILURES TO ADEQUATELY MEET REQUIREMENTS.—In the case where the Secretary determines that information submitted by an MA organization under subparagraph (A) contains consistent misrepresentations and failures to adequately meet requirements of the organization, the Secretary may refuse to accept any additional such bid amounts from the organization for the plan year and the Chief Actuary shall, if the Chief Actuary determines that the actuaries of the organization were complicit in those misrepresentations and failures, report those actuaries to the Actuarial Board for Counseling and Discipline.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to bid amounts submitted on or after January 1, 2012.

(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended—

(A) in the subsection heading, by striking ''MA REGION'' and inserting ''MA REGION; MA LOCAL PLAN SERVICE AREA'';

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

''(A) with respect to an MA local plan—

''(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

''(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and''; and

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

''(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

''(A) URBAN AREAS.—

"(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

"(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

"(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

"(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

"(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of the date of enactment of the America's Healthy Future Act of 2009)—

"(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

"(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a re-

sult of the delivery system model of the MA local plan.''.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—

(i) Section 1851(b)(1) of the Social Security Act (42 U.S.C. 1395w–21(b)(1)) is amended by striking subparagraph (C).

(ii) Section 1853(b)(1)(B)(i) of such Act (42 U.S.C. 1395w–23(b)(1)(B)(i))—

(I) in the matter preceding subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''; and

(II) in subclause (I), by striking ''MA payment area'' and inserting ''MA local area (as so defined)''.

(iii) Section 1853(b)(4) of such Act (42 U.S.C. 1395w–23(b)(4)) is amended by striking ''Medicare Advantage payment area'' and inserting ''MA local area (as so defined)''.

(iv) Section 1853(c)(1) of such Act (42 U.S.C. 1395w–23(c)(1)) is amended—

(I) in the matter preceding subparagraph (A), by striking ''a Medi-

care Advantage payment area that is''; and

(II) in subparagraph (D)(i), by striking ''MA payment area'' and inserting ''MA local area (as defined in subsection (d)(2))''.

(v) Section 1854 of such Act (42 U.S.C. 1395w–24) is amended by striking subsection (h).

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall take effect on January 1, 2012.

(f) PERFORMANCE BONUSES.—

(1) MA PLANS.—

(A) IN GENERAL.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(n) PERFORMANCE BONUSES.—

''(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

''(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with

respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments to the MA plan in an amount equal to the product of—

"(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

"(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

"(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

"(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

"(i) Care management programs that—

"(I) target individuals with 1 or more chronic conditions;

"(II) identify gaps in care; and

"(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

"(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

"(I) help manage chronic conditions;

"(II) reduce declines in health status; and

"(III) foster patient and provider collaboration.

"(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

''(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

''(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

''(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

''(vii) Medication therapy management programs that are more extensive than is required under section 1860D–4(c) (as determined by the Secretary).

''(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

''(ix) Such other care management and coordination programs as the Secretary determines appropriate.

''(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

''(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide for the reporting to the Secretary of information specified by the Secretary (in order to determine whether an MA plan is eligible for a care coordination and management performance bonus under this paragraph) at such time and in such manner as the Secretary shall specify.

''(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

''(2) QUALITY PERFORMANCE BONUSES.—

''(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

''(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating on such system, 4 percent of such national monthly per capita cost for the year.

''(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall,

in addition to any other payment provided under this part, make monthly payments to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

''(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

''(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

''(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

''(D) DATA USED IN DETERMINING SCORE.—

''(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

"(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

"(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

"(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that has been in operation for less than 3 years and was not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the

MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

''(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

''(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

''(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection

(b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''.

(B) CONFORMING AMENDMENT.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended—

(i) in clause (i), by inserting ''and any performance bonus under subsection (n)'' before the period at the end; and

(ii) in clause (ii), by striking ''(G)'' and inserting ''(G), plus the amount (if any) of any performance bonus under subsection (n)''.

(2) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—Section 1858 of the So-

cial Security Act (42 U.S.C. 1395w–27a) is amended—

(A) in subsection (f)(1), by striking ''subsection (e)'' and inserting ''subsections (e) and (i)''; and

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

''(i) APPLICATION OF PERFORMANCE BONUSES TO MA REGIONAL PLANS.—For years beginning with 2014, the Secretary shall apply the performance bonuses under section 1853(n) (relating to bonuses for care coordination and management, quality performance, and new and low enrollment MA plans) to MA regional plans in a similar manner as such performance bonuses apply to MA plans under such subsection.''.

(g) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsection (f), is amended by adding at the end the following new subsection:

''(o) GRANDFATHERING SUPPLEMENTAL BENEFITS FOR CURRENT ENROLLES AFTER IMPLEMENTATION OF COMPETITIVE BIDDING.—

"(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2011, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

"(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year.

''(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

''(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

''(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

''(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

''(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

''(i) for 2012 and 2013, the sum of—

"(I) the bid amount under section 1854(a) for the MA local plan; and

"(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

"(ii) for 2014 and subsequent years, the sum of—

"(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

"(II) the applicable amount (as so defined) for the MA local plan for the year.

"(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single

bid amount under section 1854(a) for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

''(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

''(D) NONAPPLICATION OF SERVICE AREAS.—The service areas established under subsection (d)(5) shall not apply with respect to the MA local plan in the area so identified.

''(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1854(b)(1)(C), in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

''(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

''(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (as of the date of enactment of this subsection) in an MA local plan in an area that is identified by the Secretary under paragraph (1).''.

(h) TRANSITIONAL EXTRA BENEFITS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23), as amended by subsections (f) and (g), is amended by adding at the end the following new subsection:

''(p) TRANSITIONAL EXTRA BENEFITS.—

''(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

''(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

''(A) enrolls in an MA local plan in an applicable area; and

"(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1854(b)(1)(C) as a result of competitive bidding under this part (as determined by the Secretary).

"(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

"(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

"(B) A county where—

"(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

"(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in an MA plan for 2011 is greater than 30 percent (as determined by the Secretary); and

"(iii) average bids submitted by an MA organization under section 1854(a) for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1848(o), 1886(n), and 1886(h).

"(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

"(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

"(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal

Supplementary Medical Insurance Trust Fund established under section 1841, in such proportion as the Secretary determines appropriate, of $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(C) for the provision of extra benefits under this subsection.''.

(i) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395eee) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

''(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this section, the following provisions (and regulations relating to such provisions) shall not apply:

''(1) Section 1853(j)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

''(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

''(3) Section 1853(n), relating to the payment of performance bonuses.

''(4) Section 1853(o), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding.

''(5) Section 1853(p), relating to transitional extra benefits.''.

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–23(d)), as amended by subsection (e), is amended by adding at the end the following new paragraph:

''(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with 2012, in the case of a PACE program under section 1894, the MA payment area shall be the MA local area (as defined in paragraph (2)).''.

(j) LIMITATION ON EFFECTIVE DATE.—Notwithstanding any other provision of this section or the amendments made by this section, such provisions or amend-

ments shall not take effect if the Chief Actuary of the Centers for Medicare & Medicaid Services certifies, not later than 3 months after the date of enactment of this Act, that Medicare beneficiaries currently enrolled in Medicare Advantage plans will, as a result of the implementation of those provisions or amendments, lose basic benefits which are available under parts A and B of title XVIII of the Social Security Act to individuals entitled to benefits under such part A and enrolled under such part B.

SEC. 3202. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (i), by inserting ", subject to clause (iii)," after "and B or"; and

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

"(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

''(iv) SERVICES DESCRIBED.—The following services are described in this clause:

''(I) Chemotherapy administration services.

''(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

''(III) Skilled nursing care.

''(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

''(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND PREMIUMS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (ii), by striking ''REBATE.—A rebate'' and inserting ''REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate'';

(B) by redesignating clauses (iii) and (iv) as clauses (iv) and (v); and

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

''(iii) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(III) and shall be provided through the application of the amount of the rebate in the following priority order:

''(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A

and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, co-payments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses under the preceding sentence shall apply to all benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

''(II) Second, to use the next most significant share to meaningfully provide coverage of preventive and wellness health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

"(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental coverage, and are not benefits described in subclause (II).".

(2) APPLICATION OF PERFORMANCE BONUSES.—Section 1853(n) of the Social Security Act, as added by section 3201(f), is amended by adding at the end the following new paragraph:

"(6) APPLICATION OF PERFORMANCE BONUSES.—For plan years beginning on or after January 1, 2014, any performance bonus paid to an MA plan under this subsection shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of section 1854(b)(1)(C)(iii).".

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking "PREMIUM.—The term" and inserting "PREMIUM.—

''(i) IN GENERAL.—The term''; and

(i) by adding at the end the following new clause:

''(ii) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subclauses (I) through (III) of paragraph (1)(C)(iii).''.

(c) CATEGORIZATION OF MEDICARE ADVANTAGE PLANS.—

(1) IN GENERAL.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(k) CATEGORIZATION OF PLANS.—

''(1) IN GENERAL.—Not later than January 1, 2011, the Secretary shall establish 2 or more categories of MA plans offered by Medicare Advantage organizations based on the ratio of the amount described in paragraph (2) to the aggregate monthly bid amount submitted under clause (i) of section

1854(a)(6)(A) for the year, expressed as a percentage.

''(2) AMOUNT DESCRIBED.—The amount described in this paragraph is the sum of—

''(A) the amount of such aggregate monthly bid amount that is attributable under clause (ii)(III) of such section to the provision of supplemental health care benefits; and

''(B) the amount (if any) of any rebate under section 1853(a)(1)(E).

''(3) REQUIRED INCLUSION OF CATEGORY IN PLAN NAME AND MARKETING MATERIALS.—For plan years beginning on or after January 1, 2011, a Medicare Advantage organization shall ensure that the name of each MA plan offered by the Medicare Advantage organization and any marketing materials with respect to such plan include the category of the plan, as determined under paragraph (1).''.

(2) REQUIRED INCLUSION OF CATEGORY IN INFORMATION PROVIDED TO PROMOTE INFORMED CHOICE.—Section 1851(d)(4) of the Social Security Act (42 U.S.C. 1395w–21(d)(4)) is amended by adding at the end the following new subparagraph:

''(F) INFORMATION REGARDING PLAN CATEGORY.—For plan years beginning on or after

January 1, 2011, the category of the plan (as determined under subsection (k)(1)).''.

SEC. 3203. APPLICATION OF CODING INTENSITY ADJUSTMENT DURING MA PAYMENT TRANSITION.

Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

''(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

''(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.''.

SEC. 3204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1851(e)(2)(C) of the Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is amended to read as follows:

"(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.—Section

1851(e)(3)(B) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv)—

(A) by striking ''and succeeding years'' and inserting '', 2008, 2009, and 2010''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.''.

SEC. 3205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1859(f)(1) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking ''2011'' and inserting ''2014''.

(b) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES.—Section 1853(a)(1)(B)

of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)) is amended by adding at the end the following new clause:

"(iv) AUTHORITY TO APPLY FRAILTY ADJUSTMENT UNDER PACE PAYMENT RULES FOR CERTAIN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

"(I) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1894(d) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

"(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully inte-

grated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.''.

(c) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by adding at the end the following new paragraph:

''(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

''(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

''(ii) the original medicare fee-for-service program under parts A and B.

''(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term 'applicable individual' means an individual who—

"(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

"(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

"(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

"(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.".

(d) TEMPORARY EXTENSION OF AUTHORITY TO OPERATE BUT NO SERVICE AREA EXPANSION FOR DUAL

SNPS THAT DO NOT MEET CERTAIN REQUIREMENTS.—Section 164(c)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking ''December 31, 2010'' and inserting ''December 31, 2012''.

(e) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsections (a) and (c), is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

''(C) If applicable, the plan meets the requirement described in paragraph (7).'';

(2) in paragraph (3), by adding at the end the following new subparagraph:

''(E) If applicable, the plan meets the requirement described in paragraph (7).'';

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

''(C) If applicable, the plan meets the requirement described in paragraph (7).''; and

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

''(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subse-

quent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).''.

(f) RISK ADJUSTMENT.—Section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395i–23(a)(1)(C)) is amended by adding at the end the following new clause:

''(iii) IMPROVEMENTS TO RISK ADJUSTMENT FOR SPECIAL NEEDS INDIVIDUALS WITH CHRONIC HEALTH CONDITIONS.—

''(I) IN GENERAL.—For 2011 and subsequent years, for purposes of the adjustment under clause (i) with respect to individuals described in subclause (II), the Secretary shall use a risk score that reflects the known underlying risk profile and chronic health status of similar individuals. Such risk score shall be used instead of the default risk score for new enrollees in Medicare Advantage plans that are not specialized MA plans for

special needs individuals (as defined in section 1859(b)(6)).

''(II) INDIVIDUALS DESCRIBED.—An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii) who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

''(III) EVALUATION.—For 2011 and periodically thereafter, the Secretary shall evaluate and revise the risk adjustment system under this subparagraph in order to, as accurately as possible, account for higher medical and care coordination costs associated with frailty, individuals with multiple, comorbid chronic conditions, and individuals with a diagnosis of mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions.

''(IV) PUBLICATION OF EVALUATION AND REVISIONS.—The Secretary

shall publish, as part of an announcement under subsection (b), a description of any evaluation conducted under subclause (III) during the preceding year and any revisions made under such subclause as a result of such evaluation.''.

(g) TECHNICAL CORRECTION.—Section 1859(f)(5) of the Social Security Act (42 U.S.C. 1395w–28(f)(5)) is amended, in the matter preceding subparagraph (A), by striking ''described in subsection (b)(6)(B)(i)''.

SEC. 3206. EXTENSION OF REASONABLE COST CONTRACTS.

Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2010'' and inserting ''January 1, 2013''.

SEC. 3207. TECHNICAL CORRECTION TO MA PRIVATE FEE-FOR-SERVICE PLANS.

(a) CLARIFICATION REGARDING DEFINITION OF NETWORK AREA.—

(1) IN GENERAL.—Section 1852(d)(5)(B) of the Social Security Act (42 U.S.C. 1395w–22(d)(5)(B)) is amended by striking ''network-based plans'' and inserting ''Medicare Advantage organizations offering a network-based plan''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect as if included in the enactment of section 162 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275; 122 Stat. 2569).

(b) APPLICATION OF SERVICE AREA WAIVER TO CERTAIN EMPLOYER PLANS.—For plan year 2011 and subsequent plan years, to the extent that the Secretary of Health and Human Services is applying the 2008 service area extension waiver policy (as modified in the April 11, 2008, Centers for Medicare & Medicaid Services' memorandum with the subject ''2009 Employer Group Waiver-Modification of the 2008 Service Area Extension Waiver Granted to Certain MA Local Coordinated Care Plans'') to Medicare Advantage coordinated care plans, the Secretary shall extend the application of such waiver policy to employers who contract directly with the Secretary as a Medicare Advantage private fee-for-service plan under section 1857(i)(2) of the Social Security Act (42 U.S.C. 1395w–27(i)(2)) and that had enrollment as of October 1, 2009.

SEC. 3208. MAKING SENIOR HOUSING FACILITY DEMONSTRATION PERMANENT.

(a) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

''(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

''(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

''(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

''(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

''(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

''(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2010, and shall apply to plan years beginning on or after such date.

SEC. 3209. DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDIGAP PLANS.

(a) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(y) DEVELOPMENT OF NEW STANDARDS FOR CERTAIN MEDICARE SUPPLEMENTAL POLICIES.—

''(1) IN GENERAL.—The Secretary shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages described in paragraph (2) under subsection (p)(1), to otherwise update standards to include requirements for nominal cost sharing to encourage the use of appropriate physicians' services under part B. Such revisions shall be based on evi-

dence published in peer-reviewed journals or current examples used by integrated delivery systems and made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the '1991 NAIC Model Regulation' deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law and the reference to 'date of enactment of this subsection' deemed a reference to the date of enactment of the America's Healthy Future Act of 2009. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2015.

''(2) BENEFIT PACKAGES DESCRIBED.—The benefit packages described in this paragraph are benefit packages classified as 'C' and 'F'.''.

(b) CONFORMING AMENDMENT.—Section 1882(o)(1) of the Social Security Act (42 U.S.C. 1395ss(o)(1)) is amended by striking '', and (w)'' and inserting ''(w), and (y)''.

Subtitle D—Medicare Part D Improvements for Prescription Drug Plans and MA–PD Plans

SEC. 3301. MEDICARE PRESCRIPTION DRUG DISCOUNT PROGRAM FOR BRAND-NAME DRUGS.

(a) CONDITION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new section:

''CONDITION FOR COVERAGE OF DRUGS UNDER THIS PART

''SEC. 1860D–43. (a) IN GENERAL.—In order for coverage to be available under this part for covered part D drugs (as defined in section 1860D–2(e)) of a manufacturer, the manufacturer must—

''(1) participate in the Medicare prescription drug discount program under section 1860D–14A;

''(2) have entered into and have in effect an agreement described in subsection (b) of such section with the Secretary; and

''(3) have entered into and have in effect, under terms and conditions specified by the Secretary, a contract with a third party that the Secretary has entered into a contract with under subsection (d)(3) of such section.

''(b) EFFECTIVE DATE.—Subsection (a) shall apply to covered part D drugs dispensed under this part on or after July 1, 2010.

''(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

''(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

''(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

''(d) DEFINITION OF MANUFACTURER.—In this section, the term 'manufacturer' has the meaning given such term in section 1860D–14(g)(5).''.

(b) MEDICARE PRESCRIPTION DRUG DISCOUNT PROGRAM FOR BRAND-NAME DRUGS.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following new section:

''MEDICARE PRESCRIPTION DRUG DISCOUNT PROGRAM FOR BRAND-NAME DRUGS

''SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare prescription drug discount program (in this section referred to as the 'program') by not later than July 1, 2010. Under the pro-

gram, the Secretary shall enter into agreements described in subsection (b) with manufacturers and provide for the performance of the duties described in subsection (c)(1).

''(b) TERMS OF AGREEMENT.—

''(1) IN GENERAL.—

''(A) AGREEMENT.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

''(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in subsection (c)(1)(A)(iii), such discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

''(C) TIMING OF AGREEMENT.—

''(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on July 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than March 1, 2010.

''(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

''(2) PROVISION OF APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate compliance with the requirements of paragraph (1).

''(3) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall comply with requirements imposed by the Secretary or a third party with a contract under subsection (d)(3), as applicable, for purposes of administering the program, including any determination under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A).

''(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY THE SECRETARY.—The Secretary may provide for termination of an agreement under this section for violation of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 30 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination.

"(ii) BY A MANUFACTURER.—A manufacturer may terminate an agreement under this section for any reason. Any such termination shall not be effective, with respect to a plan year—

"(I) if the termination occurs before January 30 of a plan year, the end of the plan year; and

"(II) if the termination occurs on or after January 30 of a plan year, the end of the succeeding plan year.

"(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect discounts for applicable drugs of the manufacturer that are due under the agreement before the effective date of its termination.

"(iv) NOTICE TO THIRD PARTY.—The Secretary shall provide notice of such termination to a third party with a contract under subsection (d)(3) within not less than 30 days before the effective date of such termination.

"(c) DUTIES DESCRIBED AND SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—

"(1) DUTIES DESCRIBED.—The duties described in this subsection are the following:

"(A) ADMINISTRATION OF PROGRAM.—Administering the program, including—

"(i) the determination of the amount of the discounted price of an applicable drug of a manufacturer;

"(ii) except as provided in clause (iii), the establishment of procedures under which discounted prices are provided to applicable beneficiaries at pharmacies or by mail order service at the point-of-sale of an applicable drug;

"(iii) in the case where, during the period beginning on July 1, 2010, and ending on December 31, 2011, it is not practicable to provide such discounted prices at the point-of-sale (as described in clause (ii)), the establishment of procedures to provide such discounted prices as soon as practicable after the point-of-sale;

"(iv) the establishment of procedures to ensure that, not later than the applicable number of calendar days after the dispensing of an applicable drug by a pharmacy or mail order service, the pharmacy or mail order service is reimbursed for an amount equal to the difference between—

''(I) the negotiated price of the applicable drug; and

''(II) the discounted price of the applicable drug;

''(v) the establishment of procedures to ensure that the discounted price for an applicable drug under this section is applied before any coverage or financial assistance under other health benefit plans or programs that provide coverage or financial assistance for the purchase or provision of prescription drug coverage on behalf of applicable beneficiaries as the Secretary may specify; and

''(vi) the establishment of procedures to implement the special rule for supplemental benefits under paragraph (2).

''(B) MONITORING COMPLIANCE.—

''(i) IN GENERAL.—Monitoring compliance by a manufacturer with the terms of an agreement under this section.

''(ii) NOTIFICATION.—If a third party with a contract under subsection (d)(3) determines that the manufacturer is not in compliance with such agreement, the third

party shall notify the Secretary of such noncompliance for appropriate enforcement under subsection (e).

''(2) SPECIAL RULE FOR SUPPLEMENTAL BENEFITS.—For plan year 2010 and each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

''(d) ADMINISTRATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

''(2) LIMITATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program.

''(B) EXCEPTION.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

''(3) CONTRACT WITH THIRD PARTIES.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

''(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate; and

''(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to

meet the obligations of manufacturers under agreements under this section.

''(4) PERFORMANCE REQUIREMENTS.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (3).

''(5) IMPLEMENTATION.—The Secretary may implement the program under this section by program instruction or otherwise.

''(6) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program under this section.

''(e) ENFORCEMENT.—

''(1) AUDITS.—Each manufacturer with an agreement in effect under this section shall be subject to periodic audit by the Secretary.

''(2) CIVIL MONEY PENALTY.—

''(A) IN GENERAL.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiaries discounts for applicable drugs of the manufacturer in accordance with such agreement for each such failure in an amount the Secretary determines is commensurate with the sum of—

"(i) the amount that the manufacturer would have paid with respect to such discounts under the agreement; and

"(ii) 25 percent of such amount.

"(B) APPLICATION.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(f) CLARIFICATION REGARDING AVAILABILITY OF OTHER COVERED PART D DRUGS.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in).

"(g) DEFINITIONS.—In this section:

"(1) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

"(A) is enrolled in a prescription drug plan or an MA–PD plan;

"(B) is not enrolled in a qualified retiree prescription drug plan;

''(C) is not entitled to an income-related subsidy under section 1860D–14(a);

''(D) is not subject to a reduction in premium subsidy under section 1839(i) or an increase in the base beneficiary premium under section 1860D–13(a)(7); and

''(E) who—

''(i) has reached or exceeded the initial coverage limit under section 1860D–2(b)(3) during the year; and

''(ii) has not incurred costs for covered part D drugs in the year equal to the annual out-of-pocket threshold specified in section 1860D–2(b)(4)(B).

''(2) APPLICABLE DRUG.—The term 'applicable drug' means, with respect to an applicable beneficiary, a covered part D drug—

''(A) approved under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act; and

''(B)(i) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan uses a formulary, which is on the formulary of the prescription drug plan or

MA–PD plan that the applicable beneficiary is enrolled in;

"(ii) if the PDP sponsor of the prescription drug plan or the MA organization offering the MA–PD plan does not use a formulary, for which benefits are available under the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in; or

"(iii) is provided through an exception or appeal.

"(3) APPLICABLE NUMBER OF CALENDAR DAYS.—The term 'applicable number of calendar days' means—

"(A) with respect to claims for reimbursement submitted electronically, 14 days; and

"(B) with respect to claims for reimbursement submitted otherwise, 30 days.

"(4) DISCOUNTED PRICE.—

"(A) IN GENERAL.—The term 'discounted price' means 50 percent of the negotiated price of the applicable drug of a manufacturer.

"(B) CLARIFICATION.—Nothing in this section shall be construed as affecting the responsibility of an applicable beneficiary for payment of a dispensing fee for an applicable drug.

''(5) MANUFACTURER.—The term 'manufacturer' means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drug products, either directly or indirectly by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis. Such term does not include a wholesale distributor of drugs or a retail pharmacy licensed under State law.

''(6) NEGOTIATED PRICE.—The term 'negotiated price' has the meaning given such term in section 423.100 of title 42, Code of Federal Regulations (as in effect on the date of enactment of this section), except that such negotiated price shall not include any dispensing fee for the applicable drug.

''(7) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D–22(a)(2).''.

(c) INCLUSION IN INCURRED COSTS.—

(1) IN GENERAL.—Section 1860D–2(b)(4) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)) is amended—

(A) in subparagraph (C), in the matter preceding clause (i), by striking ''In applying'' and inserting ''Except as provided in subparagraph (E), in applying''; and

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

''(E) INCLUSION OF COSTS OF APPLICABLE DRUGS UNDER MEDICARE PRESCRIPTION DRUG DISCOUNT PROGRAM.—In applying subparagraph (A), incurred costs shall include the negotiated price (as defined in paragraph (6) of section 1860D–14A(g)) of an applicable drug (as defined in paragraph (2) of such section) of a manufacturer) that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare prescription drug discount program under section 1860D–14A, regardless of whether part of such costs were paid by a manufacturer under such program.''.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to costs incurred on or after July 1, 2010.

(d) CONFORMING AMENDMENT PERMITTING PRESCRIPTION DRUG DISCOUNTS.—

(1) IN GENERAL.—Section 1128B(b)(3) of the Social Security Act (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (G);

(B) by striking ''1853(a)(4).'' at the end of the first subparagraph (H) and inserting ''1853(a)(4);'';

(C) by redesignating the second subparagraph (H) as subparagraph (I) and by striking the period at the end and inserting ''; and''; and

(D) by adding at the end the following new subparagraph:

''(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A(g)) of a manufacturer) that is furnished to an applicable beneficiary (as defined in paragraph (1) of such section) under the Medicare prescription drug discount program under section 1860D–14A.''.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs dispensed on or after July 1, 2010.

SEC. 3302. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENCHMARK PREMIUM.

(a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–114(b)(2)(B)(iii)) is amended by inserting ", determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1854(b)(1)(C) or bonus payment under section 1853(n)" before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3303. VOLUNTARY DE MINIMUS POLICY FOR SUBSIDY ELIGIBLE INDIVIDUALS UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended by adding at the end the following new paragraph:

"(5) WAIVER OF DE MINIMUS PREMIUMS.—The Secretary shall, under procedures established by the Secretary, permit a prescription drug plan or an MA–PD plan to waive the monthly beneficiary premium for a subsidy eligible individual if the amount of such premium is de minimus. If such premium is waived under the plan, the Secretary shall not reas-

sign subsidy eligible individuals enrolled in the plan to other plans based on the fact that the monthly beneficiary premium under the plan was greater than the low-income benchmark premium amount.''.

(b) AUTHORIZING THE SECRETARY TO AUTO-ENROLL SUBSIDY ELIGIBLE INDIVIDUALS IN PLANS THAT WAIVE DE MINIMUS PREMIUMS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in subparagraph (C), by inserting ''except as provided in subparagraph (D),'' after ''shall include,''

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

''(D) SPECIAL RULE FOR PLANS THAT WAIVE DE MINIMUS PREMIUMS.—The process established under subparagraph (A) may include, in the case of a part D eligible individual who is a subsidy eligible individual (as defined in section 1860D–14(a)(3)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan or MA–PD plan that has waived the monthly beneficiary premium for such subsidy eligible individual under section 1860D–

14(a)(5). If there is more than one such plan available, the Secretary shall enroll such an individual under the preceding sentence on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.''.

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to premiums for months, and enrollments for plan years, beginning on or after January 1, 2011.

SEC. 3304. SPECIAL RULE FOR WIDOWS AND WIDOWERS REGARDING ELIGIBILITY FOR LOW-INCOME ASSISTANCE.

(a) IN GENERAL.—Section 1860D–14(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)) is amended by adding at the end the following new clause:

''(vi) SPECIAL RULE FOR WIDOWS AND WIDOWERS.—Notwithstanding the preceding provisions of this subparagraph, in the case of an individual whose spouse dies during the effective period for a determination or redetermination that has been made under this subparagraph, such effective period shall be extended through the

date that is 1 year after the date on which the determination or redetermination would (but for the application of this clause) otherwise cease to be effective.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

''(d) FACILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned by the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

''(1) information on formulary differences between the individual's former plan and the plan to

which the individual is reassigned with respect to the individual's drug regimens; and

''(2) a description of the individual's right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(f).''.

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PROGRAMS.—Subsection (a)(1)(B) of section 119 of the Medicare Improvements for Patients and Providers Act of 2008 (42 U.S.C. 1395b–3 note) is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Centers for Medicare & Medicaid Services Program Management Account—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(1)(B) of such section 119 is

amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $7,500,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $15,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(c) ADDITIONAL FUNDING FOR AGING AND DISABILITY RESOURCE CENTERS.—Subsection (c)(1)(B) of such section 119 is amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $10,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(d) ADDITIONAL FUNDING FOR CONTRACT WITH THE NATIONAL CENTER FOR BENEFITS AND OUTREACH ENROLLMENT.—Subsection (d)(2) of such section 119 is

amended by striking ''(42 U.S.C. 1395w–23(f))'' and all that follows through the period at the end and inserting ''(42 U.S.C. 1395w–23(f)), to the Administration on Aging—

''(i) for fiscal year 2009, of $5,000,000; and

''(ii) for the period of fiscal years 2010 through 2012, of $5,000,000.

Amounts appropriated under this subparagraph shall remain available until expended.''.

(e) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—Such section 119 is amended by adding at the end the following new subsection:

''(g) SECRETARIAL AUTHORITY TO ENLIST SUPPORT IN CONDUCTING CERTAIN OUTREACH ACTIVITIES.—The Secretary may request that an entity awarded a grant under this section support the conduct of outreach activities aimed at preventing disease and promoting wellness. Notwithstanding any other provision of this section, an entity may use a grant awarded under this subsection to support the conduct of activities described in the preceding sentence.''.

SEC. 3307. IMPROVING FORMULARY REQUIREMENTS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS WITH RESPECT TO CERTAIN CATEGORIES OR CLASSES OF DRUGS.

(a) IMPROVING FORMULARY REQUIREMENTS.—Section 1860D–4(b)(3)(G) of the Social Security Act is amended to read as follows:

"(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

"(i) FORMULARY REQUIREMENTS.—

"(I) IN GENERAL.—Subject to subclause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (ii)(I)

"(II) EXCEPTIONS.—The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subclause (I) (or to otherwise limit access to such a

drug, including through prior authorization or utilization management).

"(ii) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

"(I) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

"(II) CRITERIA.—The Secretary shall use criteria established by the Secretary in making any determination under subclause (I).

"(iii) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (ii)(II) and any exceptions under clause (i)(II) through the promulgation of a regulation which includes a public notice and comment period.

"(iv) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES UNTIL CRITERIA ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (ii)(II) the following categories and

classes of drugs shall be identified under clause (ii)(I):

''(I) Anticonvulsants.

''(II) Antidepressants.

''(III) Antineoplastics.

''(IV) Antipsychotics.

''(V) Antiretrovirals.

''(VI) Immunosuppressants for the treatment of transplant rejection.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year 2011 and subsequent plan years.

SEC. 3308. REDUCING PART D PREMIUM SUBSIDY FOR HIGH-INCOME BENEFICIARIES.

(a) INCOME-RELATED INCREASE IN PART D PREMIUM.—

(1) IN GENERAL.—Section 1860D–13(a) of the Social Security Act (42 U.S.C. 1395w–113(a)) is amended by adding at the end the following new paragraph:

''(7) INCREASE IN BASE BENEFICIARY PREMIUM BASED ON INCOME.—

''(A) IN GENERAL.—In the case of an individual whose modified adjusted gross income

exceeds the threshold amount applicable under paragraph (2) of section 1839(i) (including application of paragraph (5) of such section) for the calendar year, the monthly amount of the beneficiary premium applicable under this section for a month after December 2010 shall be increased by the monthly adjustment amount specified in subparagraph (B).

''(B) MONTHLY ADJUSTMENT AMOUNT.—The monthly adjustment amount specified in this subparagraph for an individual for a month in a year is equal to the product of—

''(i) the quotient obtained by dividing—

''(I) the applicable percentage determined under paragraph (3)(C) of section 1839(i) (including application of paragraph (5) of such section) for the individual for the calendar year reduced by 25.5 percent; by

''(II) 25.5 percent; and

''(ii) the base beneficiary premium (as computed under paragraph (2)).

''(C) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this paragraph, the

term 'modified adjusted gross income' has the meaning given such term in subparagraph (A) of section 1839(i)(4), determined for the taxable year applicable under subparagraphs (B) and (C) of such section.

''(D) DETERMINATION BY COMMISSIONER OF SOCIAL SECURITY.—The Commissioner of Social Security shall make any determination necessary to carry out the income-related increase in the base beneficiary premium under this paragraph.

''(E) PROCEDURES TO ASSURE CORRECT INCOME-RELATED INCREASE IN BASE BENEFICIARY PREMIUM.—

''(i) DISCLOSURE OF BASE BENEFICIARY PREMIUM.—Not later than September 15 of each year beginning with 2010, the Secretary shall disclose to the Commissioner of Social Security the amount of the base beneficiary premium (as computed under paragraph (2)) for the purpose of carrying out the income-related increase in the base beneficiary premium under this paragraph with respect to the following year.

"(ii) ADDITIONAL DISCLOSURE.—Not later than 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 increase in the base beneficiary premium 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 (5) 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 necessary to carry out the income-related increase in the base

beneficiary premium under this paragraph.

''(F) RULE OF CONSTRUCTION.—The formula used to determine the monthly adjustment amount specified under subparagraph (B) shall only be used for the purpose of determining such monthly adjustment amount under such subparagraph.''.

(2) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—Section 1860D–13(c) of the Social Security Act (42 U.S.C. 1395w–113(c)) is amended—

(A) in paragraph (1), by striking ''(2) and (3)'' and inserting ''(2), (3), and (4)''; and

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

''(4) COLLECTION OF MONTHLY ADJUSTMENT AMOUNT.—

''(A) IN GENERAL.—Notwithstanding any provision of this subsection or section 1854(d)(2), subject to subparagraph (B), the amount of the income-related increase in the base beneficiary premium for an individual for a month (as determined under subsection (a)(7)) shall be paid through withholding from

benefit payments in the manner provided under section 1840.

''(B) AGREEMENTS.—In the case where the monthly benefit payments of an individual that are withheld under subparagraph (A) are insufficient to pay the amount described in such subparagraph, the Commissioner of Social Security shall enter into agreements with the Secretary, the Director of the Office of Personnel Management, and the Railroad Retirement Board as necessary in order to allow other agencies to collect the amount described in subparagraph (A) that was not withheld under such subparagraph.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1860D–13(a)(1) of the Social Security Act (42 U.S.C. 1395w–113(a)(1)) is amended—

(A) by redesignating subparagraph (F) as subparagraph (G);

(B) in subparagraph (G), as redesignated by subparagraph (A), by striking ''(D) and (E)'' and inserting ''(D), (E), and (F)''; and

(C) by inserting after subparagraph (E) the following new subparagraph:

''(F) INCREASE BASED ON INCOME.—The monthly beneficiary premium shall be increased pursuant to paragraph (7).''.

(2) INTERNAL REVENUE CODE.—Section 6103(l)(20) of the Internal Revenue Code of 1986 (relating to disclosure of return information to carry out Medicare part B premium subsidy adjustment) is amended—

(A) in the heading, by inserting ''AND PART D BASE BENEFICIARY PREMIUM INCREASE'' and inserting ''PART B PREMIUM SUBSIDY ADJUSTMENT'';

(B) in subparagraph (A)—

(i) in the matter preceding clause (i), by inserting ''or increase under section 1860D–13(a)(7)'' after ''1839(i)''; and

(ii) in clause (vii), by inserting after ''subsection (i) of such section'' the following: ''or increase under section 1860D–13(a)(7) of such Act''; and

(C) in subparagraph (B)—

(i) by striking ''Return information'' and inserting the following:

''(i) IN GENERAL.—Return information'';

(ii) by inserting ''or increase under such section 1860D–13(a)(7)'' before the period at the end;

(iii) as amended by clause (i), by inserting ''or for the purpose of resolving taxpayer appeals with respect to any such premium adjustment or increase'' before the period at the end; and

(iv) by adding at the end the following new clause:

''(ii) DISCLOSURE TO OTHER AGENCIES.—Officers, employees, and contractors of the Social Security Administration may disclose—

''(I) the taxpayer identity information and the amount of the premium subsidy adjustment or premium increase with respect to a taxpayer described in subparagraph (A) to officers, employees, and contractors of the Centers for Medicare and Medicaid Services, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

''(II) the taxpayer identity information and the amount of the premium subsidy adjustment or the increased premium amount with respect to a taxpayer described in subparagraph (A) to officers and employees of the Office of Personnel Management and the Railroad Retirement Board, to the extent that such disclosure is necessary for the collection of the premium subsidy amount or the increased premium amount,

''(III) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Health and Human Services to the extent necessary to resolve administrative appeals of such premium subsidy adjustment or increased premium, and

''(IV) return information with respect to a taxpayer described in subparagraph (A) to officers and employees of the Department of Justice for use in judicial proceedings to the ex-

tent necessary to carry out the purposes described in clause (i).''.

SEC. 3309. SIMPLIFICATION OF PLAN INFORMATION.

(a) PRESCRIPTION DRUG PLANS.—Section 1860D–1(c) of the Social Security Act (42 U.S.C. 1395w–101(c)) is amended by adding at the end the following new paragraph:

''(5) CATEGORIZATION OF PLANS.—

''(A) IN GENERAL.—The Secretary shall do the following:

''(i) Establish 2 or more categories of prescription drug plans offered by PDP sponsors and MA–PD plans offered by Medicare Advantage organizations based on the actuarial value or range of values of the prescription drug benefits, including supplemental prescription drug coverage, provided under the plans as of the date of enactment of this subsection.

''(ii) Develop standardized nomenclature, definitions, and language to describe the prescription drug benefits provided under the plans in each such category.

"(iii) Ensure that the Medicare Prescription Drug Plan Finder on the Internet website of the Department of Health and Human Services includes the plan name under subparagraph (B).

"(iv) In establishing categories of prescription drug plans and MA–PD plans under clause (i), the Secretary shall ensure that there is a meaningful difference between the actuarial value of prescription drug benefits provided under the plans in different categories.

"(B) REQUIRED INCLUSION OF CATEGORY IN PLAN NAME AND MARKETING MATERIALS.—For plan years beginning on or after January 1, 2011, a PDP sponsor shall ensure that the name of each prescription drug plan offered by the PDP sponsor and any marketing materials with respect to such plan include the category of the plan, as determined under subparagraph (A) (using standardized nomenclature, definitions, and language developed by the Secretary under such subparagraph).".

(b) MA–PD PLANS.—Section 1856(f)(3) of the Social Security Act (42 U.S.C. 1395w–26(f)(3)) is amended by adding at the end the following new subparagraph:

"(D) REQUIRED INCLUSION OF CATEGORY IN PLAN NAME AND MARKETING MATERIALS.—Section 1860D–1(c)(5)(B).".

SEC. 3310. LIMITATION ON REMOVAL OR CHANGE OF COVERAGE OF COVERED PART D DRUGS UNDER A FORMULARY UNDER A PRESCRIPTION DRUG PLAN OR AN MA–PD PLAN.

(a) LIMITATION ON REMOVAL OR CHANGE.—Section 1860D–4(b)(3)(E) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)(E)) is amended to read as follows:

"(E) REMOVING OR CHANGING A DRUG ON A FORMULARY.—

"(i) LIMITATION.—Subject to clause (ii), with respect to plan years beginning on or after January 1, 2011, the PDP sponsor of a prescription drug plan may not remove a covered part D drug from the plan formulary, apply a cost or utilization management tool that imposes a restriction or limitation on the coverage of such a drug (such as through the application of a preferred status, usage restriction, step

therapy, prior authorization, or quantity limitation), or increase the cost-sharing of such a drug (such as through placement of a drug on a tier that would result in higher cost-sharing for a beneficiary) other than on a date specified by the Secretary (but not later than the date on which PDP sponsors begin marketing their plans with respect to the immediately succeeding plan year).

''(ii) EXCEPTIONS TO LIMITATION ON REMOVAL.—Subject to clause (iii), clause (i) shall not apply with respect to a covered part D drug that—

''(I) is a brand name drug for which there is a generic drug approved under section 505(j) of the Food and Drug Cosmetic Act that is placed on the market during the period in which there are limitations on removal or change in the formulary under clause (i);

''(II) is a drug for which the Commissioner of Food and Drugs issues a safety warning that would im-

pose a restriction on the drug or require a drug label warning during the plan year;

"(III) is a drug that the Pharmacy and Therapeutic Committee of the plan determines, based directly on evidence from peer-reviewed research, has a lower safety profile than is appropriate or is ineffective; or

"(IV) for which the Secretary establishes a specific exception through the promulgation of regulations relating to plan formularies.

"(iii) LIMITED APPLICATION OF EXCEPTIONS TO DRUGS IN CERTAIN CATEGORIES AND CLASSES.—Subclauses (I), (III), and (IV) of clause (ii) shall not apply to a drug in a category or class identified under subparagraph (G)(i).

"(iv) NOTICE OF REMOVAL UNDER APPLICATION OF EXCEPTION TO LIMITATION.—The PDP sponsor of a prescription drug plan shall provide appropriate notice (such as under subsection (a)(3) and including the annual notice under subsection

(a)(5)) of any removal or change under clause (ii) to the Secretary, affected enrollees, physicians, pharmacies, and pharmacists.''.

(b) NOTICE FOR CHANGE IN FORMULARY AND OTHER RESTRICTIONS OR LIMITATIONS ON COVERAGE.—

(1) IN GENERAL.—Section 1860D–4(a) of the Social Security Act (42 U.S.C. 1395w–104(a)) is amended by adding at the end the following new paragraph:

''(5) ANNUAL NOTICE OF CHANGES IN FORMULARY AND OTHER RESTRICTIONS OR LIMITATIONS ON COVERAGE.—Each PDP sponsor of a prescription drug plan shall furnish to each enrollee at the time of each annual coordinated election period (referred to in section 1860D–1(b)(1)(B)(iii)) for a plan year a notice of any changes in the formulary or other restrictions or limitations on coverage of any covered part D drug under the plan that will take effect for the plan year.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to annual coordinated election periods beginning on or after January 1, 2010.

SEC. 3311. ELIMINATION OF COST SHARING FOR CERTAIN DUAL ELIGIBLE INDIVIDUALS.

Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended by inserting ''or, effective on a date specified by the Secretary (but in no case earlier than January 1, 2012), who would be such an institutionalized individual or couple, if the full-benefit dual eligible individual were not receiving services under a home and community-based waiver authorized for a State under section 1115 or subsection (c) or (d) of section 1915 or under a State plan amendment under subsection (i) of such section or services provided through enrollment in a medicaid managed care organization'' after ''1902(q)(1)(B))''.

SEC. 3312. REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES UNDER PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(c) of the Social Security Act (42 U.S.C. 1395w–104(c)) is amended by adding at the end the following new paragraph:

''(3) REDUCING WASTEFUL DISPENSING OF OUTPATIENT PRESCRIPTION DRUGS IN LONG-TERM CARE FACILITIES.—The Secretary shall require PDP sponsors of prescription drug plans to utilize specific drug dispensing techniques, as determined by the

Secretary, such as weekly, daily, or automated dose dispensing, when dispensing medications to enrollees who reside in a long-term care facility in order to reduce waste associated with 30-day fills.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to plan years beginning on or after January 1, 2012.

SEC. 3313. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) PLAN COMPLAINT SYSTEM.—

(1) IN GENERAL.—The Secretary shall develop and maintain a compliant system to collect and maintain information on MA–PD plan and prescription drug plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a sub-contractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1874A of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the compliant is resolved.

(2) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints

under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website and on the Internet website of the Medicare Beneficiary Ombudsman.

(3) ANNUAL REPORTS BY THE SECRETARY.—The Secretary shall submit to Congress an annual report on the system. Such study shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(4) DEFINITIONS.—In this section:

(A) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(B) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

(C) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(D) SYSTEM.—The term ''system'' means the plan complaint system developed and maintained under paragraph (1).

(b) FUNDING.—There are authorized to be appropriated such sums as may be necessary for the costs of carrying out this section.

SEC. 3314. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

''(H) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, each PDP sponsor of a prescription drug plan shall, to the extent the Secretary determines feasible—

''(i) use a single, uniform exceptions and appeals process (including a single, uniform model form for use under such process) with respect to the determination of prescription drug coverage for an enrollee under the plan; and

"(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2012.

SEC. 3315. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(2) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with

such recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICAID.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(i) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title (as determined by the Inspector General based on volume and expenditures), of—

(I) the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

(II) the prices paid for covered outpatient drugs by a State plan under title XIX.

(ii) An assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal government; and

(II) the financial impact of any such discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan under title XIX.

(B) PRICE.—For purposes of subparagraph (A), the price of a covered part D drug or a covered outpatient drug shall include any rebate or discount under such program or such title, respectively, including any negotiated price concession described in section 1860D–2(d)(1)(B) of the Social Security Act (42 U.S.C. 1395w–102(d)(1)(B)) or rebate under an agreement under section 1927 of the Social Security Act (42 U.S.C. 1396r–8).

(C) AUTHORITY TO COLLECT ANY NECESSARY INFORMATION.—Notwithstanding any other provision of law, the Inspector General of

the Department of Health and Human Services shall be able to collect any information related to the prices of covered part D drugs under such program and covered outpatient drugs under such title XIX necessary to carry out the comparison under subparagraph (A).

(2) REPORT.—

(A) IN GENERAL.—Not later than October 1, 2011, subject to subparagraph (B), the Inspector General shall submit to Congress a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

(B) LIMITATION ON INFORMATION CONTAINED IN REPORT.—The report submitted under subparagraph (A) shall not include any information that the Inspector General determines is proprietary or is likely to negatively impact the ability of a PDP sponsor or a State plan under title XIX to negotiate prices for covered part D drugs or covered outpatient drugs, respectively.

(3) DEFINITIONS.—In this section:

(A) COVERED PART D DRUG.—The term ''covered part D drug'' has the meaning given such term in section 1860D–2(e) of the Social Security Act (42 U.S.C. 1395w–102(e)).

(B) COVERED OUTPATIENT DRUG.—The term ''covered outpatient drug'' has the meaning given such term in section 1927(k) of such Act (42 U.S.C. 1396r(k)).

(C) MA–PD PLAN.—The term ''MA–PD plan'' has the meaning given such term in section 1860D–41(a)(9) of such Act (42 U.S.C. 1395w–151(a)(9)).

(D) MEDICARE ADVANTAGE ORGANIZATION.—The term ''Medicare Advantage organization'' has the meaning given such term in section 1859(a)(1) of such Act (42 U.S.C. 1395w–28)(a)(1)).

(E) PDP SPONSOR.—The term ''PDP sponsor'' has the meaning given such term in section 1860D–41(a)(13) of such Act (42 U.S.C. 1395w–151(a)(13)).

(F) PRESCRIPTION DRUG PLAN.—The term ''prescription drug plan'' has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(14)).

SEC. 3316. HHS STUDY AND ANNUAL REPORTS ON COVERAGE FOR DUAL ELIGIBLES.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a study to track—

(A) how many of the new full benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1395u–5(c)(6))) enroll in a plan under part D of title XVIII of such Act and receive retroactive prescription drug coverage under the plan; and

(B) if such retroactive coverage is provided to such individuals—

(i) the number of months of coverage provided; and

(ii) the amount of reimbursements to individuals and to individuals that made payments for prescription drugs on their behalf for costs incurred during retroactive coverage periods.

(2) DATA TO USE.—In conducting the study with respect to the requirements under paragraph (1)(B), the Secretary shall examine prescription drug utilization data reported by prescription drug

plans under part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.).

(b) ANNUAL REPORTS ON ONGOING STUDY.—Not later than January 1 of each year (beginning with 2012), the Secretary shall submit a report to Congress containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(c) ANNUAL REPORTS ON SPENDING AND OUTCOMES.—Not later than January 1 of each year (beginning with 2013), the Secretary shall collect data and submit a report to Congress that includes the following information:

(1) Annual total expenditures (disaggregated by Federal and State expenditures) for dually eligible beneficiaries under title XVIII and under State plans and waivers under title XIX.

(2) An analysis of health outcomes for dually eligible beneficiaries, disaggregated by subtypes of beneficiaries (as determined by the Secretary).

(3) An analysis of the extent to which dually eligible beneficiaries are able to access benefits under title XVIII and under State plans and waivers under title XIX.

SEC. 3317. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT-OF-POCKET THRESHOLD UNDER PART D.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

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

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

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

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (i)—

(A) in subclause (XIX), by striking ''and'' at the end;

(B) in subclause (XX)—

(i) by striking ''for each subsequent fiscal year'' and inserting ''for each of fiscal years 2007 through 2009''; and

(ii) by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new subclauses:

''(XXI) for each of fiscal years 2010 through 2019, subject to clause (viii), the market basket percentage increase for hospitals in all areas minus the additional adjustment factor described in clause (x); and

''(XXII) for each subsequent fiscal year, subject to clause (viii), the market basket percentage increase for hospitals in all areas.'';

(2) in clause (iii)—

(A) by striking ''(iii) For purposes of this subparagraph,'' and inserting ''(iii)(I) For purposes of this subparagraph,'';

(B) in subclause (I), as added by subparagraph (A), by adding at the end the following new sentences: ''For 2012 and each subsequent fiscal year, such increase shall be reduced by the productivity adjustment described in subclause (II). Except as otherwise provided, any reference to the increase described in this clause shall be a reference to the percentage increase described in this subclause minus the percentage change described subclause (II).''

(C) by adding at the end the following new subclause:

''(II) The productivity adjustment described in this subclause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity adjustment equal to the 10-year moving average of changes in annual economy-wide private nonfarm business multi-factor productivity (as projected by the Secretary for the applicable fiscal year, year, cost reporting period, or other annual period).''; and

(D) by adding at the end the following new clauses:

''(x) For purposes of clause (i)(XXI), the additional adjustment factor described in this clause is—

''(I) for each of fiscal years 2010 and 2011, 0.25 percent; and

''(II) subject to clause (xi), for each of fiscal years 2012 through 2019, 0.2 percent.

''(xi) If, for each of fiscal years 2014 through 2019, the total percentage of the non-elderly insured population for the preceding fiscal year is greater than 5 percentage points below the projection of the total percentage of the non-elderly insured population for such preceding fiscal year (as of the date of enactment of the America's Healthy Future Act of 2009), as estimated by the Secretary, the additional adjustment factor described in clause (x) for the fiscal year shall be 0.0 percent.''.

(b) SKILLED NURSING FACILITIES.—Section 1888(e)(5)(B) of the Social Security Act (42 U.S.C. 1395yy(e)(4)) is amended by adding at the end the following new sentence: ''For fiscal year 2012 and each subsequent fiscal year, the percentage described in the preceding sentence shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(c) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)) is amended by adding at the end the following new paragraphs:

"(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—In implementing the system described in paragraph (1) for rate year 2010 and each subsequent rate year, to the extent that an annual percentage increase factor applies to a standard Federal rate for discharges for the hospital during the rate year, the following shall apply:

"(A) UPDATE FOR RATE YEARS 2010 THROUGH 2019.—For discharges occurring during each of rate years 2010 through 2019, the standard Federal rate for such discharges for the hospital shall be increased by the annual percentage increase factor minus the additional adjustment factor described in paragraph (4).

"(B) PRODUCTIVITY ADJUSTMENT.—For discharges occurring during rate year 2012 and each subsequent rate year, such annual percentage increase factor shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).

"(4) ADDITIONAL ADJUSTMENT FACTOR DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (3)(A), the additional adjustment factor described in this paragraph is—

"(i) for each of rate years 2010 and 2011, 0.25 percent; and

"(ii) subject to subparagraph (B), for each of rate years 2012 through 2019, 0.2 percent.

"(B) REDUCTION OF ADJUSTMENT FACTOR FOR CERTAIN HOSPITALS.—If, for each of rate years 2014 through 2019, the total percentage of the non-elderly insured population for the preceding rate year is greater than 5 percentage points below the projection of the total percentage of the non-elderly insured population for such preceding rate year (as of the date of enactment of the America's Healthy Future Act of 2009), as estimated by the Secretary, the additional adjustment factor described in subparagraph (A) for the rate year shall be 0.0 percent.".

(d) INPATIENT REHABILITATION FACILITIES.—Section 1886(j)(3) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended—

(1) in subparagraph (A)(i), by inserting "(for fiscal years before 2010 and for fiscal year 2020 and subsequent fiscal years)" after "2000 and";

(2) in subparagraph (C), by adding at the end the following new sentence: ''For fiscal year 2012 and each subsequent fiscal year, the appropriate percentage increase described in the preceding sentence shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)).''; and

(3) by adding at the end the following new subparagraph:

''(D) UPDATE FOR FISCAL YEARS 2010 THROUGH 2019.—

''(i) IN GENERAL.—For purposes of this subsection for payment units in each of fiscal years 2010 through 2019, the payment rate determined under this paragraph shall be increased by the increase factor described in subparagraph (C) minus the additional adjustment factor described in clause (ii).

''(ii) ADDITIONAL ADJUSTMENT FACTOR DESCRIBED.—For purposes of clause (i), the additional adjustment factor described in this clause is—

''(I) for each of fiscal years 2010 and 2011, 0.25 percent; and

"(II) subject to clause (iii), for each of fiscal years 2012 through 2019, 0.2 percent.

"(iii) REDUCTION OF ADJUSTMENT FACTOR FOR CERTAIN REHABILITATION FACILITIES.—If, for each of fiscal years 2014 through 2019, the total percentage of the non-elderly insured population for the preceding fiscal year is greater than 5 percentage points below the projection of the total percentage of the non-elderly insured population for such preceding fiscal year (as of the date of enactment of the America's Healthy Future Act of 2009), as estimated by the Secretary, the additional adjustment factor described in clause (ii) for the fiscal year shall be 0.0 percent.".

(e) HOME HEALTH AGENCIES.—Section 1895(b)(3) of the Social Security Act (42 U.S.C. 1395fff(b)(3)) is amended—

(1) in subparagraph (B)—

(A) in clause (ii)—

(i) in subclause (IV), by striking "and";

(ii) in subclause (V)—

(I) by striking ''any subsequent year'' and inserting ''each of 2007, 2008, 2009, and 2010''; and

(II) by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following subclauses:

''(VI) each of 2011 and 2012, subject to clause (v), the home health market basket percentage increase minus the additional adjustment factor described in subparagraph (D); and

''(VII) any subsequent year, subject to clause (v), the home health market basket percentage increase.''; and

(B) in clause (iii), by inserting ''(including, for 2015 and each subsequent year, being reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II))'' after ''in the same manner''; and

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

"(D) ADDITIONAL ADJUSTMENT FACTOR DESCRIBED.—For purposes of subparagraph (B)(ii)(VI), the additional adjustment factor described in this subparagraph is 1.0 percent.".

(f) PSYCHIATRIC HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, 3133, is amended by adding at the end the following new subsection:

"(s) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

"(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the matter following clause (v) of such subsection), see section 124 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

"(2) IMPLEMENTATION FOR RATE YEAR BEGINNING IN 2010 AND SUBSEQUENT RATE YEARS.—In implementing the system described in paragraph (1) for the rate year beginning in 2010 and any subse-

quent rate year, to the extent that an annual percentage increase factor applies to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, the following shall apply:

"(A) UPDATE FOR RATE YEARS BEGINNING IN 2010 THROUGH 2019.—For days occurring during each of the rate years beginning in 2010 through 2019, the base rate for such days for the hospital or unit shall be increased by the annual percentage increase factor minus the additional adjustment factor described in paragraph (3).

"(B) PRODUCTIVITY ADJUSTMENT.—For days occurring during the rate year beginning in 2012 and any subsequent rate year, such factor shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).

"(3) ADDITIONAL ADJUSTMENT FACTOR DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (2)(A), the additional adjustment factor described in this paragraph is—

"(i) for each of the rate years beginning in 2010 and 2011, 0.25 percent; and

"(ii) subject to subparagraph (B), for each of the rate years beginning in 2012 through 2019, 0.2 percent.

"(B) REDUCTION OF ADJUSTMENT FACTOR FOR CERTAIN PSYCHIATRIC HOSPITALS AND UNITS.—If, for each of the rate years beginning in 2014 through 2019, the total percentage of the non-elderly insured population for the rate year beginning in the preceding year is greater than 5 percentage points below the projection of the total percentage of the non-elderly insured population for the rate year beginning in such preceding year (as of the date of enactment of the America's Healthy Future Act of 2009), as estimated by the Secretary, the additional adjustment factor described in subparagraph (A) for the rate year shall be 0.0 percent.".

(g) HOSPICE CARE.—Section 1814(i)(1)(C) of the Social Security Act (42 U.S.C. 1395f(i)(1)(C)), as amended by section 3132, is amended—

(1) in clause (ii)—

(A) in subclause (VI), by striking "and" at the end; and

(B) in subclause (VII)—

(i) by striking ''for a subsequent fiscal year (before fiscal year 2014)'' and inserting ''for each of fiscal years 2003 through 2012'';

(ii) by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new subclause:

''(VIII) for fiscal year 2013, the market basket percentage increase for the fiscal year (which is reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)) minus the additional adjustment factor described in clause (iv).'';

(2) in clause (iii)—

(A) in subclause (I)—

(i) by inserting ''(which is reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)) minus the additional adjustment factor described in clause (iv)'' before the semicolon at the end; and

(ii) by striking ''and'' at the end;

(B) in subclause (II)—

(i) by striking ''for a subsequent fiscal year'' and inserting ''for each of fiscal

years 2015 through 2019, subject to clause (v),'';

(ii) by inserting ''(which is reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)) minus the additional adjustment factor described in clause (iv)'' after ''for the fiscal year''; and

(iii) by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(III) for a subsequent fiscal year, the payment rates in effect under this clause during the previous fiscal year increased by the market basket percentage increase for the fiscal year (which is reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)).''; and

(3) by adding at the end the following new clauses:

''(iv) For purposes of clause (ii)(VIII) and clause (iii)(II), the additional adjustment factor described in this clause is 0.5 percent.

''(v) If, for each of fiscal years 2014 through 2019, the total percentage of the non-elderly insured population for the preceding fiscal year is greater than 5 percentage

points below the projection of the total percentage of the non-elderly insured population for such preceding fiscal year (as of the date of enactment of the America's Healthy Future Act of 2009), as estimated by the Secretary, the additional adjustment factor described in clause (iv) for the fiscal year shall be 0.0 percent''.

(h) DIALYSIS.—Section 1881(b)(14)(F) of the Social Security Act (42 U.S.C. 1395rr(b)(14)(F)) is amended by striking ''minus 1.0 percentage points'' and inserting ''reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'' each place it appears in clauses (i) and (ii)(II).

(i) OUTPATIENT HOSPITALS.—Section 1833(t)(3) of the Social Security Act (42 U.S.C. 1395l(t)(3)) is amended—

(1) in subparagraph (C)(iv)—

(A) in the first sentence, by inserting (which, for fiscal year 2012 and each subsequent fiscal year, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)) after ''1886(b)(3)(B)(iii)''; and

(B) in the second sentence, by inserting '', and which, for 2012 and each subsequent year, is reduced by the productivity adjustment de-

scribed in section 1886(b)(3)(iii)(II)'' before the period at the end; and

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

''(F) UPDATE FOR 2010 THROUGH 2019.—

''(i) IN GENERAL.—With respect to covered OPD services furnished in each of 2010 through 2019, the amount of payment under the prospective payment system established under this subsection shall be increased by the increase factor described in subparagraph (C) minus the additional adjustment factor described in clause (ii).

''(ii) ADDITIONAL ADJUSTMENT FACTOR DESCRIBED.—For purposes of clause (i), the additional adjustment factor described in this clause is—

''(I) for each of 2010 and 2011, 0.25 percent; and

''(II) subject to clause (iii), for each of 2012 through 2019, 0.2 percent.

''(iii) REDUCTION OF ADJUSTMENT FACTOR FOR CERTAIN HOSPITALS.—If, for

each of 2014 through 2019, the total percentage of the non-elderly insured population for the preceding year is greater than 5 percentage points below the projection of the total percentage of the non-elderly insured population for such preceding year (as of the date of enactment of the America's Healthy Future Act of 2009), as estimated by the Secretary, the additional adjustment factor described in clause (ii) for the year shall be 0.0 percent.''.

(j) AMBULANCE SERVICES.—Section 1834(l)(3)(B) of the Social Security Act (42 U.S.C. 1395m(l)(3)(B)) is amended by inserting before the period at the end the following: ''and, in the case of 2011 and each subsequent year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)''.

(k) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

(1) by redesignating clause (v) as clause (vi); and

(2) by inserting after clause (iv) the following new clause:

''(v) In implementing the system described in clause (i), for services furnished during 2011 and each subsequent year, to the extent that an annual percentage change factor applies, such factor shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II).''.

(l) LABORATORY SERVICES.—Section 1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)) is amended—

(1) in clause (i), by striking ''minus, for each of the years 2009 through 2013, 0.5 percentage points'' and inserting ''reduced, for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II), except that the application of such productivity adjustment shall not result in the annual adjustment under this clause being less than 0.0''; and

(2) in clause (ii)—

(A) by striking ''and'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting a comma; and

(C) by adding at the end the following new subclauses:

"(V) the annual adjustment in the fee schedules, as determined under clause (i), for each of 2009 and 2010 shall be reduced by 0.5 percentage points,

"(VI) the annual adjustment in the fee schedules, as determined under clause (i), for each of the years 2011 through 2014 shall be reduced by 1.75 percentage points (which may include a reduction below zero), and

"(VII) the annual adjustment in the fee schedules, as determined under clause (i), for 2015 shall be reduced by 1.95 percentage points (which may include a reduction below zero).".

(m) CERTAIN DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—

(1) by redesignating subparagraphs (L) and (M) as subparagraphs (M) and (N), respectively;

(2) in subparagraph (K), by striking "2011, 2012, and 2013,";

(3) by inserting after subparagraph (K), the following new subparagraph:

"(L) for 2011, 2012, and 2013, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II);".

(4) in subparagraph (M), as redesignated by paragraph (1)—

(A) in clause (i), by striking ", plus 2.0 percentage points"; and

(B) in each of clauses (i) and (ii), by inserting "reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)," after "June 2013,"; and

(5) in subparagraph (N), as redesignated by paragraph (1), by inserting ", reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)" before the period at the end.

(n) PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Section 1834(h)(4)(A)(x) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)(x)) is amended by inserting "and, in the case of 2011 and each subsequent

year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'' before the semicolon at the end.

(o) OTHER ITEMS.—The second sentence of section 1842(s)(1) of the Social Security Act (42 U.S.C. 1395u(s)(1)), in the matter preceding subparagraph (A), is amended by inserting ''and, in the case of 2011 and each subsequent year, reduced by the productivity adjustment described in section 1886(b)(3)(B)(iii)(II)'' after ''preceding year''.

(p) NO APPLICATION PRIOR TO JANUARY 1, 2010.—Notwithstanding the preceding provisions of this section—

(1) the amendments made by subsections (a), (c), and (d) shall not apply to discharges occurring before January 1, 2010; and

(2) the amendments made by subsection (f) shall not apply to days occurring before January 1, 2010.

SEC. 3402. TEMPORARY ADJUSTMENT TO THE CALCULATION OF PART B PREMIUMS.

Section 1839(i) of the Social Security Act (42 U.S.C. 1395r(i)) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by inserting ''subject to paragraph (6),'' after ''subsection,'';

(2) in paragraph (3)(A)(i), by striking ''The applicable'' and inserting ''Subject to paragraph (6), the applicable'';

(3) by redesignating paragraph (6) as paragraph (7); and

(4) by inserting after paragraph (5) the following new paragraph:

''(6) TEMPORARY ADJUSTMENT TO INCOME THRESHOLDS.—Notwithstanding any other provision of this subsection, during the period beginning on January 1, 2011, and ending on December 31, 2019—

''(A) the threshold amount otherwise applicable under paragraph (2) shall be equal to such amount for 2010; and

''(B) the dollar amounts otherwise applicable under paragraph (3)(C)(i) shall be equal to such dollar amounts for 2010.''.

SEC. 3403. MEDICARE COMMISSION.

(a) COMMISSION.—

(1) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 3022, is amended by adding at the end the following new section:

''MEDICARE COMMISSION

''SEC. 1899A. (a) ESTABLISHMENT.—There is established an independent commission to be known as the 'Medicare Commission'

''(b) PURPOSE.—It is the purpose of this section to, in accordance with the following provisions of this section, reduce the per capita rate of growth in Medicare spending—

''(1) by requiring the Chief Actuary of the Centers for Medicare & Medicaid Services to determine in each year to which this section applies (in this section referred to as 'a determination year ') the projected per capita growth rate under Medicare for the second year following the determination year (in this section referred to as 'an implementation year');

''(2) if the projection for the implementation year exceeds the target growth rate for that year, by requiring the Commission to develop and submit during the first year following the determination year (in this section referred to as 'a proposal year ') a proposal to reduce the Medicare per capita growth rate to the extent required by this section; and

''(3) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

''(c) COMMISSION PROPOSALS.—

''(1) DEVELOPMENT AND SUBMISSION.—

''(A) IN GENERAL.—The Commission shall develop and submit detailed and specific proposals to Congress in accordance with the succeeding provisions of this section.

''(B) ADVISORY REPORTS.—Beginning January 1, 2014, the Commission may submit to Congress advisory reports on matters related to the Medicare program, regardless of whether or not the Commission submitted a proposal for such year. Such a report may, for years prior to 2020, include recommendations regarding improvements to payment systems for providers of services and suppliers who are not otherwise subject to the scope of the Commission's recommendations in a proposal under this section. Any advisory report submitted under this subparagraph shall not be subject to the rules for congressional consideration under subsection (d).

''(2) SCOPE OF PROPOSALS.—

"(A) REQUIREMENTS.—Each proposal submitted under this section in a proposal year shall meet each of the following requirements:

"(i) If the Chief Actuary of the Centers for Medicare & Medicaid Services has made a determination under paragraph (5)(A) in the determination year, the proposal shall include recommendations so that the proposal as a whole (after taking into account recommendations under clause (v)) will result in a net reduction in total Medicare program spending in the implementation year equal to the applicable savings target established under paragraph (5)(B) for such implementation year. In determining whether a proposal meets the requirement of the preceding sentence, reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation of recommendations contained in the proposal for a change in the payment rate for an item or service that was effective during

such period pursuant to subsection (e)(2)(A).

''(ii) The proposal shall not include any recommendation to ration health care, raise revenues or Medicare beneficiary premiums under section 1818, 1818A, or 1839, increase Medicare beneficiary cost-sharing (including deductibles, coinsurance, and copayments), or otherwise restrict benefits or modify eligibility criteria.

''(iii) In the case of proposals submitted prior to December 31, 2018, the proposal shall not include any recommendation that would impact, prior to December 31, 2019, providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d)) scheduled to receive a reduction to the inflationary payment updates of such providers of services and suppliers in excess of a reduction due to productivity in a year in which such recommendations would take effect.

''(iv) As appropriate, the proposal shall include recommendations to reduce

Medicare payments under parts C and D, such as reductions under such parts in the Federal premium subsidies to Medicare Advantage and prescription drug plans and the performance bonuses.

''(v) The proposal shall include recommendations with respect to administrative funding for the Secretary to carry out the recommendations contained in the proposal.

''(B) ADDITIONAL CONSIDERATIONS.—In developing and submitting each proposal under this section in a proposal year, the Commission shall, to the extent feasible—

''(i) include recommendations that target reductions in Medicare program spending to sources of excess cost growth;

''(ii) include recommendations that—

''(I) improve the health care delivery system and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement; and

"(II) protect and improve Medicare beneficiaries' access to necessary and evidence-based items and services, including in rural and frontier areas;

"(iii) give priority to recommendations that extend Medicare solvency;

"(iv) consider the effects on Medicare beneficiaries of changes in payments to providers of services (as defined in section 1861(u)) and suppliers (as defined in section 1861(d));

"(v) consider the effects of the recommendations on providers of services and suppliers with actual or projected negative cost margins or payment updates; and

"(vi) consider the unique needs of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under title XIX.

"(C) NO INCREASE IN TOTAL MEDICARE PROGRAM SPENDING.—Each proposal submitted under this section shall be designed in such a manner that implementation of the recommendations contained in the proposal would not be expected to result, over the 10-year pe-

riod starting with the implementation year, in any increase in the total amount of net Medicare program spending relative to the total amount of net Medicare program spending that would have occurred absent such implementation.

''(D) CONSULTATION WITH MEDPAC.—The Commission shall submit a draft copy of each proposal to be submitted to Congress under this section to the Medicare Payment Advisory Commission established under section 1805 for its review. The commission shall submit such draft copy by not later than September 1 of the year preceding the year for which the proposal is to be submitted. Not later than February 1 of the succeeding year, the Medicare Payment Advisory Commission shall submit a report to Congress on the results of such review.

''(E) REVIEW AND COMMENT BY THE SECRETARY.—The Commission shall submit a draft copy of each proposal to be submitted to Congress under this section to the Secretary for the Secretary's review and comment. The Commission shall submit such draft copy by not later than September 1 of the year preceding the

year for which the proposal is to be submitted. Not later than February 1 of the succeeding year, the Secretary shall submit a report to Congress on the results of such review, unless the Secretary submits a proposal under paragraph (3)(C) in that year.

''(F) CONSULTATIONS.—In carrying out its duties under this section, the Commission shall engage in regular consultations with the Medicaid and CHIP Payment and Access Commission under section 1900.

''(3) SUBMISSION.—

''(A) REQUIRED INFORMATION.—Each proposal submitted by the Commission to Congress under this section shall include—

''(i) an explanation of each recommendation contained in the proposal and the reasons for including such recommendation; and

''(ii) an actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the proposal meets the requirements of subparagraphs (A)(i) and (C) of paragraph (2).

''(B) DATES FOR SUBMISSION.—

''(i) IN GENERAL.—Except as provided in clause (ii) and subsection (f)(3)(B), the Commission shall submit a proposal to Congress on January 1, 2014, and annually thereafter.

''(ii) EXCEPTION.—The Commission shall not submit a proposal to Congress under this section in a proposal year if the year is—

''(I) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Services make a determination in the determination year under paragraph (4)(A) that the growth rate described in clause (i) of such paragraph does not exceed the growth rate described in clause (ii) of such paragraph; or

''(II) a year in which the percentage increase (if any) for the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average) for the implementation year is less than the percentage increase (if any)

in the Consumer Price Index for All Urban Consumers (all items; United States city average) for such implementation year;

"(III) the year referred to in subsection (f)(1)(A).

"(iii) START-UP PERIOD.—The Commission may not submit a proposal to Congress prior to January 1, 2014.

"(C) CONTINGENT SECRETARIAL SUBMISSION.—If, with respect to a proposal year, the Commission is required to but fails to submit a proposal by the deadline applicable under subparagraph (B)(i), the Secretary shall submit a detailed and specific proposal to Congress that satisfies the requirements of subparagraph (A) and subparagraphs (A), (B), and (C) of paragraph (2) not later than January 5 of the year. The Secretary shall transmit a copy of the proposal to the Medicare Payment Advisory Commission for its review. The Medicare Payment Advisory Commission shall submit a report to Congress on the results of such review by February 1 of the year.

"(4) PER CAPITA GROWTH RATE PROJECTIONS BY CHIEF ACTUARY.—

"(A) IN GENERAL.—Subject to subsection (f)(3)(A), not later than April 30, 2013, and annually thereafter, the Chief Actuary of the Centers for Medicare & Medicaid Services shall determine in each such year whether—

"(i) the projected Medicare per capita growth rate for the implementation year (as determined under subparagraph (B)); exceeds

"(ii) the projected Medicare per capita target growth rate for the implementation year (as determined under subparagraph (C)).

"(B) MEDICARE PER CAPITA GROWTH RATE.—

"(i) IN GENERAL.—For purposes of this section, the Medicare per capita growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

"(ii) REQUIREMENT.—The projection under clause (i) shall—

"(I) to the extent that there is projected to be a negative update to the single conversion factor applicable to payments for physicians' services under section 1848(d) furnished in the proposal year or the implementation year, assume that such update for such services is 0 percent rather than the negative percent that would otherwise apply; and

"(II) take into account any delivery system reforms or other payment changes that have been enacted or published in final rules but not yet implemented as of the making of such calculation.

"(C) MEDICARE PER CAPITA TARGET GROWTH RATE.—For purposes of this section, the Medicare per capita target growth rate for an implementation year shall be calculated as the projected 5-year average (ending with such year) percentage increase in—

"(i) in the case of a determination year that is prior to 2018, the average of the projected percentage increase (if any) in—

"(I) the Consumer Price Index for All Urban Consumers (all items; United States city average); and

"(II) the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average); and

"(ii) in the case of a determination year that is after 2017, the nominal gross domestic product per capita plus 1.0 percentage point.

"(5) SAVINGS REQUIREMENT.—

"(A) IN GENERAL.—If, with respect to a determination year, the Chief Actuary of the Centers for Medicare & Medicaid Services makes a determination under paragraph (4)(A) that the growth rate described in clause (i) of such paragraph exceeds the growth rate described in clause (ii) of such paragraph, the Chief Actuary shall establish an applicable savings target for the implementation year.

"(B) APPLICABLE SAVINGS TARGET.—For purposes of this section, the applicable savings target for an implementation year shall be an amount equal to the product of—

"(i) the total amount of projected Medicare program spending for the proposal year; and

"(ii) the applicable percent for the implementation year.

"(C) APPLICABLE PERCENT.—For purposes of subparagraph (B), the applicable percent for a projection is the lesser of—

"(i) in the case of—

"(I) implementation year 2015, 0.5 percent;

"(II) implementation year 2016, 1.0 percent;

"(III) implementation year 2017, 1.25 percent; and

"(IV) implementation year 2018 or any subsequent implementation year, 1.5 percent; and

"(ii) the projected excess for the implementation year (expressed as a percent) determined under subparagraph (A).

"(d) CONGRESSIONAL CONSIDERATION.—

"(1) COMMITTEE CONSIDERATION OF PROPOSAL; DISCHARGE; CONTINGENCY FOR INTRODUCTION.—Not later than April 1 of any proposal year in which a Commission proposal or Secretarial proposal is submitted to Congress under this section, the appropriate committees of Congress shall report legislation implementing the recommendations contained in the proposal or legislation that satisfies the requirements of subparagraphs (A), (B), and (C) of subsection (c)(2). If, with respect to the House involved, any such committee has not reported such legislation by such date, such committees shall be deemed to be discharged from further consideration of the proposal and any member of the House of Representatives or the Senate, respectively, may introduce legislation implementing the recommendations contained in the proposal and such legislation shall be placed on the appropriate calendar of the House involved.

"(2) EXPEDITED PROCEDURE.—

"(A) CONSIDERATION.—If legislation is reported out of committee or legislation is introduced under paragraph (1), not later than 15 calendar days after the date on which a com-

mittee has been or could have been discharged from consideration of such legislation or such legislation is introduced, the Speaker of the House of Representatives, or the Speaker's designee, or the majority leader of the Senate, or the leader's designee, shall move to proceed to the consideration of the legislation. It shall also be in order for any member of the Senate or the House of Representatives, respectively, to move to proceed to the consideration of the legislation at any time after the conclusion of such 15-day period. All points of order against the legislation (and against consideration of the legislation) with the exception of points of order under the Congressional Budget Act of 1974 and points of order to strike any matters extraneous to Medicare are waived. A motion to proceed to the consideration of the legislation is privileged in the Senate and highly privileged in the House of Representatives and is not debatable. The motion is not subject to amendment, to a motion to postpone consideration of the legislation, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion to pro-

ceed is agreed to or not agreed to shall not be in order. If the motion to proceed is agreed to, the Senate or the House of Representatives, as the case may be, shall immediately proceed to consideration of the legislation in accordance with the Standing Rules of the Senate or the House of Representatives, as the case may be, without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the Senate or the House of Representatives, as the case may be, until disposed of.

''(B) CONSIDERATION BY OTHER HOUSE.—If, before the passage by one House of the legislation that was introduced in such House, such House receives from the other House legislation as passed by such other House—

''(i) the legislation of the other House shall not be referred to a committee and shall immediately displace the legislation that was reported or introduced in the House in receipt of the legislation of the other House; and

"(ii) the legislation of the other House shall immediately be considered by the receiving House under the same procedures applicable to legislation reported by or discharged from a committee or introduced under paragraph (1).

Upon disposition of legislation that is received by one House from the other House, it shall no longer be in order to consider the legislation that was reported or introduced in the receiving House.

"(C) SENATE LIMITS ON DEBATE.—In the Senate, consideration of the legislation and on all debatable motions and appeals in connection therewith shall not exceed a total of 30 hours, which shall be divided equally between those favoring and those opposing the legislation. A motion further to limit debate on the legislation is in order and is not debatable. Any debatable motion or appeal is debatable for not to exceed 1 hour, to be divided equally between those favoring and those opposing the motion or appeal. All time used for consideration of the legislation, including time used for quorum calls and

voting, shall be counted against the total 30 hours of consideration.

''(D) CONSIDERATION IN CONFERENCE.—Immediately upon a final passage of the legislation that results in a disagreement between the two Houses of Congress with respect to the legislation, conferees shall be appointed and a conference convened. Not later than 15 days after the date on which conferees are appointed (excluding periods in which one or both Houses are in recess), the conferees shall file a report with the Senate and the House of Representatives resolving the differences between the Houses on the legislation. Notwithstanding any other rule of the Senate or the House of Representatives, it shall be in order to immediately consider a report of a committee of conference on the legislation filed in accordance with this subsection. Debate in the Senate and the House of Representatives on the conference report shall be limited to 10 hours, equally divided and controlled by the majority and minority leaders of the Senate or their designees and the Speaker of the House of Representatives and the minority leader of the House of Representatives or

their designees. A vote on final passage of the conference report shall occur immediately at the conclusion or yielding back of all time for debate on the conference report.

''(3) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

''(A) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and is deemed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of legislation under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

''(B) with full recognition of the constitutional right of either House to change the rules (so far as they relate to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

''(e) IMPLEMENTATION OF PROPOSAL.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as pro-

vided in paragraph (3), implement the recommendations contained in a proposal submitted by the Commission or the Secretary to Congress under this section on August 15 of the year in which the proposal is so submitted.

''(2) APPLICATION.—

''(A) IN GENERAL.—A recommendation described in paragraph (1) shall apply as follows:

''(i) In the case of a recommendation that is a change in the payment rate for an item or service under Medicare in which payment rates change on a fiscal year basis (or a cost reporting period basis that relates to a fiscal year), on a calendar year basis (or a cost reporting period basis that relates to a calendar year), or on a rate year basis (or a cost reporting period basis that relates to a rate year), such recommendation shall apply to items and services furnished on the first day of the first fiscal year, calendar year, or rate year (as the case may be) that begins after such August 15.

''(ii) In the case of a recommendation relating to payments to plans under parts

C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

''(iii) In the case of any other recommendation, such recommendation shall be addressed in the regular regulatory process timeframe and shall apply as soon as practicable.

''(B) INTERIM FINAL RULEMAKING.—The Secretary may use interim final rulemaking to implement any recommendation described in paragraph (1).

''(3) EXCEPTION.—The Secretary shall not be required to implement the recommendations contained in a proposal submitted in a proposal year by the Commission or the Secretary to Congress under this section if—

''(A) prior to August 15 of the proposal year, Federal legislation is enacted that satisfies the requirements of subparagraphs (A), (B), and (C) of subsection (c)(2), and which may implement all, some, or none of the recommendations contained in the proposal; or

"(B) in the case of implementation year 2020 and subsequent implementation years, a joint resolution described in subsection (f)(1) is enacted not later than August 15, 2017.

"(4) NO AFFECT ON AUTHORITY TO IMPLEMENT CERTAIN PROVISIONS.—Nothing in paragraph (3) shall be construed to affect the authority of the Secretary to implement any recommendation contained in a proposal or advisory report under this section to the extent that the Secretary otherwise has the authority to implement such recommendation administratively.

"(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the implementation by the Secretary under this subsection of the recommendations contained in a proposal.

"(f) JOINT RESOLUTION REQUIRED TO DISCONTINUE AUTOMATIC IMPLEMENTATION OF RECOMMENDATIONS IN PROPOSALS.—

"(1) IN GENERAL.—For purposes of subsection (e)(3)(B), a joint resolution described in this paragraph means only a joint resolution—

"(A) that is introduced in 2017 by not later than February 1 of such year;

"(B) which does not have a preamble;

"(C) the title of which is as follows: 'Joint resolution approving the discontinuation of the process for consideration and automatic implementation of the biennial proposal of the Medicare Commission under section 1899A of the Social Security Act'; and

"(D) the matter after the resolving clause of which is as follows: 'That Congress approves the discontinuation of the process for consideration and automatic implementation of the biennial proposal of the Medicare Commission under section 1899A of the Social Security Act.'.

"(2) PROCEDURE.—

"(A) IN GENERAL.—Subject to subparagraph (B), the procedures described in subsections (b)(1), (c), (d), and (f) of section 802 of title 5, United States Code, shall apply to the consideration of a joint resolution described in paragraph (1).

"(B) TERMS AND EXCEPTIONS.—For purposes of this subsection—

"(i) the references to 'subsection (a)' in subsections (b)(1)(A), (c), (d), and (f) of

section 802 of that title shall be considered to refer to paragraph (1) of this subsection; and

''(ii) the 20 calendar day period described in section 802(c) shall be considered to refer to the period ending on the 20th calendar day occurring after the date on which a resolution described in paragraph (1) is introduced.

''(C) EXCLUDED DAYS.—For purposes of determining the period specified in subparagraph (B), there shall be excluded any days either House of Congress is adjourned for more than 3 days during a session of Congress.

''(3) TERMINATION.—If a joint resolution described in paragraph (1) is enacted not later than August 15, 2017—

''(A) the Chief Actuary of the Medicare & Medicaid Services shall not make any determinations under paragraph (4) after the date of the enactment of such joint resolution;

''(B) the Commission shall not submit any proposals or advisory reports to Congress under this section after the date of the enactment of such joint resolution; and

"(C) the Commission and the consumer advisory council under subsection (k) shall terminate 60 days after the date of the enactment of such joint resolution.

"(g) COMMISSION MEMBERSHIP; TERMS OF OFFICE; CHAIRPERSON; REMOVAL.—

"(1) MEMBERSHIP.—

"(A) IN GENERAL.—The Commission shall be composed of—

"(i) 15 members appointed by the President, by and with the advice and consent of the Senate; and

"(ii) the Secretary, the Administrator of the Center for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Commission.

"(B) QUALIFICATIONS.—

"(i) IN GENERAL.—The appointed membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated

delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(ii) INCLUSION.—The appointed membership of the Commission shall include (but not be limited to) physicians and other health professionals, experts in the area of pharmaco-economics or prescription drug benefit programs, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(iii) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision or management of the delivery of items and services covered under this title

shall not constitute a majority of the appointed membership of the Commission.

''(C) ETHICAL DISCLOSURE.—The President shall establish a system for public disclosure by appointed members of the Commission of financial and other potential conflicts of interest relating to such members. Appointed members of the Commission shall be treated as officers in the executive branch for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(D) CONFLICTS OF INTEREST.—No individual may serve as an appointed member if that individual engages in any other business, vocation, or employment.

''(E) CONSULTATION WITH CONGRESS.—In selecting individuals for nominations for appointments to the Commission, the President shall consult with—

''(i) the majority leader of the Senate concerning the appointment of 3 members;

''(ii) the Speaker of the House of Representatives concerning the appointment of 3 members;

"(iii) the minority leader of the Senate concerning the appointment of 3 members; and

"(iv) the minority leader of the House of Representatives concerning the appointment of 3 members.

"(2) TERM OF OFFICE.—Each appointed member shall hold office for a term of 6 years except that—

"(A) a member appointed to fill a vacancy occurring prior to the expiration of the term for which that member's predecessor was appointed shall be appointed for the remainder of such term;

"(B) a member may continue to serve after the expiration of the member's term until a successor has taken office; and

"(C) of the members first appointed under this section, 5 shall be appointed for a term of 1 year, 5 shall be appointed for a term of 3 years, and 5 shall be appointed for a term of 6 years, the term of each to be designated by the President at the time of nomination.

"(3) CHAIRPERSON.—

"(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Commission.

"(B) DUTIES.—The Chairperson shall be the principal executive officer of the Commission, and shall exercise all of the executive and administrative functions of the Commission, including functions of the Commission with respect to—

"(i) the appointment and supervision of personnel employed by the Commission;

"(ii) the distribution of business among personnel appointed and supervised by the Chairperson and among administrative units of the Commission; and

"(iii) the use and expenditure of funds.

"(C) GOVERNANCE.—In carrying out any of the functions under subparagraph (B), the Chairperson shall be governed by the general policies established by the Commission and by the decisions, findings, and determinations the Commission shall by law be authorized to make.

''(D) REQUESTS FOR APPROPRIATIONS.—Requests or estimates for regular, supplemental, or deficiency appropriations on behalf of the Commission may not be submitted by the Chairperson without the prior approval of a majority vote of the Commission.

''(4) REMOVAL.—Any appointed member may be removed by the President for neglect of duty or malfeasance in office, but for no other cause.

''(h) VACANCIES; QUORUM; SEAL; VICE CHAIRPERSON; VOTING ON REPORTS.—

''(1) VACANCIES.—No vacancy on the Commission shall impair the right of the remaining members to exercise all the powers of the Commission.

''(2) QUORUM.—A majority of the appointed members of the Commission shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

''(3) SEAL.—The Commission shall have an official seal, of which judicial notice shall be taken.

''(4) VICE CHAIRPERSON.—The Commission shall annually elect a Vice Chairperson to act in the absence or disability of the Chairperson or in case of a vacancy in the office of the Chairperson.

''(5) VOTING ON PROPOSALS.—Any proposal of the Commission must be approved by the majority of appointed members present.

''(i) POWERS OF THE COMMISSION.—

''(1) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

''(2) AUTHORITY TO INFORM RESEARCH PRIORITIES FOR DATA COLLECTION.—The Commission may advise the Secretary on priorities for health services research, particularly as such priorities pertain to necessary changes and issues regarding payment reforms under Medicare.

''(3) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairperson, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(4) POSTAL SERVICES.—The Commission may use the United States mails in the same manner and

under the same conditions as other departments and agencies of the Federal Government.

''(5) GIFTS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

''(6) OFFICES.—The Commission shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

''(j) PERSONNEL MATTERS.—

''(1) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the annual rate of basic pay prescribed for level III of the Executive Schedule under section 5315 of title 5, United States Code. The Chairperson shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 5315 of title 5, United States Code.

''(2) TRAVEL EXPENSES.—The appointed members shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from

their homes or regular places of business in the performance of services for the Commission.

''(3) STAFF.—

''(A) IN GENERAL.—The Chairperson may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

''(B) COMPENSATION.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

''(4) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Commission without reimbursement, and such

detail shall be without interruption or loss of civil service status or privilege.

''(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The Chairperson may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''(k) CONSUMER ADVISORY COUNCIL.—

''(1) IN GENERAL.—There is established a consumer advisory council to advise the Commission on the impact of payment policies under this title on consumers.

''(2) MEMBERSHIP.—

''(A) NUMBER AND APPOINTMENT.—The consumer advisory council shall be composed of 10 consumer representatives appointed by the Comptroller General of the United States, 1 from among each of the 10 regions established by the Secretary as of the date of enactment of this section.

''(B) QUALIFICATIONS.—The membership of the council shall represent the interests of consumers and particular communities.

''(3) DUTIES.—The consumer advisory council shall, subject to the call of the Commission, meet not less frequently than 2 times each year in the District of Columbia.

''(4) OPEN MEETINGS.—Meetings of the consumer advisory council shall be open to the public.

''(5) ELECTION OF OFFICERS.—Members of the consumer advisory council shall elect their own officers.

''(6) APPLICATION OF FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the consumer advisory council except that section 14 of such Act shall not apply.

''(l) DEFINITIONS.—In this section:

''(1) APPROPRIATE COMMITTEES OF CONGRESS.—The term 'appropriate committees of Congress' means the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(2) COMMISSION; CHAIRPERSON; MEMBER.—The terms 'Commission', 'Chairperson', and 'Mem-

ber' mean the Medicare Commission established under subsection (a) and the Chairperson and any Member thereof, respectively.

''(3) MEDICARE.—The term 'Medicare' means the program established under this title, including parts A, B, C, and D.

''(4) MEDICARE BENEFICIARY.—The term 'Medicare beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

''(5) MEDICARE PROGRAM SPENDING.—The term 'Medicare program spending' means program spending under parts A, B, and D net of premiums.

''(m) FUNDING.—

''(1) IN GENERAL.—There are appropriated to the Commission to carry out its duties and functions—

''(A) for fiscal year 2012, $15,000,000; and

''(B) for each subsequent fiscal year, the amount appropriated under this paragraph for the previous fiscal year increased by the annual percentage increase in the Consumer Price Index for All Urban Consumers (all items;

United States city average) as of June of the previous fiscal year.

''(2) FROM TRUST FUNDS.—Sixty percent of amounts appropriated under paragraph (1) shall be derived by transfer from the Federal Hospital Insurance Trust Fund under section 1817 and 40 percent of amounts appropriated under such paragraph shall be derived by transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841.''.

(2) LOBBYING COOLING-OFF PERIOD FOR MEMBERS OF THE MEDICARE COMMISSION.—Section 207(c) of title 18, United States Code, is amended by inserting at the end the following:

''(3) MEMBERS OF THE MEDICARE COMMISSION.—

''(A) IN GENERAL.—Paragraph (1) shall apply to a member of the Medicare Commission under section 1899A.

''(B) AGENCIES AND CONGRESS.—For purposes of paragraph (1), the agency in which the individual described in subparagraph (A) served shall be considered to be the Medicare Commission, the Department of Health and Human Services, and the relevant committees of juris-

diction of Congress, including the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.''.

(b) GAO STUDY AND REPORT ON DETERMINATION AND IMPLEMENTATION OF PAYMENT AND COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

(1) INITIAL STUDY AND REPORT.—

(A) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on changes to payment policies, methodologies, and rates and coverage policies and methodologies under the Medicare program under title XVIII of the Social Security Act as a result of the recommendations contained in the proposals made by the Medicare Commission under section 1899A of such Act (as added by subsection (a)), including an analysis of the effect of such recommendations on—

(i) Medicare beneficiary access to providers and items and services;

(ii) the affordability of Medicare premiums and cost-sharing (including deductibles, coinsurance, and copayments);

(iii) the potential impact of changes on other government or private-sector purchasers and payers of care; and

(iv) quality of patient care, including patient experience, outcomes, and other measures of care.

(B) REPORT.—Not later than July 1, 2015, the Comptroller General shall submit to Congress a report containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) SUBSEQUENT STUDIES AND REPORTS.—The Comptroller General shall periodically conduct such additional studies and submit reports to Congress on changes to Medicare payments policies, methodologies, and rates and coverage policies and methodologies as the Comptroller General determines appropriate, in consultation with the appropriate committees of jurisdiction of Congress.

(c) CONFORMING AMENDMENTS.—Section 1805(b) of the Social Security Act (42 U.S.C. 1395b–6(b)) is amended—

(1) by redesignating paragraphs (4) through (8) as paragraphs (5) through (9), respectively; and

(2) by inserting after paragraph (3) the following:

''(4) REVIEW AND COMMENT ON MEDICARE COMMISSION OR SECRETARIAL PROPOSAL.—If the Medicare Commission (as established under subsection (a) of section 1899A) or the Secretary submits a proposal to the Commission under such section in a year, the Commission shall review the proposal and, not later than February 1 of that year, submit to the appropriate committees of Congress written comments on such proposal. Such comments may include such recommendations as the Commission deems appropriate.''.

SEC. 3404. ENSURING MEDICARE SAVINGS ARE KEPT IN THE MEDICARE PROGRAM.

No reduction in outlays under the Medicare program under title XVIII of the Social Security Act under the provisions of and amendments made by this Act may be utilized to offset any outlays under any other program or activity of the Federal government.

Subtitle F—Comparative Effectiveness Research

SEC. 3501. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—COMPARATIVE EFFECTIVENESS RESEARCH

''COMPARATIVE EFFECTIVENESS RESEARCH

''SEC. 1181. (a) DEFINITIONS.—In this section:

''(1) BOARD.—The term 'Board' means the Board of Governors established under subsection (f).

''(2) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—

''(A) IN GENERAL.—The term 'comparative clinical effectiveness research' means research evaluating and comparing the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

''(B) MEDICAL TREATMENTS, SERVICES, AND ITEMS DESCRIBED.—The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic

tools, pharmaceuticals (including drugs and biologicals), and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, patients.

''(3) COMPARATIVE EFFECTIVENESS RESEARCH.—The term 'comparative effectiveness research' means research evaluating and comparing the implications and outcomes of 2 or more health care strategies to address a particular medical condition for specific patient populations.

''(4) CONFLICTS OF INTEREST.—The term 'conflicts of interest' means associations, including financial and personal, that may be reasonably assumed to have the potential to bias an individual's decisions in matters related to the Institute or the conduct of activities under this section.

''(5) INSTITUTE.—The term 'Institute' means the 'Patient-Centered Outcomes Research Institute' established under subsection (b)(1).

''(b) PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—

''(1) ESTABLISHMENT.—There is authorized to be established a nonprofit corporation, to be known as the 'Patient-Centered Outcomes Research Insti-

tute' which is neither an agency nor establishment of the United States Government.

''(2) APPLICATION OF PROVISIONS.—The Institute shall be subject to the provisions of this section, and, to the extent consistent with this section, to the District of Columbia Nonprofit Corporation Act.

''(3) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2010 and each subsequent fiscal year, amounts in the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the 'PCORTF') under section 9511 of the Internal Revenue Code of 1986 shall be available, without further appropriation, to the Institute to carry out this section.

''(c) PURPOSE.—The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative clinical outcomes, clinical effec-

tiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).

''(d) DUTIES.—

''(1) IDENTIFYING RESEARCH PRIORITIES AND ESTABLISHING RESEARCH PROJECT AGENDA.—

''(A) IDENTIFYING RESEARCH PRIORITIES.—The Institute shall identify national priorities for comparative clinical effectiveness research, taking into account factors, including—

''(i) disease incidence, prevalence, and burden in the United States;

''(ii) evidence gaps in terms of clinical outcomes;

''(iii) practice variations, including variations in delivery and outcomes by geography, treatment site, provider type, and patient subgroup;

''(iv) the potential for new evidence concerning certain categories of health care services or treatments to improve patient health and well-being and the quality of care;

''(v) the effect or potential for an effect on health expenditures associated with

a health condition or the use of a particular medical treatment, service, or item;

''(vi) the effect or potential for an effect on patient needs, outcomes, and preferences, including quality of life; and

''(vii) the relevance to assisting patients and clinicians in making informed health decisions.

''(B) ESTABLISHING RESEARCH PROJECT AGENDA.—

''(i) IN GENERAL.—The Institute shall establish and update a research project agenda for comparative clinical effectiveness research to address the priorities identified under subparagraph (A), taking into consideration the types of such research that might address each priority and the relative value (determined based on the cost of conducting such research compared to the potential usefulness of the information produced by such research) associated with the different types of research, and such other factors as the Institute determines appropriate.

"(ii) CONSIDERATION OF NEED TO CONDUCT A SYSTEMATIC REVIEW.—In establishing and updating the research project agenda under clause (i), the Institute shall consider the need to conduct a systematic review of existing research before providing for the conduct of new research under paragraph (2)(A).

"(2) CARRYING OUT RESEARCH PROJECT AGENDA.—

"(A) COMPARATIVE CLINICAL EFFECTIVENESS RESEARCH.—In carrying out the research project agenda established under paragraph (1)(B), the Institute shall provide for the conduct of appropriate research and the synthesis of evidence, in accordance with the methodological standards adopted under paragraph (10), using methods, including the following:

"(i) Systematic reviews and assessments of existing research and evidence.

"(ii) Primary research, such as randomized clinical trials, molecularly informed trials, and observational studies.

"(iii) Any other methodologies recommended by the methodology committee

established under paragraph (7) that are adopted by the Board under paragraph (10).

"(B) CONTRACTS FOR THE MANAGEMENT AND CONDUCT OF RESEARCH.—

"(i) IN GENERAL.—The Institute may enter into contracts for the management and conduct of research in accordance with the research project agenda established under paragraph (1)(B) with the following:

"(I) Agencies and instrumentalities of the Federal Government that have experience in conducting comparative clinical effectiveness research, such as the Agency for Healthcare Research and Quality, to the extent that such contracts are authorized under the governing statutes of such agencies and instrumentalities.

"(II) Appropriate private sector research or study-conducting entities that have demonstrated the experience and capacity to achieve the goals of comparative effectiveness research.

"(ii) CONDITIONS FOR CONTRACTS.—A contract entered into under this subparagraph shall require that the agency, instrumentality, or other entity—

"(I) abide by the transparency and conflicts of interest requirements that apply to the Institute with respect to the research managed or conducted under such contract;

"(II) comply with the methodological standards adopted under paragraph (10) with respect to such research;

"(III) take into consideration public comments on the study design that are transmitted by the Institute to the agency, instrumentality, or other entity under subsection (i)(1)(B) during the finalization of the study design and transmit responses to such comments to the Institute, which will publish such comments, responses, and finalized study design in accordance with subsection

(i)(3)(A)(iii) prior to the conduct of such research;

''(IV) in the case where the agency, instrumentality, or other entity is managing or conducting a comparative effectiveness research study for a rare disease, consult with the expert advisory panel for rare disease appointed under paragraph (5)(A)(iii) with respect to such research study; and

''(V) subject to clause (iv), permit a researcher who conducts original research under the contract for the agency, instrumentality, or other entity to have such research published in a peer-reviewed journal or other publication.

''(iii) COVERAGE OF COPAYMENTS OR COINSURANCE.—A contract entered into under this subparagraph may allow for the coverage of copayments or coinsurance, or allow for other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the va-

lidity of a research project, such as in the case where the research project must be blinded.

''(iv) REQUIREMENTS FOR PUBLICATION OF RESEARCH.—

''(I) IN GENERAL.—Any research published under clause (ii)(V) shall be within the bounds of and entirely consistent with the evidence and findings produced under the contract with the Institute under this subparagraph and disseminated by the Institute under paragraph (9).

''(II) LIMITATION ON CONTRACTING WITH CERTAIN AGENCIES, INSTRUMENTALITIES, AND ENTITIES.—In the case where the Institute determines that such published research does not meet the requirements under subclause (I), the Institute shall not enter into another contract with the agency, instrumentality, or entity which managed or conducted such research under a contract under this subparagraph for a period deter-

mined appropriate by the Institute (but not less than 5 years).

"(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis, in order to take into account new research, evolving evidence, advances in medical technology, and changes in the standard of care as they become available, as appropriate.

"(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall—

"(i) be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care treatments, services, and items as used with various subpopulations, such as racial and ethnic minorities, women, age, and groups of individuals with different comorbidities, genetic and molecular subtypes, or quality of life preferences; and

"(ii) include members of such subpopulations as subjects in the research as feasible and appropriate.

"(E) DIFFERENCES IN TREATMENT MODALITIES.—Research shall be designed, as ap-

propriate, to take into account different characteristics of treatment modalities that may affect research outcomes, such as the phase of the treatment modality in the innovation cycle and the impact of the skill of the operator of the treatment modality.

''(3) STUDY AND REPORT ON FEASIBILITY OF CONDUCTING RESEARCH IN-HOUSE.—

''(A) STUDY.—The Institute shall conduct a study on the feasibility of conducting research in-house.

''(B) REPORT.—Not later than 5 years after the date of enactment of this section, the Institute shall submit a report to Congress containing the results of the study conducted under subparagraph (A).

''(4) DATA COLLECTION.—

''(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI as the Institute may require to carry out this section. The Institute may also request and, if such request is granted, obtain data

from Federal, State, or private entities, including data from clinical databases and registries.

''(B) USE OF DATA.—The Institute shall only use data provided to the Institute under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable confidentiality and privacy standards.

''(5) APPOINTING EXPERT ADVISORY PANELS.—

''(A) APPOINTMENT.—

''(i) IN GENERAL.—The Institute shall, as appropriate, appoint expert advisory panels to assist in identifying research priorities and establishing the research project agenda under paragraph (1). Panels shall advise the Institute in matters such as identifying gaps in and updating medical evidence in order to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

''(ii) EXPERT ADVISORY PANELS FOR PRIMARY RESEARCH.—The Institute shall appoint expert advisory panels in carrying

out the research project agenda under paragraph (2)(A)(ii). Such expert advisory panels shall, upon request, advise the Institute and the agency, instrumentality, or entity conducting the research on the research question involved and the research design or protocol, including the appropriate comparator technologies, important patient subgroups, and other parameters of the research, as necessary. Upon the request of such agency, instrumentality, or entity, such panels shall be available as a resource for technical questions that may arise during the conduct of such research.

''(iii) EXPERT ADVISORY PANEL FOR RARE DISEASE.—In the case of a comparative effectiveness research study for rare disease, the Institute shall appoint an expert advisory panel for purposes of assisting in the design of such research study and determining the relative value and feasibility of conducting such research study.

''(B) COMPOSITION.—

''(i) IN GENERAL.—An expert advisory panel appointed under subparagraph

(A) shall include individuals who have experience in the relevant topic, project, or category for which the panel is established, including—

"(I) practicing and research clinicians (including relevant specialists and subspecialists), patients, and representatives of patients; and

"(II) experts in scientific and health services research, health services delivery, and evidence-based medicine.

"(ii) INCLUSION OF REPRESENTATIVES OF MANUFACTURERS OF MEDICAL TECHNOLOGY.—An expert advisory panel appointed under subparagraph (A) may include a representative of each manufacturer of each medical technology that is included under the relevant topic, project, or category for which the panel is established.

"(6) SUPPORTING PATIENT AND CONSUMER REPRESENTATIVES.—The Institute shall provide support and resources to help patient and consumer representatives on the Board and expert advisory panels appointed by the Institute under paragraph

(5) to effectively participate in technical discussions regarding complex research topics. Such support shall include initial and continuing education to facilitate effective engagement in activities undertaken by the Institute and may include regular and ongoing opportunities for patient and consumer representatives to interact with each other and to exchange information and support regarding their involvement in the Institute's activities. The Institute shall provide per diem and other appropriate compensation to patient and consumer representatives for their time spent participating in the activities of the Institute under this paragraph.

''(7) ESTABLISHING METHODOLOGY COMMITTEE.—

''(A) IN GENERAL.—The Institute shall establish a standing methodology committee to carry out the functions described in subparagraph (C).

''(B) APPOINTMENT AND COMPOSITION.—The methodology committee established under subparagraph (A) shall be composed of not more than 17 members appointed by the Comptroller General of the United States. Members appointed to the methodology committee shall

be experts in their scientific field, such as health services research, clinical research, comparative effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise may be appointed to the methodology committee.

''(C) FUNCTIONS.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative effectiveness research by undertaking, directly or through subcontract, the following activities:

''(i) Not later than 2 years after the date on which the members of the methodology committee are appointed under subparagraph (B), developing and periodically updating the following:

''(I) Establish and maintain methodological standards for comparative clinical effectiveness research on major categories of interventions to prevent, diagnose, or treat a clinical condition or improve the delivery of care. Such methodological standards shall provide specific criteria for inter-

nal validity, generalizability, feasibility, and timeliness of such research and for clinical outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of such research. Any methodological standards developed and updated under this subclause shall be scientifically based and include methods by which new information, data, or advances in technology are considered and incorporated into ongoing research projects by the Institute, as appropriate. The process for developing and updating such standards shall include input from relevant experts, stakeholders, and decisionmakers, and shall provide opportunities for public comment. Such standards shall also include methods by which patient subpopulations can be accounted for and evaluated in different types of research. As appropriate, such standards shall build on existing work on methodo-

logical standards for defined categories of health interventions and for each of the major categories of comparative effectiveness research methods (determined as of the date of enactment of the America's Healthy Future Act of 2009).

''(II) A translation table that is designed to provide guidance and act as a reference for the Board to determine research methods that are most likely to address each specific comparative clinical effectiveness research question.

''(ii) Not later than 3 years after such date, examining the following:

''(I) Methods by which various aspects of the health care delivery system (such as benefit design and performance, and health services organization, management, information communication, and delivery) could be assessed and compared for their relative effectiveness, benefits, risks, advan-

tages, and disadvantages in a scientifically valid and standardized way.

''(II) Methods by which efficiency and value (including the full range of harms and benefits, such as quality of life) could be assessed in a scientifically valid and standardized way.

''(D) CONSULTATION AND CONDUCT OF EXAMINATIONS.—

''(i) IN GENERAL.—Subject to clause (iii), in undertaking the activities described in subparagraph (C), the methodology committee shall—

''(I) consult or contract with 1 or more of the entities described in clause (ii); and

''(II) consult with stakeholders and other entities knowledgeable in relevant fields, as appropriate.

''(ii) ENTITIES DESCRIBED.—The following entities are described in this clause:

''(I) The Institute of Medicine of the National Academies.

''(II) The Agency for Healthcare Research and Quality.

''(III) The National Institutes of Health.

''(IV) Academic, non-profit, or other private entities with relevant expertise.

''(iii) CONDUCT OF EXAMINATIONS.—The methodology committee shall contract with the Institute of Medicine of the National Academies for the conduct of the examinations described in subclauses (I) and (II) of subparagraph (C)(ii).

''(E) REPORTS.—The methodology committee shall submit reports to the Board on the committee's performance of the functions described in subparagraph (C). Reports submitted under the preceding sentence with respect to the functions described in clause (i) of such subparagraph shall contain recommendations—

''(i) for the Institute to adopt methodological standards developed and updated by the methodology committee under such subparagraph; and

''(ii) for such other action as the methodology committee determines is nec-

essary to comply with such methodological standards.

''(8) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

''(A) IN GENERAL.—The Institute shall ensure that there is a process for peer review of the research conducted under paragraph (2)(A)(ii). Under such process—

''(i) evidence from research conducted under such paragraph shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (10); and

''(ii) a list of the names of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (12)(D).

''(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to avoid bias and conflicts of interest on the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

''(C) USE OF EXISTING PROCESSES.—

"(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the conduct or management of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

"(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

"(9) DISSEMINATION OF RESEARCH FINDINGS.—

"(A) IN GENERAL.—The Institute shall disseminate research findings to clinicians, patients, and the general public in accordance with the dissemination protocols and strategies adopted under paragraph (10). Research findings disseminated—

"(i) shall convey findings of research so that they are comprehensible and useful

to patients and providers in making health care decisions;

''(ii) shall discuss findings and other considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

''(iii) shall include considerations such as limitations of research and what further research may be needed, as appropriate;

''(iv) shall not include practice guidelines, coverage recommendations, or policy recommendations; and

''(v) shall not include any data the dissemination of which would violate the privacy of research participants or violate any confidentiality agreements made with respect to the use of data under this section.

''(B) DISSEMINATION PROTOCOLS AND STRATEGIES.—The Institute shall develop protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of such findings and the use and incorporation of such findings into relevant activities for the purpose of in-

forming higher quality and more effective and timely decisions regarding medical treatments, services, and items. In developing and adopting such protocols and strategies, the Institute shall consult with stakeholders, including practicing clinicians and patients, concerning the types of dissemination that will be most useful to the end users of the information and may provide for the utilization of multiple formats for conveying findings to different audiences.

''(C) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term 'research findings' means the results of a study or assessment.

''(10) ADOPTION.—Subject to subsection (i)(1)(A)(i), the Institute shall adopt the national priorities identified under paragraph (1)(A), the research project agenda established under paragraph (1)(B), the methodological standards developed and updated by the methodology committee under paragraph (7)(C)(i), any peer-review process provided under paragraph (8), and dissemination protocols and strategies developed under paragraph (9)(B) by majority vote. In the case where the Institute does not adopt such national priorities, research project

agenda, methodological standards, peer-review process, or dissemination protocols and strategies in accordance with the preceding sentence, the national priorities, research project agenda, methodological standards, peer-review process, or dissemination protocols and strategies shall be referred to the appropriate staff or entity within the Institute (or, in the case of the methodological standards, the methodology committee) for further review.

''(11) COORDINATION OF RESEARCH AND RESOURCES AND BUILDING CAPACITY FOR RESEARCH.—

''(A) COORDINATION OF RESEARCH AND RESOURCES.—The Institute shall coordinate research conducted, commissioned, or otherwise funded under this section with comparative clinical effectiveness and other relevant research and related efforts conducted by public and private agencies and organizations in order to ensure the most efficient use of the Institute's resources and that research is not duplicated unnecessarily.

''(B) BUILDING CAPACITY FOR RESEARCH.—The Institute may build capacity for comparative clinical effectiveness research and

methodologies, including research training and development of data resources (such as clinical registries), through appropriate activities, including using up to 20 percent of the amounts appropriated or credited to the PCORTF under section 9511(b) of the Internal Revenue Code of 1986 with respect to a fiscal year to fund extramural efforts of organizations such as the Cochrane Collaboration (or a successor organization) and other organizations (including public-private partnerships) in order to develop and maintain a comprehensive, interoperable data network to collect, link, and analyze data on outcomes and effectiveness from multiple sources, including electronic health records.

''(C) INCLUSION IN ANNUAL REPORTS.—The Institute shall report on any coordination and capacity building conducted under this paragraph in annual reports in accordance with paragraph (12)(E).

''(12) ANNUAL REPORTS.—The Institute shall submit an annual report to Congress and the President, and shall make the annual report available to the public. Such report shall contain—

''(A) a description of the activities conducted under this section during the preceding year, including the use of amounts appropriated or credited to the PCORTF under section 9511(b) of the Internal Revenue Code of 1986 to carry out this section, research projects completed and underway, and a summary of the findings of such projects;

''(B) the research project agenda and budget of the Institute for the following year;

''(C) a description of research priorities identified under paragraph (1)(A), dissemination protocols and strategies developed by the Institute under paragraph (9)(B), and methodological standards developed and updated by the methodology committee under paragraph (7)(C)(i) that are adopted under paragraph (10) during the preceding year;

''(D) the names of individuals contributing to any peer-review process provided under paragraph (8) during the preceding year or years, in a manner such that those individuals cannot be identified with a particular research project;

''(E) a description of efforts by the Institute under paragraph (11) to—

"(i) coordinate the research conducted, commissioned, or otherwise funded under this section and the resources of the Institute with research and related efforts conducted by other private and public entities; and

"(ii) build capacity for comparative clinical effectiveness research and other relevant research and related efforts through appropriate activities; and

"(F) any other relevant information (including information on the membership of the Board, expert advisory panels appointed under paragraph (5), the methodology committee established under paragraph (7), and the executive staff of the Institute, any conflicts of interest with respect to the members of such Board, expert advisory panels, and methodology committee, or with respect to any individuals selected for employment as executive staff of the Institute, and any bylaws adopted by the Board during the preceding year).

"(e) ADMINISTRATION.—

"(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

''(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(10) are nondelegable.

''(f) BOARD OF GOVERNORS.—

''(1) IN GENERAL.—The Institute shall have a Board of Governors, which shall consist of 15 members appointed by the Comptroller General of the United States not later than 6 months after the date of enactment of this section, as follows:

''(A) 3 members representing patients and health care consumers.

''(B) 3 members representing practicing physicians, including surgeons.

''(C) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

''(D) 3 members representing pharmaceutical, device, and diagnostic manufacturers or developers.

''(E) 1 member representing nonprofit organizations involved in health services research.

"(F) 1 member representing organizations that focus on quality measurement and improvement or decision support.

"(G) 1 member representing independent health services researchers.

"(2) QUALIFICATIONS.—

"(A) DIVERSE REPRESENTATION OF PERSPECTIVES.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, decisions sciences, health economics, and statistics.

"(B) CONFLICTS OF INTEREST.—

"(i) IN GENERAL.—In appointing members of the Board, the Comptroller General of the United States shall take into consideration any conflicts of interest of potential appointees. Any conflicts of interest of members appointed to the Board shall be disclosed in accordance with subsection (i)(4)(B).

"(ii) RECUSAL.—A member of the Board shall be recused from participating with respect to a particular research project or other matter considered by the

Board in carrying out its research project agenda under subsection (d)(2) in the case where the member (or an immediate family member of such member) has a financial or personal interest directly related to the research project or the matter that could affect or be affected by such participation.

''(3) TERMS.—

''(A) IN GENERAL.—A member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed—

''(i) 6 shall be appointed for a term of 6 years;

''(ii) 6 shall be appointed for a term of 4 years; and

''(iii) 6 shall be appointed for a term of 2 years.

''(B) LIMITATION.—No individual shall be appointed to the Board for more than 2 terms.

''(C) EXPIRATION OF TERM.—Any member of the Board whose term has expired may serve until such member's successor has taken office, or until the end of the calendar year in which

such member's term has expired, whichever is earlier.

"(D) VACANCIES.—

"(i) IN GENERAL.—Any member appointed to fill a vacancy prior to the expiration of the term for which such member's predecessor was appointed shall be appointed for the remainder of such term.

"(ii) VACANCIES NOT TO AFFECT POWER OF BOARD.—A vacancy on the Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

"(4) CHAIRPERSON AND VICE-CHAIRPERSON.—

"(A) IN GENERAL.—The Comptroller General of the United States shall designate a Chairperson and Vice-Chairperson of the Board from among the members of the Board.

"(B) TERM.—The members so designated shall serve as Chairperson and Vice-Chairperson of the Board for a period of 3 years.

"(5) COMPENSATION.—

"(A) IN GENERAL.—A member of the Board shall be entitled to compensation at the per diem equivalent of the rate provided for

level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(B) TRAVEL EXPENSES.—While away from home or regular place of business in the performance of duties for the Board, each member of the Board may receive reasonable travel, subsistence, and other necessary expenses.

''(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—The Board may—

''(A) employ and fix the compensation of an executive director and such other personnel as may be necessary to carry out the duties of the Institute;

''(B) seek such assistance and support as may be required in the performance of the duties of the Institute from appropriate departments and agencies of the Federal Government;

''(C) enter into contracts or make other arrangements and make such payments as may be necessary for performance of the duties of the Institute;

''(D) provide travel, subsistence, and per diem compensation for individuals performing the duties of the Institute, including members of any expert advisory panel appointed under

subsection (d)(5), members of the methodology committee established under subsection (d)(7), and individuals selected to contribute to any peer-review process under subsection (d)(8); and

''(E) prescribe such rules, regulations, and bylaws as the Board determines necessary with respect to the internal organization and operation of the Institute.

''(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. In the case where the Board is meeting on matters not related to personnel, Board meetings shall be open to the public and advertised through public notice at least 7 days prior to the meeting.

''(8) QUORUM.—A majority of the members of the Board shall constitute a quorum for purposes of conducting the duties of the Institute, but a lesser number of members may meet and hold hearings.

''(g) FINANCIAL OVERSIGHT.—

''(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

''(2) REVIEW OF AUDIT AND REPORT TO CONGRESS.—The Comptroller General of the United States shall—

''(A) review the results of the audits conducted under paragraph (1); and

''(B) submit a report to Congress containing the results of such audits and review.

''(h) GOVERNMENTAL OVERSIGHT.—

''(1) REVIEW AND REPORTS.—

''(A) IN GENERAL.—The Comptroller General of the United States shall review the following:

''(i) Processes established by the Institute, including those with respect to the identification of research priorities under subsection (d)(1)(A) and the conduct of research projects under this section. Such review shall determine whether information produced by such research projects—

''(I) is objective and credible;

''(II) is produced in a manner consistent with the requirements under this section; and

''(III) is developed through a transparent process.

"(ii) The overall effect of the Institute and the effectiveness of activities conducted under this section, including an assessment of—

"(I) the utilization of the findings of research conducted under this section by health care decisionmakers; and

"(II) the effect of the Institute and such activities on innovation and on the health economy of the United States.

"(B) REPORTS.—Not later than 5 years after the date of enactment of this section, and not less frequently than every 5 years thereafter, the Comptroller General of the United States shall submit a report to Congress containing the results of the review conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

"(2) FUNDING ASSESSMENT.—

"(A) IN GENERAL.—The Comptroller General of the United States shall assess the ade-

quacy and use of funding for the Institute and activities conducted under this section under the PCORTF under section 9511 of the Internal Revenue Code of 1986. Such assessment shall include a determination as to whether, based on the utilization of findings by public and private payers, each of the following are appropriate sources of funding for the Institute, including a determination of whether such sources of funding should be continued or adjusted, or whether other sources of funding not described in clauses (i) through (iii) would be appropriate:

"(i) The transfer of funds from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the PCORTF under section 1183.

"(ii) The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) of subsection (b)(1) of such section 9511.

"(iii) Private sector contributions under subparagraphs (D)(i) and (E)(i) of such subsection (b)(1).

"(B) REPORT.—Not later than 8 years after the date of enactment of this section, the Comptroller General of the United States shall submit a report to Congress containing the results of the assessment conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

"(i) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—The Institute shall establish procedures to ensure that the following requirements for ensuring transparency, credibility, and access are met:

"(1) PUBLIC COMMENT PERIODS.—

"(A) IN GENERAL.—The Institute shall provide for a public comment period of not less than 45 and not more than 60 days at the following times:

"(i) Prior to the adoption of the national priorities identified under subsection (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the

methodological standards developed and updated by the methodology committee under subsection (d)(7)(C)(i), the peer-review process generally provided under subsection (d)(8), and dissemination protocols and strategies developed by the Institute under subsection (d)(9)(B) in accordance with subsection (d)(10).

''(ii) Prior to the finalization of individual study designs.

''(iii) After the release of draft findings with respect to a systematic review and assessment of existing research and evidence under subsection (d)(2)(A)(i).

''(B) TRANSMISSION OF PUBLIC COMMENTS ON STUDY DESIGN.—The Institute shall transmit public comments submitted during the public comment period described in subparagraph (A)(ii) to the entity conducting research with respect to which the individual study design is being finalized.

''(2) ADDITIONAL FORUMS.—The Institute shall, in addition to the public comment periods described in paragraph (1)(A), support forums to increase public awareness and obtain and incorporate

public input and feedback through media (such as an Internet website) on the following:

"(A) The identification of research priorities, including research topics, and the establishment of the research project agenda under subparagraphs (A) and (B), respectively, of subsection (d)(1).

"(B) Research findings.

"(C) Any other duties, activities, or processes the Institute determines appropriate.

"(3) PUBLIC AVAILABILITY.—The Institute shall make available to the public and disclose through the official public Internet website of the Institute, and through other forums and media the Institute determines appropriate, the following:

"(A) The process and methods for the conduct of research under this section, including—

"(i) the identity of the entity conducting such research;

"(ii) any links the entity has to industry (including such links that are not directly tied to the particular research being conducted under this section);

"(iii) draft study designs (including research questions and the finalized study

design, together with public comments on such study design and responses to such comments);

''(iv) research protocols (including measures taken, methods of research, methods of analysis, research results, and such other information as the Institute determines appropriate) with respect to each medical treatment, service, and item described in subsection (a)(2)(B);

''(v) any key decisions made by the Institute and any appropriate committees of the Institute;

''(vi) the identity of investigators conducting such research and any conflicts of interest of such investigators; and

''(vii) any progress reports the Institute determines appropriate.

''(B) Notice of each of the public comment periods under paragraph (1)(A), including deadlines for public comments for such periods.

''(C) Public comments submitted during each of the public comment periods under paragraph (1)(A), including such public comments

submitted on draft findings under clause (iii) of such paragraph.

''(D) Bylaws, processes, and proceedings of the Institute, to the extent practicable and as the Institute determines appropriate.

''(E) Not later than 90 days after receipt by the Institute of a relevant report or research findings, appropriate information contained in such report or findings.

''(4) CONFLICTS OF INTEREST.—The Institute shall—

''(A) in appointing members to an expert advisory panel under subsection (d)(5) and the methodology committee under subsection (d)(7), and in selecting individuals to contribute to any peer-review process under subsection (d)(8) and for employment as executive staff of the Institute, take into consideration any conflicts of interest of potential appointees, participants, and staff; and

''(B) include a description of any such conflicts of interest and conflicts of interest of Board members in the annual report under subsection (d)(12), except that, in the case of individuals contributing to any such peer review

process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

''(j) RULES.—

''(1) GIFTS.—The Institute, or the Board and staff of the Institute acting on behalf of the Institute, may not accept gifts, bequeaths, or donations of services or property.

''(2) ESTABLISHMENT AND PROHIBITION ON ACCEPTING OUTSIDE FUNDING OR CONTRIBUTIONS.—The Institute may not—

''(A) establish a corporation other than as provided under this section; or

''(B) accept any funds or contributions other than as provided under this part.

''(k) RULES OF CONSTRUCTION.—

''(1) COVERAGE.—Nothing in this section shall be construed—

''(A) to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer; or

''(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI in the case

where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.

''(2) REPORTS AND FINDINGS.—None of the reports submitted under this section or research findings disseminated by the Institute shall be construed as mandates, guidelines, or recommendations for payment, coverage, or treatment.

''LIMITATIONS ON CERTAIN USES OF COMPARATIVE EFFECTIVENESS RESEARCH

''SEC. 1182. (a) The Secretary may only use evidence and findings from comparative effectiveness research conducted under section 1181 to make a determination regarding coverage under title XVIII if such use is through an iterative and transparent process which meets the following requirements:

''(1) Stakeholders and other individuals have the opportunity to provide informed and relevant information with respect to the determination.

''(2) Stakeholders and other individuals have the opportunity to review draft proposals of the determination and submit public comments with respect to such draft proposals.

''(3) In making the determination, the Secretary considers—

''(A) other relevant evidence, studies, and research in addition to such comparative effectiveness research; and

''(B) evidence and research that demonstrates or suggests a benefit of coverage with respect to a specific subpopulation of individuals, even if the evidence and findings from the comparative effectiveness research demonstrates or suggests that, on average, with respect to the general population the benefits of coverage do not exceed the harm.

''(b) Nothing in this section shall be construed as—

''(1) superceding or modifying the coverage of items or services under title XVIII that the Secretary determines are reasonable and necessary under section 1862(l)(1); or

''(2) authorizing the Secretary to deny coverage of items or services under such title solely on the basis of comparative effectiveness research.

''(c)(1) The Secretary shall not use evidence or findings from comparative effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that treats extending the life of an elderly, disabled, or terminally ill individual as of lower value than extending

the life of an individual who is younger, nondisabled, or not terminally ill.

''(2) Paragraph (1) shall not be construed as preventing the Secretary from using evidence or findings from such comparative effectiveness research in determining coverage, reimbursement, or incentive programs under title XVIII based upon a comparison of the difference in the effectiveness of alternative treatments in extending an individual's life due to the individual's age, disability, or terminal illness.

''(d)(1) The Secretary shall not use evidence or findings from comparative effectiveness research conducted under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with an intent to discourage, an individual from choosing a health care treatment based on how the individual values the tradeoff between extending the length of their life and the risk of disability.

''(2)(A) Paragraph (1) shall not be construed to—

''(i) limit the application of differential copayments under title XVIII based on factors such as cost or type of service; or

''(ii) prevent the Secretary from using evidence or findings from such comparative effectiveness research in determining coverage, reimbursement, or

incentive programs under such title based upon a comparison of the difference in the effectiveness of alternative health care treatments in extending an individual's life due to that individual's age, disability, or terminal illness.

''(3) Nothing in the provisions of, or amendments made by the America's Healthy Future Act of 2009, shall be construed to limit comparative effectiveness research or any other research, evaluation, or dissemination of information concerning the likelihood that a health care treatment will result in disability.

''(e)(1) The Patient-Centered Outcomes Research Institute established under section 1181(b)(1) shall not develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) as a threshold to establish what type of health care is cost effective or recommended.

''(2) The Secretary shall not utilize such an adjusted life year (or such a similar measure) as a threshold to determine coverage, reimbursement, or incentive programs under title XVIII.

''TRUST FUND TRANSFERS TO PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND

''SEC. 1183. (a) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Sup-

plementary Medical Insurance Trust Fund under section 1841, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII from the respective trust fund, to the Patient-Centered Outcomes Research Trust Fund (referred to in this section as the 'PCORTF') under section 9511 of the Internal Revenue Code of 1986, the following:

"(1) For fiscal year 2013, an amount equal to $1 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

"(2) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019, an amount equal to $2 multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII during such fiscal year.

"(b) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a)(2) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

"(1) such dollar amount for the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year.''.

(b) COORDINATION WITH PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Section 1889(a) of the Social Security Act (42 U.S.C. 1395zz(a)) is amended by inserting ''and to enhance the understanding of and utilization by providers of services and suppliers of research findings disseminated by the Patient-Centered Outcomes Research Institute established under section 1181'' before the period at the end.

(c) PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

"SEC. 9511. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Patient-Centered Outcomes Research Trust Fund' (hereafter in this section referred to as the 'PCORTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—

"(1) APPROPRIATION.—There are hereby appropriated to the Trust Fund the following:

"(A) For fiscal year 2010, $10,000,000.

"(B) For fiscal year 2011, $50,000,000.

"(C) For fiscal year 2012, $150,000,000.

"(D) For fiscal year 2013—

"(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

"(ii) $150,000,000.

"(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

"(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

"(ii) $150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

"(2) TRUST FUND TRANSFERS.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

"(3) AMERICAN RECOVERY AND REINVESTMENT FUNDS.—In addition to the amounts appropriated under paragraph (1) and the amounts credited under paragraph (2), of amounts appropriated for comparative effectiveness research to be allocated at the discretion of the Secretary of Health and Human Services under the heading Agency for Healthcare Research and Quality under the heading Department of Health and Human Services under

title VIII of Division A of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), $10,000,000 shall be transferred to the Trust Fund.

''(4) LIMITATION ON TRANSFERS TO PCORTF.—No amount may be appropriated or transferred to the PCORTF on and after the date of any expenditure from the PCORTF which is not an expenditure permitted under this section. The determination of whether an expenditure is so permitted shall be made without regard to—

''(A) any provision of law which is not contained or referenced in this chapter or in a revenue Act, and

''(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of this paragraph.

''(c) TRUSTEE.—The Secretary of Health and Human Services shall be a trustee of the PCORTF.

''(d) EXPENDITURES FROM FUND.—Amounts in the PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established by section 3501(a) of the America's Healthy Future Act of 2009 for carrying out part D of title XI of the

Social Security Act (as in effect on the date of enactment of such Act).

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary of the Treasury based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

''(f) TERMINATION.—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.''.

(B) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

''Sec. 9511. Patient-Centered Outcomes Research Trust Fund.''.

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of $2 ($1 in the case of policy years ending during fiscal year 2013) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section:

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States.

"(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any policy year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such policy year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (deter-

mined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year ending after September 30, 2012, there is hereby imposed a fee equal to $2 ($1 in the case of plan years ending during fiscal year 2013) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-in-

sured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by 1 or more employers for the benefit of their employees or former employees,

''(B) by 1 or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for plan years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

''(1) such dollar amount for plan years ending in the previous fiscal year, multiplied by

''(2) the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary of Health and Human Services before the beginning of the fiscal year.

''(e) TERMINATION.—This section shall not apply to plan years ending after September 30, 2019.

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy,

would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

"(A) any insurance program established under title XVIII of the Social Security Act,

"(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

"(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

"(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.".

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

"SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

"SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

"Subchapter A—Policies Issued By Foreign Insurers".

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES".

(d) TAX-EXEMPT STATUS OF THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subsection 501(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(4) The Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act.".

SEC. 3502. COORDINATION WITH FEDERAL COORDINATING COUNCIL FOR COMPARATIVE EFFECTIVENESS RESEARCH.

Section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8) is amended—

(1) in subsection (c)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period at the end and inserting ''; and''; and

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

''(3) provide support to the Patient-Centered Outcomes Research Institute established under section 1181(b)(1) of the Social Security Act (referred to in this section as the 'Institute').'';

(2) in subsection (e)(2), by striking ''regarding its activities'' and all that follows through the period at the end and inserting ''containing—

''(A) an inventory of its activities with respect to comparative effectiveness research conducted by relevant Federal departments and agencies; and

''(B) recommendations concerning better coordination of comparative effectiveness research by such departments and agencies.'';

(3) by redesignating subsection (g) as subsection (h); and

(4) by inserting after subsection (f) the following new subsection:

''(g) COORDINATION WITH THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—The Council shall coordinate with the Institute in carrying out its duties under this section.''.

SEC. 3503. GAO REPORT ON NATIONAL COVERAGE DETERMINATIONS PROCESS.

Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit a report to Congress on the process for making national coverage determinations (as defined in section 1869(f)(1)(B) of the Social Security Act (42 U.S.C. 1395ff(f)(1)(B))) under the Medicare program under title XVIII of the Social Security Act. Such report shall include a determination whether, in initiating and conducting such process, the Secretary of Health and Human Services has complied with applicable law and regulations, including requirements for consultation with appropriate outside experts, providing appropriate notice and comment opportu-

nities to the public, and making information and data (other than proprietary data) considered in making such determinations available to the public and to nonvoting members of any advisory committees established to advise the Secretary with respect to such determinations.

Subtitle G—Administrative Simplification

SEC. 3601. ADMINISTRATIVE SIMPLIFICATION.

(a) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d) is amended by adding at the end the following:

''(9) OPERATING RULES.—The term 'operating rules' means the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part.''.

(2) OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

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

''(J) Electronic funds transfers.''; and

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

''(g) OPERATING RULES.—

''(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction described in subsection (a)(2) with the goal of creating as much uniformity in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

''(2) OPERATING RULES DEVELOPMENT.—In adopting operating rules under this subsection, the Secretary shall rely on recommendations for operating rules developed by a qualified nonprofit entity, as selected by the Secretary, that meets the following requirements:

''(A) The entity focuses its mission on administrative simplification.

''(B) The entity demonstrates an established multi-stakeholder and consensus-based process for development of operating rules, in-

cluding representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

''(C) The entity has established a public set of guiding principles that ensure the operating rules and process are open and transparent.

''(D) The entity coordinates its activities with the HIT Policy Committee and the HIT Standards Committee (as established under title XXX of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

''(E) The entity incorporates national standards, including the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

''(F) The entity supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

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

''(3) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

''(A) review the operating rules developed by a nonprofit entity described under paragraph (2);

''(B) determine whether such rules represent a consensus view of the health care industry and are consistent with and do not alter current standards;

''(C) evaluate whether such rules are consistent with electronic standards adopted for health information technology; and

''(D) submit to the Secretary a recommendation as to whether the Secretary should adopt such rules.

''(4) IMPLEMENTATION.—

''(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the rules developed by the non-profit entity described in paragraph (2) and the recommendation submitted by the National Committee on Vital and Health

Statistics under paragraph (3)(D) and having ensured consultation with providers.

''(B) ADOPTION REQUIREMENTS; EFFECTIVE DATES.—

''(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for transactions for eligibility for a health plan and health claim status shall be adopted not later than July 1, 2011, in a manner ensuring that such rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

''(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice shall be adopted not later than July 1, 2012, in a manner ensuring that such rules are effective not later than January 1, 2014.

''(iii) OTHER COMPLETED TRANSACTIONS.—The set of operating rules for

the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, shall be adopted not later than July 1, 2014, in a manner ensuring that such rules are effective not later than January 1, 2016.

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

''(h) COMPLIANCE.—

''(1) HEALTH PLAN CERTIFICATION.—

''(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December

31, 2013, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards (as described under paragraph (7) of section 1171) and operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

''(B) OTHER COMPLETED TRANSACTIONS.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with any applicable standards and operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, respectively. A health plan shall provide the same level of

documentation to certify compliance with such transactions as is required to certify compliance with the transactions specified in subparagraph (A).

''(2) DOCUMENTATION OF COMPLIANCE.—A health plan shall provide the Secretary, in such form as the Secretary may require, with adequate documentation of compliance with the standards and operating rules described under paragraph (1). A health plan shall not be considered to have provided adequate documentation and shall not be certified as being in compliance with such standards, unless the health plan—

''(A) demonstrates to the Secretary that the plan conducts the electronic transactions specified in paragraph (1) in a manner that fully complies with the regulations of the Secretary; and

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

''(3) SERVICE CONTRACTS.—A health plan shall be required to comply with any applicable certification and compliance requirements (and provide the

Secretary with adequate documentation of such compliance) under this subsection for any entities that provide services pursuant to a contract with such health plan.

''(4) CERTIFICATION BY OUTSIDE ENTITY.—The Secretary may contract with an independent, outside entity to certify that a health plan has complied with the requirements under this subsection, provided that the certification standards employed by such entities are in accordance with any standards or rules issued by the Secretary.

''(5) COMPLIANCE WITH REVISED STANDARDS AND RULES.—A health plan (including entities described under paragraph (3)) shall comply with the certification and documentation requirements under this subsection for any interim final rule promulgated by the Secretary under subsection (i) that amends any standard or operating rule described under paragraph (1) of this subsection. A health plan shall comply with such requirements not later than the effective date of the applicable interim final rule.

''(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described under

paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1).

''(i) REVIEW AND AMENDMENT OF STANDARDS AND RULES.—

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

''(2) EVALUATIONS AND REPORTS.—

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

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

''(3) INTERIM FINAL RULEMAKING.—

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

"(B) PUBLIC COMMENT.—

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

"(ii) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be 25 months following the close of such public comment period.

"(4) REVIEW COMMITTEE.—

"(A) DEFINITION.—For the purposes of this subsection, the term 'review committee' means a committee within the Department of

Health and Human services that has been designated by the Secretary to carry out this subsection, including—

"(i) the National Committee on Vital and Health Statistics; or

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

"(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall consider the standards approved by the Office of the National Coordinator for Health Information Technology.

"(j) PENALTIES.—

"(1) PENALTY FEE.—

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

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

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

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

"(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis—

"(i) an amount equal to $20 per covered life under such plan; or

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

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

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

"(3) PENALTY FEE REPORT.—Not later than May 1, 2014, and annually thereafter, the Secretary

shall provide the Secretary of the Treasury with a report identifying those health plans that have been assessed a penalty fee under this subsection.

''(4) COLLECTION OF PENALTY FEE.—

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

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

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

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

''(i) increased by the interest accrued on such amount, as determined pursuant to the underpayment rate established under section 6601 of the Internal Revenue Code of 1986; and

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

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

(b) PROMULGATION OF RULES.—

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C.

1320d-2(b))) based on the input of the National Committee of Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

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

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

(1) in paragraph (23), by striking the ''or'' at the end;

(2) in paragraph (24), by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (24) the following new paragraph:

''(25) not later than January 1, 2014, for which the payment is other than by electronic funds

transfer (EFT) or an electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.''.

(d) MEDICARE AND MEDICAID COMPLIANCE REPORTS.—Not later than July 1, 2013, the Secretary of Health and Human Services shall submit a report to the Chairs and Ranking Members of the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Chairs and Ranking Members of the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate on the extent to which the Medicare program and providers that serve beneficiaries under that program, and State Medicaid programs and providers that serve beneficiaries under those programs, transact electronically in accordance with transaction standards issued under the Health Insurance Portability and Accountability Act of 1996, part C of title XI of the Social Security Act, and regulations promulgated under such Acts.

Subtitle H—Sense of the Senate Regarding Medical Malpractice

SEC. 3701. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual's right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.

TITLE IV—TRANSPARENCY AND PROGRAM INTEGRITY

Subtitle A—Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals

SEC. 4001. LIMITATION ON MEDICARE EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395nn) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(C) in the case where the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking ''and'' at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.''; and

(3) by adding at the end the following new subsection:

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had—

''(i) physician ownership or investment on November 1, 2009; and

''(ii) a provider agreement under section 1866 in effect on such date.

''(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in para-

graph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of the enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

''(C) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

''(II) the nature and extent of all ownership and investment interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, by a time that permits the patient to make a meaningful decision

regarding the receipt of care, as determined by the Secretary—

"(I) the ownership or investment interest, as applicable, of such referring physician in the hospital; and

"(II) if applicable, any such ownership or investment interest of the treating physician.

"(iii) The hospital does not condition any physician ownership or investment interests either directly or indirectly on the physician owner or investor making or influencing referrals to the hospital or otherwise generating business for the hospital.

"(iv) The hospital discloses the fact that the hospital is partially owned or invested in by physicians—

"(I) on any public website for the hospital; and

"(II) in any public advertising for the hospital.

"(D) ENSURING BONA FIDE INVESTMENT.—

"(i) The percentage of the total value of the ownership or investment interests

held in the hospital, or in an entity whose assets include the hospital, by physician owners or investors in the aggregate does not exceed such percentage as of the date of enactment of this subsection.

''(ii) Any ownership or investment interests that the hospital offers to a physician owner or investor are not offered on more favorable terms than the terms offered to a person who is not a physician owner or investor.

''(iii) The hospital (or any owner or investor in the hospital) does not directly or indirectly provide loans or financing for any investment in the hospital by a physician owner or investor.

''(iv) The hospital (or any owner or investor in the hospital) does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or investor or group of physician owners or investors that is related to acquiring any ownership or investment interest in the hospital.

''(v) Ownership or investment returns are distributed to each owner or investor in the hospital in an amount that is directly proportional to the ownership or investment interest of such owner or investor in the hospital.

''(vi) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

''(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner or investor.

''(E) PATIENT SAFETY.—

''(i) Insofar as the hospital admits a patient and does not have any physician

available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

"(I) the hospital discloses such fact to a patient; and

"(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

"(ii) The hospital has the capacity to—

"(I) provide assessment and initial treatment for patients; and

"(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

"(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

"(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update

on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

''(A) PROCESS.—

''(i) ESTABLISHMENT.—The Secretary shall establish and implement a process under which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

''(ii) OPPORTUNITY FOR COMMUNITY INPUT.—The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception is located with the opportunity to provide input with respect to the application.

''(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on May 1, 2011.

''(iv) REGULATIONS.—Not later than April 1, 2011, the Secretary shall promul-

gate regulations to carry out the process under clause (i).

''(B) FREQUENCY.—The process described in subparagraph (A) shall permit an applicable hospital to apply for an exception up to once every 2 years.

''(C) PERMITTED INCREASE.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital (or, if the applicable hospital has been granted a previous exception under this paragraph, above the number of operating rooms, procedure rooms, and beds for which the hospital is licensed after the application of the most recent increase under such an exception).

''(ii) 100 PERCENT INCREASE LIMITATION.—The Secretary shall not permit an

increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

''(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term 'baseline number of operating rooms, procedure rooms, and beds' means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed as of the date of enactment of this subsection.

''(D) INCREASE LIMITED TO FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, and beds for which an applicable hospital is licensed pursuant to this para-

graph may only occur in facilities on the main campus of the applicable hospital.

''(E) APPLICABLE HOSPITAL.—In this paragraph, the term 'applicable hospital' means a hospital—

''(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period (as of the date of the application under subparagraph (A)) is at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during that period, as estimated by Bureau of the Census;

''(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX is equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

''(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physicians

practicing at the hospital to discriminate against such beneficiaries;

"(iv) that is located in a State in which the average bed capacity in the State is less than the national average bed capacity; and

"(v) that has an average bed occupancy rate that is greater than the average bed occupancy rate in the State in which the hospital is located.

"(F) PROCEDURE ROOMS.—In this subsection, the term 'procedure rooms' includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed, except such term shall not include emergency rooms or departments (exclusive of rooms in which catheterizations, angiographies, angiograms, and endoscopies are performed).

"(G) PUBLICATION OF FINAL DECISIONS.—Not later than 60 days after receiving a complete application under this paragraph, the Secretary shall publish in the Federal Register the final decision with respect to such application.

"(H) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the process under this paragraph (including the establishment of such process).

"(4) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of subparagraphs (A)(i) and (D)(i) of paragraph (1), the Secretary shall collect physician ownership and investment information for each hospital.

"(5) PHYSICIAN OWNER OR INVESTOR DEFINED.—For purposes of this subsection, the term 'physician owner or investor' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership or investment interest in the hospital.

"(6) CLARIFICATION.—Nothing in this subsection shall be construed as preventing the Secretary from revoking a hospital's provider agreement if not in compliance with regulations implementing section 1866.".

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the re-

quirements described in subsection (i)(1) of section 1877 of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than August 1, 2011, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

Subtitle B—Physician Ownership and Other Transparency

SEC. 4101. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

"SEC. 1128G. TRANSPARENCY REPORTS AND REPORTING OF PHYSICIAN OWNERSHIP OR INVESTMENT INTERESTS.

''(a) TRANSPARENCY REPORTS.—

''(1) PAYMENTS OR OTHER TRANSFERS OF VALUE.—

"(A) IN GENERAL.—On March 31, 2012, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer that provides a payment or other transfer of value to a covered recipient (or to an entity or individual at the request of or designated on behalf of a covered recipient), shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

"(i) The name of the covered recipient.

"(ii) The business address of the covered recipient and, in the case of a covered recipient who is a physician, the specialty and National Provider Identifier of the covered recipient.

"(iii) The amount of the payment or other transfer of value.

"(iv) The dates on which the payment or other transfer of value was provided to the covered recipient.

"(v) A description of the form of the payment or other transfer of value, indi-

cated (as appropriate for all that apply) as—

"(I) cash or a cash equivalent;

"(II) in-kind items or services;

"(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

"(IV) any other form of payment or other transfer of value (as defined by the Secretary).

"(vi) A description of the nature of the payment or other transfer of value, indicated (as appropriate for all that apply) as—

"(I) consulting fees;

"(II) compensation for services other than consulting;

"(III) honoraria;

"(IV) gift;

"(V) entertainment;

"(VI) food;

"(VII) travel (including the specified destinations);

"(VIII) education;

"(IX) research;

"(X) charitable contribution;

"(XI) royalty or license;

"(XII) current or prospective ownership or investment interest;

"(XIII) direct compensation for serving as faculty or as a speaker for a medical education program;

"(XIV) grant; or

"(XV) any other nature of the payment or other transfer of value (as defined by the Secretary).

"(vii) If the payment or other transfer of value is related to marketing, education, or research specific to a covered drug, device, biological, or medical supply, the name of that covered drug, device, biological, or medical supply.

"(viii) Any other categories of information regarding the payment or other transfer of value the Secretary determines appropriate.

"(B) SPECIAL RULE FOR CERTAIN PAYMENTS OR OTHER TRANSFERS OF VALUE.—In the case where an applicable manufacturer pro-

vides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the applicable manufacturer shall disclose that payment or other transfer of value under the name of the covered recipient.

''(2) PHYSICIAN OWNERSHIP.—In addition to the requirement under paragraph (1)(A), on March 31, 2012, and on the 90th day of each calendar year beginning thereafter, any applicable manufacturer or applicable group purchasing organization shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than an ownership or investment interest in a publicly traded security and mutual fund, as described in section 1877(c)) held by a physician (or an immediate family member of such physician (as defined for purposes of section 1877(a))) in the applicable manufacturer or applicable group purchasing organization during the preceding year:

''(A) The dollar amount invested by each physician holding such an ownership or investment interest.

''(B) The value and terms of each such ownership or investment interest.

''(C) Any payment or other transfer of value provided to a physician holding such an ownership or investment interest (or to an entity or individual at the request of or designated on behalf of a physician holding such an ownership or investment interest), including the information described in clauses (i) through (viii) of paragraph (1)(A), except that in applying such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

''(D) Any other information regarding the ownership or investment interest the Secretary determines appropriate.

''(b) PENALTIES FOR NONCOMPLIANCE.—

''(1) FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty

of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

''(2) KNOWING FAILURE TO REPORT.—

''(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment

or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $1,000,000.

''(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

''(c) PROCEDURES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—Not later than October 1, 2010, the Secretary shall establish procedures—

"(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a); and

"(ii) for the Secretary to make such information submitted available to the public.

"(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms (other than those terms defined in subsection (e)), as appropriate, for purposes of this section.

"(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(ii) shall ensure that, not later than September 30, 2012, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

"(i) is searchable and is in a format that is clear and understandable;

"(ii) contains information that is presented by the name of the applicable man-

ufacturer or applicable group purchasing organization, the name of the covered recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(v), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(A)(vi), and the name of the covered drug, device, biological, or medical supply, as applicable;

''(iii) contains information that is able to be easily aggregated and downloaded;

''(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year;

''(v) contains background information on industry-physician relationships;

''(vi) in the case of information submitted with respect to a payment or other transfer of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and designates such separately listed information as funding for clinical research;

''(vii) contains any other information the Secretary determines would be helpful to the average consumer;

''(viii) does not contain the National Provider Identifier of the covered recipient, and

''(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public.

"(D) CLARIFICATION OF TIME PERIOD FOR REVIEW AND CORRECTIONS.—In no case may the 45-day period for review and submission of corrections to information under subparagraph (C)(ix) prevent such information from being made available to the public in accordance with the dates described in the matter preceding clause (i) in subparagraph (C).

"(E) DELAYED PUBLICATION FOR PAYMENTS MADE PURSUANT TO PRODUCT RESEARCH OR DEVELOPMENT AGREEMENTS AND CLINICAL INVESTIGATIONS.—

"(i) IN GENERAL.—In the case of information submitted under subsection (a) with respect to a payment or other transfer of value made to a covered recipient by an applicable manufacturer pursuant to a product research or development agreement for services furnished in connection with research on a potential new medical technology or a new application of an existing medical technology or the development of a new drug, device, biological, or medical supply, or by an applicable manufacturer in connection with a clinical inves-

tigation regarding a new drug, device, biological, or medical supply, the procedures established under subparagraph (A)(ii) shall provide that such information is made available to the public on the first date described in the matter preceding clause (i) in subparagraph (C) after the earlier of the following:

''(I) The date of the approval or clearance of the covered drug, device, biological, or medical supply by the Food and Drug Administration.

''(II) Four calendar years after the date such payment or other transfer of value was made.

''(ii) CONFIDENTIALITY OF INFORMATION PRIOR TO PUBLICATION.—Information described in clause (i) shall be considered confidential and shall not be subject to disclosure under section 552 of title 5, United States Code, or any other similar Federal, State, or local law, until on or after the date on which the information is made available to the public under such clause.

''(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the Inspector General of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

''(d) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

''(1) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2012, the Secretary shall submit to Congress a report that includes the following:

''(A) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which

such information is made available to the public under such subsection).

''(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

''(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2012 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2011, subject to sub-

paragraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information (as described in subsection (a)) regarding such payment or other transfer of value.

''(B) NO PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

''(i) not of the type required to be disclosed or reported under this section;

''(ii) described in subsection (e)(10)(B), except in the case of information described in clause (i) of such subsection;

''(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

''(iv) to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

''(C) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

''(4) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

''(e) DEFINITIONS.—In this section:

''(1) APPLICABLE GROUP PURCHASING ORGANIZATION.—The term 'applicable group purchasing organization' means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(2) APPLICABLE MANUFACTURER.—The term 'applicable manufacturer' means a manufacturer of a covered drug, device, biological, or medical supply

which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

''(3) CLINICAL INVESTIGATION.—The term 'clinical investigation' means any experiment involving 1 or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

''(4) COVERED DEVICE.—The term 'covered device' means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(5) COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'covered drug, device, biological, or medical supply' means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(6) COVERED RECIPIENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'covered recipient' means the following:

''(i) A physician.

''(ii) A teaching hospital.

"(B) EXCLUSION.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

"(7) EMPLOYEE.—The term 'employee' has the meaning given such term in section 1877(h)(2).

"(8) KNOWINGLY.—The term 'knowingly' has the meaning given such term in section 3729(b) of title 31, United States Code.

"(9) MANUFACTURER OF A COVERED DRUG, DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The term 'manufacturer of a covered drug, device, biological, or medical supply' means any entity which is engaged in the production, preparation, propagation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, propagation, compounding, conversion, marketing, promotion, sale, or distribution of a covered drug, device, biological, or medical supply).

"(10) PAYMENT OR OTHER TRANSFER OF VALUE.—

"(A) IN GENERAL.—The term 'payment or other transfer of value' means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is unaware of the identity of the covered recipient.

"(B) EXCLUSIONS.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

"(i) A transfer of anything the value of which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2012, the dollar amounts specified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for

the 12-month period ending with June of the previous year.

''(ii) Product samples that are not intended to be sold and are intended for patient use.

''(iii) Educational materials that directly benefit patients or are intended for patient use.

''(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

''(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

''(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity of a covered recipient.

''(vii) Discounts (including rebates).

''(viii) In-kind items used for the provision of charity care.

"(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

"(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

"(xi) In the case of a covered recipient who is a licensed non-medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the non-medical professional services of such licensed non-medical professional.

"(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

"(11) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).".

SEC. 4102. DISCLOSURE REQUIREMENTS FOR IN-OFFICE ANCILLARY SERVICES EXCEPTION TO THE PROHIBITION ON PHYSICIAN SELF-REFERRAL FOR CERTAIN IMAGING SERVICES.

(a) IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by adding at the end the following new sentence: ''Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after January 1, 2010.

SEC. 4103. PRESCRIPTION DRUG SAMPLE TRANSPARENCY.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 4101, is

amended by inserting after section 1128G the following new section:

"SEC. 1128H. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

"(a) IN GENERAL.—Not later than April 1 of each year (beginning with 2012), each manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

"(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353), the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

"(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(2) In the case of a manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and the identity and quantity of drug samples distributed under such subsection during that year, aggregated by—

''(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

''(B) any other category of information determined appropriate by the Secretary.

''(b) DEFINITIONS.—In this section:

''(1) APPLICABLE DRUG.—The term 'applicable drug' means a drug—

''(A) which is subject to subsection (b) of such section 503; and

''(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

''(2) AUTHORIZED DISTRIBUTOR OF RECORD.—The term 'authorized distributor of record' has the meaning given that term in subsection (e)(3)(A) of such section.

''(3) MANUFACTURER.—The term 'manufacturer' has the meaning given that term for purposes of subsection (d) of such section.''.

Subtitle C—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 4201. REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) IN GENERAL.—Section 1124 of the Social Security Act (42 U.S.C. 1320a–3) is amended by adding at the end the following new subsection:

''(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

''(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available—

''(A) during the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 4201(b) of the America's Healthy Future Act of 2009 for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

''(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

Nothing in subparagraph (A) shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

''(2) INFORMATION DESCRIBED.—

''(A) IN GENERAL.—The following information is described in this paragraph:

''(i) The information described in subsections (a) and (b), subject to subparagraph (C).

''(ii) The identity of and information on—

''(I) each member of the governing body of the facility, including the name, title, and period of service of each such member;

''(II) each person or entity who is an officer, director, member, partner, trustee, or managing employee of the facility, including the name, title, and period of service of each such person or entity; and

''(III) each person or entity who is an additional disclosable party of the facility.

''(iii) The organizational structure of each additional disclosable party of the facility and a description of the relationship of each such additional disclosable party to the facility and to one another.

''(B) SPECIAL RULE WHERE INFORMATION IS ALREADY REPORTED OR SUBMITTED.—To

the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the facility may provide such Form or such information submitted to meet the requirements of paragraph (1).

''(C) SPECIAL RULE.—In applying subparagraph (A)(i)—

''(i) with respect to subsections (a) and (b), 'ownership or control interest' shall include direct or indirect interests, including such interests in intermediate entities; and

''(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured, in whole or in part, by the entity or any of the property or assets thereof, if the interest is equal to or exceeds 5 percent of the total property or assets of the entirety.

''(3) REPORTING.—

''(A) IN GENERAL.—Not later than the date that is 2 years after the date of the enactment of this subsection, the Secretary shall promulgate final regulations requiring, effective on the date that is 90 days after the date on which such final regulations are published in the Federal Register, a facility to report the information described in paragraph (2) to the Secretary in a standardized format, and such other regulations as are necessary to carry out this subsection. Such final regulations shall ensure that the facility certifies, as a condition of participation and payment under the program under title XVIII or XIX, that the information reported by the facility in accordance with such final regulations is, to the maximum extent practicable (as determined by the facility), accurate and current.

''(B) GUIDANCE.—The Secretary shall provide guidance and technical assistance to States on how to adopt the standardized format under subparagraph (A).

''(4) NO EFFECT ON EXISTING REPORTING REQUIREMENTS.—Nothing in this subsection shall re-

duce, diminish, or alter any reporting requirement for a facility that is in effect as of the date of the enactment of this subsection.

''(5) DEFINITIONS.—In this subsection:

''(A) ADDITIONAL DISCLOSABLE PARTY.—The term 'additional disclosable party' means, with respect to a facility, any person or entity who—

''(i) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility;

''(ii) leases or subleases real property to the facility, or owns a whole or part interest equal to or exceeding 5 percent of the total value of such real property; or

''(iii) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility.

''(B) FACILITY.—The term 'facility' means a disclosing entity which is—

"(i) a skilled nursing facility (as defined in section 1819(a)); or

"(ii) a nursing facility (as defined in section 1919(a)).

"(C) MANAGING EMPLOYEE.—The term 'managing employee' means, with respect to a facility, an individual (including a general manager, business manager, administrator, director, or consultant) who directly or indirectly manages, advises, or supervises any element of the practices, finances, or operations of the facility.

"(D) ORGANIZATIONAL STRUCTURE.—The term 'organizational structure' means, in the case of—

"(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

"(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

''(iii) a general partnership, the partners of the general partnership;

''(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;

''(v) a trust, the trustees of the trust;

''(vi) an individual, contact information for the individual; and

''(vii) any other person or entity, such information as the Secretary determines appropriate.''.

(b) PUBLIC AVAILABILITY OF INFORMATION.—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1124(c)(3)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(B) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by striking subparagraph (B) and redesignating subparagraph (C) as subparagraph (B).

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 4202. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND NURSING FACILITIES.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 4103, is amended by inserting after section 1128H the following new section:

"SEC. 1128I. ACCOUNTABILITY REQUIREMENTS FOR FACILITIES.

"(a) DEFINITION OF FACILITY.—In this section, the term 'facility' means—

"(1) a skilled nursing facility (as defined in section 1819(a)); or

"(2) a nursing facility (as defined in section 1919(a)).

"(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

"(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the entity that operates the facility (in this subparagraph referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with regulations developed under paragraph (2).

"(2) DEVELOPMENT OF REGULATIONS.—

"(A) IN GENERAL.—Not later than the date that is 2 years after such date of the enactment, the Secretary, working jointly with the Inspector General of the Department of Health and Human Services, shall promulgate regula-

tions for an effective compliance and ethics program for operating organizations, which may include a model compliance program.

''(B) DESIGN OF REGULATIONS.—Such regulations with respect to specific elements or formality of a program may vary with the size of the organization, such that larger organizations should have a more formal program and include established written policies defining the standards and procedures to be followed by its employees. Such requirements may specifically apply to the corporate level management of multi unit nursing home chains.

''(C) EVALUATION.—Not later than 3 years after the date of the promulgation of regulations under this paragraph, the Secretary shall complete an evaluation of the compliance and ethics programs required to be established under this subsection. Such evaluation shall determine if such programs led to changes in deficiency citations, changes in quality performance, or changes in other metrics of patient quality of care. The Secretary shall submit to Congress a report on such evaluation and shall include in such report such recommendations

regarding changes in the requirements for such programs as the Secretary determines appropriate.

''(3) REQUIREMENTS FOR COMPLIANCE AND ETHICS PROGRAMS.—In this subsection, the term 'compliance and ethics program' means, with respect to a facility, a program of the operating organization that—

''(A) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

''(B) includes at least the required components specified in paragraph (4).

''(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

''(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

''(B) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance with such standards and procedures and have sufficient resources and authority to assure such compliance.

''(C) The organization must have used due care not to delegate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under this Act.

''(D) The organization must have taken steps to communicate effectively its standards and procedures to all employees and other agents, such as by requiring participation in training programs or by disseminating publications that explain in a practical manner what is required.

''(E) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations

under this Act by its employees and other agents and by having in place and publicizing a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

''(F) The standards must have been consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect an offense.

''(G) After an offense has been detected, the organization must have taken all reasonable steps to respond appropriately to the offense and to prevent further similar offenses, including any necessary modification to its program to prevent and detect criminal, civil, and administrative violations under this Act.

''(H) The organization must periodically undertake reassessment of its compliance program to identify changes necessary to reflect changes within the organization and its facilities.

''(c) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

''(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this subparagraph referred to as the 'QAPI program') for facilities, including multi unit chains of facilities. Under the QAPI program, the Secretary shall establish standards relating to quality assurance and performance improvement with respect to facilities and provide technical assistance to facilities on the development of best practices in order to meet such standards. Not later than 1 year after the date on which the regulations are promulgated under paragraph (2), a facility must submit to the Secretary a plan for the facility to meet such standards and implement such best practices, including how to coordinate the implementation of such plan with quality assessment and assurance activities conducted under sections 1819(b)(1)(B) and 1919(b)(1)(B), as applicable.

''(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.''.

SEC. 4203. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395i–3) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

"(i) NURSING HOME COMPARE WEBSITE.—

"(1) INCLUSION OF ADDITIONAL INFORMATION.—

"(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

"(i) Information that is reported to the Secretary under section 1124(c)(3).

"(ii) Information on the 'Special Focus Facility program' (or a successor program) established by the Centers for Medicare and Medicaid Services, according

to procedures established by the Secretary. Such procedures shall provide for the inclusion of information with respect to, and the names and locations of, those facilities that, since the previous quarter—

"(I) were newly enrolled in the program;

"(II) are enrolled in the program and have failed to significantly improve;

"(III) are enrolled in the program and have significantly improved;

"(IV) have graduated from the program; and

"(V) have closed voluntarily or no longer participate under this title.

"(iii) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare dif-

ferences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as a plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(iv) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility

plan of correction or other response to such report.

''(v) The standardized complaint form developed under section 1128I(f), including explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(vii) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

''(I) that were committed inside the facility;

''(II) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual abuse, or other violations or crimes that resulted in serious bodily injury; and

"(III) the number of civil monetary penalties levied against the facility, employees, contractors, and other agents.

"(B) DEADLINE FOR PROVISION OF INFORMATION.—

"(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

"(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than the date on which the requirements under section 1124(c)(3) and section 1128I(g) are implemented.

"(2) REVIEW AND MODIFICATION OF WEBSITE.—

"(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups; and

''(iv) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1819(g)(5) of the Social Security Act (42 U.S.C. 1395i–

3(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

''(8) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirement of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919 of the Social Security Act (42 U.S.C. 1396r) is amended—

(A) by redesignating subsection (i) as subsection (j); and

(B) by inserting after subsection (h) the following new subsection:

''(i) NURSING HOME COMPARE WEBSITE.—

''(1) INCLUSION OF ADDITIONAL INFORMATION.—

''(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the 'Nursing Home Compare' Medicare website) (or a successor website), the following information in a manner that is prominent, easily accessible, readily understandable to consumers of long-term care services, and searchable:

''(i) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1128I(g), including information on staffing turnover and tenure, in a format that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and State and national averages for the facilities. Such format shall include—

''(I) concise explanations of how to interpret the data (such as plain English explanation of data reflecting 'nursing home staff hours per resident day');

''(II) differences in types of staff (such as training associated with different categories of staff);

''(III) the relationship between nurse staffing levels and quality of care; and

''(IV) an explanation that appropriate staffing levels vary based on patient case mix.

''(ii) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret and understand such reports, and the facility plan of correction or other response to such report.

''(iii) The standardized complaint form developed under section 1128I(f), in-

cluding explanatory material on what complaint forms are, how they are used, and how to file a complaint with the State survey and certification program and the State long-term care ombudsman program.

''(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

''(v) The number of adjudicated instances of criminal violations by a facility or the employees of a facility—

''(I) that were committed inside of the facility; and

''(II) with respect to such instances of violations or crimes committed outside of the facility, that were violations or crimes that resulted in the serious bodily injury of an elder.

''(B) DEADLINE FOR PROVISION OF INFORMATION.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website

(or a successor website) not later than 1 year after the date of the enactment of this subsection.

''(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A)(i) is included on such website (or a successor website) not later than the date on which the requirements under section 1128I(g) are implemented.

''(2) REVIEW AND MODIFICATION OF WEBSITE.—

''(A) IN GENERAL.—The Secretary shall establish a process—

''(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

''(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

''(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

''(i) State long-term care ombudsman programs;

''(ii) consumer advocacy groups;

''(iii) provider stakeholder groups;

''(iv) skilled nursing facility employees and their representatives; and

''(v) any other representatives of programs or groups the Secretary determines appropriate.''.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

''(E) SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION TO THE SECRETARY.—In order to improve the timeliness of information made available to the public under subparagraph (A) and provided on the Nursing Home Compare Medicare website under subsection (i), each State shall submit information

respecting any survey or certification made respecting a nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.''.

(B) EFFECTIVE DATE.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of such Act is amended by adding at the end of the following new paragraph:

''(10) SPECIAL FOCUS FACILITY PROGRAM.—

''(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having substantially failed to meet applicable requirements of this Act.

''(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each facility in the program not less often than once every 6 months.''.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395i–3(d)(1)), as amended by section 4201, is amended by adding at the end the following new subparagraph:

''(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 4201, is amended by adding at the end the following new subparagraph:

''(V) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A nursing facility must—

''(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and

''(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(d) GUIDANCE TO STATES ON FORM 2567 STATE INSPECTION REPORTS AND COMPLAINT INVESTIGATION REPORTS.—

(1) GUIDANCE.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall provide guidance to States on how States can establish electronic links to Form 2567 State inspection reports (or a successor form), complaint investigation reports, and a facility's plan of correction or other response to such Form 2567 State inspection reports (or a successor form) on the Internet website of the State that provides information on skilled nursing facilities and nursing facilities and the Secretary shall, if possible, include such information on Nursing Home Compare.

(2) REQUIREMENT.—Section 1902(a)(9) of the Social Security Act (42 U.S.C. 1396a(a)(9)) is amended—

(A) by striking ''and'' at the end of subparagraph (B);

(B) by striking the semicolon at the end of subparagraph (C) and inserting '', and''; and

(C) by adding at the end the following new subparagraph:

''(D) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, in-

cluding for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;''.

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(B) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)).

(e) DEVELOPMENT OF CONSUMER RIGHTS INFORMATION PAGE ON NURSING HOME COMPARE WEBSITE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall ensure that the Department of Health and Human Services, as part of the information

provided for comparison of nursing facilities on the Nursing Home Compare Medicare website develops and includes a consumer rights information page that contains links to descriptions of, and information with respect to, the following:

(1) The documentation on nursing facilities that is available to the public.

(2) General information and tips on choosing a nursing facility that meets the needs of the individual.

(3) General information on consumer rights with respect to nursing facilities.

(4) The nursing facility survey process (on a national and State-specific basis).

(5) On a State-specific basis, the services available through the State long-term care ombudsman for such State.

SEC. 4204. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(f) REPORTING OF DIRECT CARE EXPENDITURES.—

''(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods beginning

on or after the date that is 2 years after the date of the enactment of this subsection, skilled nursing facilities shall separately report expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff).

''(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with Medicare and Medicaid nursing facility home cost reports, shall redesign such reports to meet the requirement of paragraph (1) not later than 1 year after the date of the enactment of this subsection.

''(3) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Not later than 30 months after the date of the enactment of this subsection, the Secretary, working in consultation with the Medicare Payment Advisory Commission, the Medicaid and CHIP Payment and Access Commission, the Inspector General of the Department of Health and Human Services, and other expert parties the Secretary determines appropriate, shall take the expenditures listed on cost reports, as modified under paragraph (1), submitted by skilled nursing facilities and categorize

such expenditures, regardless of any source of payment for such expenditures, for each skilled nursing facility into the following functional accounts on an annual basis:

''(A) Spending on direct care services (including nursing, therapy, and medical services).

''(B) Spending on indirect care (including housekeeping and dietary services).

''(C) Capital assets (including building and land costs).

''(D) Administrative services costs.

''(4) AVAILABILITY OF INFORMATION SUBMITTED.—The Secretary shall establish procedures to make information on expenditures submitted under this subsection readily available to interested parties upon request, subject to such requirements as the Secretary may specify under the procedures established under this paragraph.''.

SEC. 4205. STANDARDIZED COMPLAINT FORM.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(f) STANDARDIZED COMPLAINT FORM.—

''(1) DEVELOPMENT BY THE SECRETARY.—The Secretary shall develop a standardized complaint

form for use by a resident (or a person acting on the resident's behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a facility.

''(2) COMPLAINT FORMS AND RESOLUTION PROCESSES.—

''(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under paragraph (1) available upon request to—

''(i) a resident of a facility; and

''(ii) any person acting on the resident's behalf.

''(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that the legal representative of a resident of a facility or other responsible party is not denied access to such resident or otherwise retaliated against if they have complained about the quality of care provided by the facility or other issues relating to the facility. Such complaint resolution process shall include—

''(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

''(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint; and

''(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a resident of a facility (or a person acting on the resident's behalf) from submitting a complaint in a manner or format other than by using the standardized complaint form developed under paragraph (1) (including submitting a complaint orally).''.

(b) EFFECTIVE DATE.—The amendment made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 4206. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(g) SUBMISSION OF STAFFING INFORMATION BASED ON PAYROLL DATA IN A UNIFORM FORMAT.—Beginning not later than 2 years after the date of the enactment of this subsection, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a facility to electronically submit to the Secretary direct care staffing information (including information with respect to agency and contract staff) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such programs, groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

''(1) specify the category of work a certified employee performs (such as whether the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other medical personnel);

''(2) include resident census data and information on resident case mix;

''(3) include a regular reporting schedule; and

''(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.''.

SEC. 4207. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented;

(2) any problems associated with such system or its implementation; and

(3) how such system could be improved.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Comptroller General shall

submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 4211. CIVIL MONEY PENALTIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)(ii)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may

reduce the amount of the penalty imposed by not more than 50 percent.

"(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

"(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

"(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

"(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

"(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

"(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

‘‘(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

‘‘(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

‘‘(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

‘‘(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be

used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—The second sentence of section 1819(h)(5) of the Social Security

Act (42 U.S.C. 1395i–3(h)(5)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396r(h)(3)(C)) is amended—

(A) by striking ''PENALTIES.—The Secretary'' and inserting ''PENALTIES.—

''(I) IN GENERAL.—Subject to subclause (II), the Secretary''; and

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

''(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

''(III) PROHIBITIONS ON REDUCTION FOR CERTAIN DEFICIENCIES.—

"(aa) REPEAT DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the Secretary had reduced a penalty imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

"(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce the amount of a penalty under subclause (II) if the penalty is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

"(IV) COLLECTION OF CIVIL MONEY PENALTIES.—In the case of a civil money penalty imposed under

this clause, the Secretary shall issue regulations that—

"(aa) subject to item (cc), not later than 30 days after the imposition of the penalty, provide for the facility to have the opportunity to participate in an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

"(bb) in the case where the penalty is imposed for each day of noncompliance, provide that a penalty may not be imposed for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

"(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an es-

crow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

''(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals;

''(ee) in the case where the facility successfully appeals the penalty, may provide for the return of such amounts collected (plus interest) to the facility; and

''(ff) in the case where all such appeals are unsuccessful, may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes

(voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).''.

(2) CONFORMING AMENDMENT.—Section 1919(h)(5)(8) of the Social Security Act (42 U.S.C. 1396r(h)(5)(8)) is amended by inserting ''(ii)(IV),'' after ''(i),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 4212. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a pilot program to develop, test, and implement an independent monitor program to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the pilot program under this section from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the pilot program under this section for a 2-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program under this section not later than 1 year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the pilot program under this section based on criteria selected by the Secretary, including where evidence suggests that 1 or more facilities

of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes 1 or more facilities participating in the ''Special Focus Facility'' program (or a successor program) or 1 or more facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the pilot program under this section shall—

(1) conduct periodic reviews and prepare root-cause quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) undertake sustained oversight of the chain, whether publicly or privately held, to involve the owners of, and any additional disclosable party with respect to a facility of, the chain in facilitating compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the pilot program shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain, the Secretary, and the State

or States, as appropriate, containing such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for a portion of the costs associated with the appointment of independent monitors under the pilot program under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as may be necessary for the purpose of carrying out the pilot program under this section.

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

(h) DEFINITIONS.—In this section:

(1) ADDITIONAL DISCLOSABLE PARTY.—The term ''additional disclosable party'' has the meaning given such term in section 1124(c)(5)(A) of the Social Security Act, as added by section 4201(a).

(2) FACILITY.—The term ''facility'' means a skilled nursing facility or a nursing facility.

(3) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section

1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—The Inspector General of the Department of Health and Human Services shall evaluate the pilot program conducted under this subsection.

(2) REPORT.—Not later than 180 days after the completion of the pilot program under this section, the Inspector General shall submit to Congress and the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations—

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Inspector General recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Inspector General determines appropriate.

SEC. 4213. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

''(h) NOTIFICATION OF FACILITY CLOSURE.—

''(1) IN GENERAL.—Any individual who is the administrator of a facility must—

''(A) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

''(i) subject to clause (ii), not later than the date that is 60 days prior to the date of such closure; and

''(ii) in the case of a facility where the Secretary terminates the facility's participation under this title, not later than the

date that the Secretary determines appropriate;

''(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

''(C) include in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the State, including assurances that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

''(2) RELOCATION.—

''(A) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

''(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with re-

spect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

''(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the requirements of paragraph (1)—

''(A) shall be subject to a civil monetary penalty of up to $1,000,000;

''(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

''(C) shall be subject to any other penalties that may be prescribed by law.

''(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to a civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).''.

(b) CONFORMING AMENDMENTS.—Section 1819(h)(4) of the Social Security Act (42 U.S.C. 1395i–3(h)(4)) is amended—

(1) in the first sentence, by striking ''the Secretary shall terminate'' and inserting ''the Secretary, subject to section 1128I(h), shall terminate''; and

(2) in the second sentence, by striking ''subsection (c)(2)'' and inserting ''subsection (c)(2) and section 1128I(h)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 4214. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facilities to find and access funding in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) GRANT AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based set-

tings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump-sum payment.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(c) DURATION AND IMPLEMENTATION.—

(1) DURATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(2) IMPLEMENTATION.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) NURSING FACILITY.—The term ''nursing facility'' has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(a)).

(2) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(3) SKILLED NURSING FACILITY.—The term ''skilled nursing facility'' has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395(a)).

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

(f) REPORT.—Not later than 9 months after the completion of the demonstration project, the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 4221. DEMENTIA AND ABUSE PREVENTION TRAINING.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1819(b)(5)(F) of the Social Security

Act (42 U.S.C. 1395i–3(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ''(including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training, and patient abuse prevention training'' before '', (II)''.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

''Such term includes an individual who provides such services through an agency or under a contract with the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

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

SEC. 4301. NATIONWIDE PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), shall establish a program to identify efficient, effective, and economical procedures for long term care facilities or providers to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the ''nationwide program''). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under

subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under such subsection (c)(1), but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain State and national criminal history background checks on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize a search of State-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee previously resided in that State, State criminal history records,

the records of any proceedings in the State that may contain disqualifying information about prospective employees (such as proceedings conducted by State professional licensing and disciplinary boards and State Medicaid Fraud Control Units), and Federal criminal history records, including a fingerprint check using the Integrated Automated Fingerprint Identification System of the Federal Bureau of Investigation;

(B) require States to describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability by the State such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department, the department will immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction; and

(C) require that criminal history background checks conducted under the nationwide program remain valid for a period of time specified by the Secretary.

(4) STATE REQUIREMENTS.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal history background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program;

(iii) as appropriate, provide for a provisional period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check and, in

the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct on-site supervision);

(iv) provide an independent process by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check performed under the nationwide program, including the specification of criteria for appeals for direct patient access employees found to have disqualifying information which shall include consideration of the passage of time, extenuating circumstances, demonstration of rehabilitation, and relevancy of the particular disqualifying information with respect to the current employment of the individual;

(v) provide for the designation of a single State agency as responsible for—

(I) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(II) overseeing the design of appropriate privacy and security safeguards for use in the review of the results of any State or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has any conviction for a relevant crime;

(III) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(IV) in the case of an employee with a conviction for a relevant crime

that is subject to reporting under section 1128E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the database established under that section;

(vi) determine which individuals are direct patient access employees (as defined in paragraph (6)(B)) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of ''rap back'' capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, and the employee's fingerprints match the prints on file with the State law enforcement department—

(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the results of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

(5) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(A)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a

condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (ii).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary

enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $1,500,000.

(6) DEFINITIONS.—Under the nationwide program:

(A) CONVICTION FOR A RELEVANT CRIME.—The term ''conviction for a relevant crime'' means any Federal or State criminal conviction for—

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1320a–7); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) DISQUALIFYING INFORMATION.—The term ''disqualifying information'' means a conviction for a relevant crime or a finding of patient or resident abuse.

(C) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ''finding of patient or resi-

dent abuse'' means any substantiated finding by a State agency under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C), 1396r(g)(1)(C)) or a Federal agency that a direct patient access employee has committed—

(i) an act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

(ii) such other types of acts as a participating State may specify for purposes of conducting the program in such State.

(D) DIRECT PATIENT ACCESS EMPLOYEE.—The term ''direct patient access employee'' means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer unless the volunteer has duties that are equivalent to the duties of a direct patient access employee and those

duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(E) LONG-TERM CARE FACILITY OR PROVIDER.—The term ''long-term care facility or provider'' means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395x(dd)(1))).

(v) A long-term care hospital (as described in section 1886(d)(1)(B)(iv) of such Act (42 U.S.C. 1395ww(d)(1)(B)(iv))).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(ix) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(x) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(7) EVALUATION AND REPORT.—

(A) EVALUATION.—

(i) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) INCLUSION OF SPECIFIC TOPICS.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or

providers, including staffing agencies, to conduct background checks of direct patient access employees under the nationwide program and identification of the most appropriate, efficient, and effective procedures for conducting such background checks.

(II) An assessment of the costs of conducting such background checks (including start up and administrative costs).

(III) A determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(IV) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of resident property to the extent practicable.

(V) An evaluation of other aspects of the nationwide program, as

determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(b) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the Treasury of the amount necessary to carry out the nationwide program under this section for the period of fiscal years 2010 through 2012, except that in no case shall such amount exceed $160,000,000.

(2) TRANSFER OF FUNDS.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(B) RESERVATION OF FUNDS FOR CONDUCT OF EVALUATION.—The Secretary may reserve not more than $3,000,000 of the amount transferred under subparagraph (A) to provide for the conduct of the evaluation under subsection (a)(7)(A).

Subtitle E—Pharmacy Benefit Managers

SEC. 4401. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 1611(c) and 1923, is amended by inserting after section 1150B the following new section:

"SEC. 1150C. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

''(a) PROVISION OF INFORMATION.—A health benefits plan or any entity that provides pharmacy benefits management services on behalf of a health benefits plan (in this section referred to as a 'PBM') that manages prescription drug coverage under a contract with—

''(1) a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan under part D of title XVIII; or

''(2) a qualified health benefits plan offered through an exchange established by a State under title XXII,

shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

''(b) INFORMATION DESCRIBED.—The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

''(1) The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

''(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding

bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs))that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

''(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

''(c) CONFIDENTIALITY.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

''(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

''(2) To permit the Comptroller General to review the information provided.

''(3) To permit the Director of the Congressional Budget Office to review the information provided.

''(4) To States to carry out title XXII.

''(d) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly provides false information in the same manner as such provisions apply to a manufacturer with an agreement under that section.''.

TITLE V—FRAUD, WASTE, AND ABUSE

Subtitle A—Medicare, Medicaid, and CHIP

SEC. 5001. PROVIDER SCREENING AND OTHER ENROLLMENT REQUIREMENTS UNDER MEDICARE, MEDICAID, AND CHIP.

(a) MEDICARE.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395cc(j)) is amended—

(1) in paragraph (1)(A), by adding at the end the following: ''Such process shall include screening of providers and suppliers in accordance with paragraph (2), a provisional period of enhanced oversight in accordance with paragraph (3), disclosure requirements in accordance with paragraph (4), the imposition of temporary enrollment moratoria in accordance with paragraph (5), and the establishment of compliance programs in accordance with paragraph (6).'';

(2) by redesignating paragraph (2) as paragraph (7); and

(3) by inserting after paragraph (1) the following:

''(2) PROVIDER SCREENING.—

''(A) PROCEDURES.—Not later than 180 days after the date of enactment of this paragraph, the Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which screening is conducted with respect to providers of medical or other items or services and suppliers under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

''(B) LEVEL OF SCREENING.—The Secretary shall determine the level of screening conducted under this paragraph according to the risk of fraud, waste, and abuse, as determined by the Secretary, with respect to the category of provider of medical or other items or services or supplier. Such screening—

''(i) shall include a licensure check, which may include such checks across States; and

''(ii) may, as the Secretary determines appropriate based on the risk of fraud, waste, and abuse described in the preceding sentence, include—

''(I) a criminal background check;

''(II) fingerprinting;

''(III) unscheduled and unannounced site visits, including preenrollment site visits;

''(IV) database checks (including such checks across States); and

''(V) such other screening as the Secretary determines appropriate.

''(C) APPLICATION FEES.—

"(i) IN GENERAL.—Except as provided in clause (ii) or (iii), the Secretary shall impose a fee on each provider of medical or other items or services or supplier with respect to which screening is conducted under this paragraph in an amount equal to—

"(I) for 2010, $350; and

"(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

"(ii) TEMPORARY REDUCED FEE FOR CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—In the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of the date of enactment of this paragraph, during the period beginning on such date of

enactment and ending on the date that is 1 year after such date, the amount of the fee imposed under this subparagraph shall be equal to $250. Such fee shall be imposed with respect to all providers of medical or other items and services and suppliers described in the preceding sentence, regardless of whether the provider or supplier is due for revalidation of enrollment in the program during such period.

''(iii) HARDSHIP EXCEPTION; WAIVER FOR CERTAIN MEDICAID PROVIDERS.—The Secretary may, on a case-by-case basis, exempt a provider of medical or other items or services or supplier from the imposition of an application fee under this subparagraph if the Secretary determines that the imposition of the application fee would result in a hardship. The Secretary may waive the application fee under this subparagraph for providers enrolled in a State Medicaid program for whom the State demonstrates that imposition of the fee would impede beneficiary access to care.

''(iv) USE OF FUNDS.—Amounts collected as a result of the imposition of a fee under this subparagraph shall be used by the Secretary for program integrity efforts, including to cover the costs of conducting screening under this paragraph and to carry out this subsection and section 1128J.

''(D) APPLICATION AND ENFORCEMENT.—

''(i) NEW PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is not enrolled in the program under this title, title XIX , or title XXI as of the date of enactment of this paragraph, on or after the date that is 1 year after such date of enactment.

''(ii) CURRENT PROVIDERS OF SERVICES AND SUPPLIERS.—The screening under this paragraph shall apply, in the case of a provider of medical or other items or services or supplier who is enrolled in the program under this title, title XIX, or title XXI as of such date of enact-

ment, on or after the date that is 2 years after such date of enactment.

''(iii) REVALIDATION OF ENROLLMENT.—Effective beginning on the date that is 180 days after such date of enactment, the screening under this paragraph shall apply with respect to the revalidation of enrollment of a provider of medical or other items or services or supplier in the program under this title, title XIX, or title XXI.

''(iv) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has not been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

''(E) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

''(3) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS OF SERVICES AND SUPPLIERS.—

''(A) IN GENERAL.—The Secretary shall establish procedures to provide for a provisional period of not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as prepayment review and payment caps, under the program under this title, the Medicaid program under title XIX. and the CHIP program under title XXI.

''(B) IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

''(4) INCREASED DISCLOSURE REQUIREMENTS.—

''(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or revalidation of enrollment in the program under this title , title XIX, or title XXI on or after the

date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner and at such time as determined by the Secretary) any current or previous affiliation (directly or indirectly) with a provider of medical or other items or services or supplier that has uncollected debt, has been or is subject to a payment suspension under a Federal health care program (as defined in section 1128B(f)), has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges denied or revoked.

''(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, or abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

''(5) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—

"(A) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

"(B) DEFINITIONS.—In this paragraph:

"(i) IN GENERAL.—The term 'applicable provider of services or supplier' means a provider of services or supplier that has the same taxpayer identification number assigned under section 6109 of the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable provider of services or supplier is assigned a different billing number or national provider identification number under the program under this title than is assigned to the obligated provider of services or supplier.

"(ii) OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term 'obligated provider of services or supplier' means a provider of services or supplier that owes a past-due obligation under the program under this title (as determined by the Secretary).

"(6) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

"(A) IN GENERAL.—The Secretary may impose a temporary moratorium on the enrollment of new providers of services and suppliers, including categories of providers of services and suppliers, in the program under this title, under the Medicaid program under title XIX, or under the CHIP program under title XXI if the Secretary determines such moratorium is necessary to prevent or combat fraud, waste, or abuse under either such program.

"(B) LIMITATION ON REVIEW.—There shall be no judicial review under section 1869, section 1878, or otherwise, of a temporary moratorium imposed under subparagraph (A).

"(7) COMPLIANCE PROGRAMS.—

"(A) IN GENERAL.—On or after the date of implementation determined by the Secretary under subparagraph (C), a provider of medical or other items or services or supplier within a particular industry sector or category shall, as a condition of enrollment in the program under this title, title XIX, or title XXI, establish a compliance program that contains the core elements established under subparagraph (B) with respect to that provider or supplier and industry or category.

"(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under subparagraph (A) for providers or suppliers within a particular industry or category.

"(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine the timeline for the establishment of the core elements under subparagraph (B) and the date of the implementation of subparagraph (A) for providers or suppliers within a particular industry or category. The Secretary shall, in determining such

date of implementation, consider the extent to which the adoption of compliance programs by a provider of medical or other items or services or supplier is widespread in a particular industry sector or with respect to a particular provider or supplier category.''.

(b) MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1601(d) and 1640, is amended—

(A) in subsection (a)—

(i) by striking ''and'' at the end of paragraph (74);

(ii) by striking the period at the end of paragraph (75) and inserting a semicolon; and

(iii) by inserting after paragraph (75) the following:

''(76) provide that the State shall comply with provider and supplier screening, oversight, and reporting requirements in accordance with subsection (ii);''; and

(B) by adding at the end the following:

''(ii) PROVIDER AND SUPPLIER SCREENING, OVERSIGHT, AND REPORTING REQUIREMENTS.—For purposes of subsection (a)(75), the requirements of this subsection are the following:

''(1) SCREENING.—The State complies with the process for screening providers and suppliers under this title, as established by the Secretary under section 1886(j)(2).

''(2) PROVISIONAL PERIOD OF ENHANCED OVERSIGHT FOR NEW PROVIDERS AND SUPPLIERS.—The State complies with procedures to provide for a provisional period of enhanced oversight for new providers and suppliers under this title, as established by the Secretary under section 1886(j)(3).

''(3) DISCLOSURE REQUIREMENTS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to comply with the disclosure requirements established by the Secretary under section 1886(j)(4).

''(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

''(A) TEMPORARY MORATORIUM IMPOSED BY THE SECRETARY.—

''(i) IN GENERAL.—Subject to clause (ii), the State complies with any temporary

moratorium on the enrollment of new providers or suppliers imposed by the Secretary under section 1886(j)(6).

''(ii) EXCEPTION.—A State shall not be required to comply with a temporary moratorium described in clause (i) if the State determines that the imposition of such temporary moratorium would adversely impact beneficiaries' access to medical assistance.

''(B) MORATORIUM ON ENROLLMENT OF PROVIDERS AND SUPPLIERS.—At the option of the State, the State imposes, for purposes of entering into participation agreements with providers or suppliers under the State plan or under a waiver of the plan, periods of enrollment moratoria, or numerical caps or other limits, for providers or suppliers identified by the Secretary as being at high-risk for fraud, waste, or abuse as necessary to combat fraud, waste, or abuse, but only if the State determines that the imposition of any such period, cap, or other limits would not adversely impact beneficiaries' access to medical assistance.

''(5) COMPLIANCE PROGRAMS.—The State requires providers and suppliers under the State plan or under a waiver of the plan to establish, in accordance with the requirements of section 1866(j)(7), a compliance program that contains the core elements established under subparagraph (B) of that section 1866(j)(7) for providers or suppliers within a particular industry or category.

''(6) REPORTING OF ADVERSE PROVIDER ACTIONS.—The State complies with the national system for reporting criminal and civil convictions, sanctions, negative licensure actions, and other adverse provider actions to the Secretary, through the Administrator of the Centers for Medicare & Medicaid Services, in accordance with regulations of the Secretary.

''(7) ENROLLMENT AND NPI OF ORDERING OR REFERRING PROVIDERS.—The State requires—

''(A) all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the plan as a participating provider; and

''(B) the national provider identifier of any ordering or referring physician or other professional to be specified on any claim for payment

that is based on an order or referral of the physician or other professional.

''(8) OTHER STATE OVERSIGHT.—Nothing in this subsection shall be interpreted to preclude or limit the ability of a State to engage in provider and supplier screening or enhanced provider and supplier oversight activities beyond those required by the Secretary.''.

(2) DISCLOSURE OF MEDICARE TERMINATED PROVIDERS AND SUPPLIERS TO STATES.—The Administrator of the Centers for Medicare & Medicaid Services shall establish a process for making available to the each State agency with responsibility for administering a State Medicaid plan (or a waiver of such plan) under title XIX of the Social Security Act or a child health plan under title XXI the name, national provider identifier, and other identifying information for any provider of medical or other items or services or supplier under the Medicare program under title XVIII or under the CHIP program under title XXI that is terminated from participation under that program within 30 days of the termination (and, with respect to all such providers or suppliers who are terminated from the Medicare pro-

gram on the date of enactment of this Act, within 90 days of such date).

(3) CONFORMING AMENDMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a), is amended by inserting before the semicolon at the end the following: ''or by a provider or supplier to which a moratorium under subsection (ii)(4) is applied during the period of such moratorium''.

(c) CHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by section 1611(d), is amended—

(1) by redesignating subparagraphs (D) through (M) as subparagraphs (E) through (N), respectively; and

(2) by inserting after subparagraph (C), the following:

''(D) Subsections (a)(76) and (ii) of section 1902 (relating to provider and supplier screening, oversight, and reporting requirements).''.

SEC. 5002. ENHANCED MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sec-

tion 4202, is amended by inserting after section 1128I the following new section:

"SEC. 1128J. MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS.

"(a) DATA MATCHING.—

"(1) INTEGRATED DATA REPOSITORY.—

"(A) INCLUSION OF CERTAIN DATA.—

"(i) IN GENERAL.—The Integrated Data Repository of the Centers for Medicare & Medicaid Services shall include, at a minimum, claims and payment data from the following:

"(I) The programs under titles XVIII and XIX (including parts A, B, C, and D of title XVIII).

"(II) The program under title XXI.

"(III) Health-related programs administered by the Secretary of Veterans Affairs.

"(IV) Health-related programs administered by the Secretary of Defense.

''(V) The program of old-age, survivors, and disability insurance benefits established under title II.

''(VI) The Indian Health Service and the Contract Health Service program.

''(ii) PRIORITY FOR INCLUSION OF CERTAIN DATA.—Inclusion of the data described in subclause (I) of such clause in the Integrated Data Repository shall be a priority. Data described in subclauses (II) through (VI) of such clause shall be included in the Integrated Data Repository as appropriate.

''(B) DATA SHARING AND MATCHING.—

''(i) IN GENERAL.—The Secretary shall enter into agreements with the individuals described in clause (ii) under which such individuals share and match data in the system of records of the respective agencies of such individuals with data in the system of records of the Department of Health and Human Services for the purpose of identifying potential fraud, waste,

and abuse under the programs under titles XVIII and XIX.

''(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause:

''(I) The Commissioner of Social Security.

''(II) The Secretary of Veterans Affairs.

''(III) The Secretary of Defense.

''(IV) The Director of the Indian Health Service.

''(iii) DEFINITION OF SYSTEM OF RECORDS.—For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.

''(2) ACCESS TO CLAIMS AND PAYMENT DATABASES.—For purposes of conducting law enforcement and oversight activities and to the extent consistent with applicable information, privacy, security, and disclosure laws, including the regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 and section 552a of title 5, United States Code, and subject to any infor-

mation systems security requirements under such laws or otherwise required by the Secretary, the Inspector General of the Department of Health and Human Services and the Attorney General shall have access to claims and payment data of the Department of Health and Human Services and its contractors related to titles XVIII, XIX, and XXI.

''(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

''(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of protecting the integrity of the programs under titles XVIII and XIX, obtain information from any individual (including a beneficiary provided all applicable privacy protections are followed) or entity that—

''(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

''(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, prescribes, supplies, or receives medical or other items or services payable by any Federal health care program (as defined in section 1128B(f))

regardless of how the item or service is paid for, or to whom such payment is made.

''(2) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including a prescribing physician's medical records for an individual who is prescribed an item or service which is covered under part B of title XVIII, a covered part D drug (as defined in section 1860D–2(e)) for which payment is made under an MA–PD plan under part C of such title, or a prescription drug plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

''(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—

''(1) IN GENERAL.—In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose

an appropriate administrative penalty commensurate with the offense or conspiracy.

''(2) APPLICABLE INDIVIDUAL.—For purposes of paragraph (1), the term 'applicable individual' means an individual—

''(A) entitled to, or enrolled for, benefits under part A of title XVIII or enrolled under part B of such title;

''(B) eligible for medical assistance under a State plan under title XIX or under a waiver of such plan; or

''(C) eligible for child health assistance under a child health plan under title XXI.

''(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

''(1) IN GENERAL.—If a person has received an overpayment, the person shall—

''(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

''(B) notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

''(2) DEADLINE FOR REPORTING AND RETURNING OVERPAYMENTS.—An overpayment must be reported and returned under paragraph (1) by the later of—

''(A) the date which is 60 days after the date on which the overpayment was identified; or

''(B) the date any corresponding cost report is due, if applicable.

''(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

''(4) DEFINITIONS.—In this subsection:

''(A) KNOWING AND KNOWINGLY.—The terms 'knowing' and 'knowingly' have the meaning given those terms in section 3729(b) of title 31, United States Code.

''(B) OVERPAYMENT.—The term ''overpayment'' means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

''(C) PERSON.—

''(i) IN GENERAL.—The term 'person' means a provider of services, supplier, medicaid managed care organization (as defined in section 1903(m)(1)(A)), Medicare Advantage organization (as defined in section 1859(a)(1)), or PDP sponsor (as defined in section 1860D–41(a)(13)).

''(ii) EXCLUSION.—Such term does not include a beneficiary.

''(e) INCLUSION OF NATIONAL PROVIDER IDENTIFIER ON ALL APPLICATIONS AND CLAIMS.—The Secretary shall promulgate a regulation that requires, not later than January 1, 2011, all providers of medical or other items or services and suppliers under the programs under titles XVIII and XIX that qualify for a national provider identifier to include their national provider identifier on all applications to enroll in such programs and on all claims for payment submitted under such programs.''.

(b) ACCESS TO DATA.—

(1) MEDICARE PART D.—Section 1860D–15(f)(2) of the Social Security Act (42 U.S.C. 1395w–116(f)(2)) is amended by striking ''may be used by'' and all that follows through the period at the end and inserting ''may be used—

''(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

''(i) carrying out this section; and

''(ii) conducting oversight, evaluation, and enforcement under this title; and

''(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.''.

(2) DATA MATCHING.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) in clause (vii), by striking ''or'' at the end;

(B) in clause (viii), by inserting ''or'' after the semicolon; and

(C) by adding at the end the following new clause:

''(ix) matches performed by the Secretary of Health and Human Services or the Inspector General of the Department of Health and Human Services with respect to potential fraud, waste, and abuse,

including matches of a system of records with non-Federal records;''.

(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

''(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

''(i) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration and the system of records of the Department of Health and Human Services; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

''(B) For purposes of this paragraph, the term 'system of records' has the meaning given such term in section 552a(a)(5) of title 5, United States Code.''.

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR STATES THAT FAIL TO REPORT ENROLLEE ENCOUNTER DATA IN THE MEDICAID STATISTICAL INFORMATION SYSTEM.—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (23), by striking ''or'' at the end;

(2) in paragraph (24), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following new paragraph:.

''(25) with respect to any amounts expended for medical assistance for individuals for whom the State does not report enrollee encounter data (as defined by the Secretary) to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary).''.

(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

(1) PERMISSIVE EXCLUSIONS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(16) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any indi-

vidual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128B(f)), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans.''.

(2) CIVIL MONETARY PENALTIES.—

(A) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(i) in paragraph (1)(D), by striking ''was excluded'' and all that follows through the period at the end and inserting ''was excluded from the Federal health care program (as defined in section 1128B(f)) under which the claim was made pursuant to Federal law.'';

(ii) in paragraph (6), by striking ''or'' at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

''(8) orders or prescribes a medical or other item or service during a period in which the person was excluded from a Federal health care program (as so defined), in the case where the person knows or should know that a claim for such medical or other item or service will be made under such a program;

''(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

''(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not re-

port and return the overpayment in accordance with such section;'';

(iv) in the first sentence—

(I) by striking the ''or'' after ''prohibited relationship occurs;''; and

(II) by striking ''act)'' and inserting ''act; or in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact)''; and

(v) in the second sentence, by striking ''purpose)'' and inserting ''purpose; or in cases under paragraph (9), an assessment of not more than 3 times the total amount claimed for each item or service for which payment was made based upon the application containing the false statement or misrepresentation of a material fact)''.

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1128A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(i) in subparagraph (C), by striking ''or'' at the end;

(ii) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end and inserting a semicolon;

(iii) by redesignating subparagraph (D), as added by section 4523(c) of such Act, as subparagraph (E) and striking the period at the end and inserting ''; or''; and

(iv) by adding at the end the following new subparagraphs:

''(F) any other remuneration which promotes access to care and poses a low risk of harm to patients and Federal health care programs (as defined in section 1128B(f) and designated by the Secretary under regulations);

''(G) the offer or transfer of items or services for free or less than fair market value by a person, if—

''(i) the items or services consist of coupons, rebates, or other rewards from a retailer;

''(ii) the items or services are offered or transferred on equal terms available to

the general public, regardless of health insurance status; and

''(iii) the offer or transfer of the items or services is not tied to the provision of other items or services reimbursed in whole or in part by the program under title XVIII or a State health care program (as defined in section 1128(h));

''(H) the offer or transfer of items or services for free or less than fair market value by a person, if—

''(i) the items or services are not offered as part of any advertisement or solicitation;

''(ii) the items or services are not tied to the provision of other services reimbursed in whole or in part by the program under title XVIII or a State health care program (as so defined);

''(iii) there is a reasonable connection between the items or services and the medical care of the individual; and

''(iv) the person provides the items or services after determining in good faith that the individual is in financial need; or

''(I) effective on a date specified by the Secretary (but not earlier than January 1, 2011), the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA–PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.''.

(e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(f) of the Social Security Act (42 U.S.C. 1320a–7(f)) is amended by adding at the end the following new paragraph:

''(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may delegate the authority granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services for purposes of any investigation under this section.''.

(f) REVISING THE INTENT REQUIREMENT FOR HEALTH CARE FRAUD.—Section 1128B of the Social Se-

curity Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

''(g) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.''.

(g) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(16)(B) of the Social Security Act (42 U.S.C. 1395m(a)(16)(B)) is amended by inserting ''that the Secretary determines is commensurate with the volume of the billing of the supplier'' before the period at the end.

(2) HOME HEALTH AGENCIES.—Section 1861(o)(7)(C) of the Social Security Act (42 U.S.C. 1395x(o)(7)(C)) is amended by inserting ''that the Secretary determines is commensurate with the volume of the billing of the home health agency'' before the semicolon at the end.

(3) REQUIREMENTS FOR CERTAIN OTHER PROVIDERS OF SERVICES AND SUPPLIERS.—Section 1862 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

''(n) REQUIREMENT OF A SURETY BOND FOR CERTAIN PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) IN GENERAL.—The Secretary may require a provider of services or supplier described in paragraph (2) to provide the Secretary on a continuing basis with a surety bond in a form specified by the Secretary in an amount (not less than $50,000) that the Secretary determines is commensurate with the volume of the billing of the provider of services or supplier. The Secretary may waive the requirement of a bond under the preceding sentence in the case of a provider of services or supplier that provides a comparable surety bond under State law.

''(2) PROVIDER OF SERVICES OR SUPPLIER DESCRIBED.—A provider of services or supplier described in this paragraph is a provider of services or supplier the Secretary determines appropriate based on the level of risk involved with respect to the provider of services or supplier, and consistent with the surety bond requirements under sections 1834(a)(16)(B) and 1861(o)(7)(C).''.

(h) SUSPENSION OF MEDICARE AND MEDICAID PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

(1) MEDICARE.—Section 1862 of the Social Security Act (42 U.S.C. 1395y), as amended by sub-

section (g)(3), is amended by adding at the end the following new subsection:

''(o) SUSPENSION OF PAYMENTS PENDING INVESTIGATION OF CREDIBLE ALLEGATIONS OF FRAUD.—

''(1) IN GENERAL.—The Secretary may suspend payments to a provider of services or supplier under this title pending an investigation of a credible allegation of fraud against the provider of services or supplier, unless the Secretary determines there is good cause not to suspend such payments.

''(2) CONSULTATION.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services in determining whether there is a credible allegation of fraud against a provider of services or supplier.

''(3) PROMULGATION OF REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection and section 1903(i)(2)(C).''.

(2) MEDICAID.—Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

(A) in subparagraph (A), by striking ''or'' at the end; and

(B) by inserting after subparagraph (B), the following:

''(C) by any individual or entity to whom the State has failed to suspend payments under the plan during any period when there is pending an investigation of a credible allegation of fraud against the individual or entity, as determined by the State in accordance with regulations promulgated by the Secretary for purposes of section 1862(o) and this subparagraph, unless the State determines in accordance with such regulations there is good cause not to suspend such payments; or''.

(i) INCREASED FUNDING TO FIGHT FRAUD AND ABUSE.—

(1) IN GENERAL.—Section 1817(k) of the Social Security Act (42 U.S.C. 1395i(k)) is amended—

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

''(7) ADDITIONAL FUNDING.—In addition to the funds otherwise appropriated to the Account from the Trust Fund under paragraphs (3) and (4) and for purposes described in paragraphs (3)(C) and (4)(A), there are hereby appropriated an additional $10,000,000 to such Account from such Trust Fund for each of fiscal years 2011 through 2020. The funds appropriated under this paragraph shall be al-

located in the same proportion as the total funding appropriated with respect to paragraphs (3)(A) and (4)(A) was allocated with respect to fiscal year 2010, and shall be available without further appropriation until expended.''; and

(B) in paragraph (4)(A), by inserting ''until expended'' after ''appropriation''.

(2) INDEXING OF AMOUNTS APPROPRIATED.—

(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(i) in subclause (III), by inserting ''and'' at the end;

(ii) in subclause (IV)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (V).

(B) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Section 1817(k)(3)(A)(ii) of such

Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended—

(i) in subclause (VIII), by inserting ''and'' at the end;

(ii) in subclause (IX)—

(I) by striking ''for each of fiscal years 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2007''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking subclause (X).

(C) FEDERAL BUREAU OF INVESTIGATION.—Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended—

(i) in clause (vii), by inserting ''and'' at the end;

(ii) in clause (viii)—

(I) by striking ''for each of fiscal years 2007, 2008, 2009, and 2010'' and inserting ''for each fiscal year after fiscal year 2006''; and

(II) by striking ''; and'' and inserting a period; and

(iii) by striking clause (ix).

(D) MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395i(k)(4)(C)) is amended by adding at the end the following new clause:

''(ii) For each fiscal year after 2010, by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year.''.

(j) MEDICARE INTEGRITY PROGRAM AND MEDICAID INTEGRITY PROGRAM.—

(1) MEDICARE INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1893(c) of the Social Security Act (42 U.S.C. 1395ddd(c)) is amended—

(i) in paragraph (3), by striking ''and'' at the end;

(ii) by redesignating paragraph (4) as paragraph (5); and

(iii) by inserting after paragraph (3) the following new paragraph:

''(4) the entity agrees to provide the Secretary and the Inspector General of the Department of

Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request; and''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(i) EVALUATIONS AND ANNUAL REPORT.—

''(1) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.

''(2) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2011), the Secretary shall submit a report to Congress which identifies—

''(A) the use of funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, to carry out this section; and

''(B) the effectiveness of the use of such funds.''.

(C) FLEXIBILITY IN PURSUING FRAUD AND ABUSE.—Section 1893(a) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by inserting '', or otherwise,'' after ''entities''.

(2) MEDICAID INTEGRITY PROGRAM.—

(A) REQUIREMENT TO PROVIDE PERFORMANCE STATISTICS.—Section 1936(c)(2) of the Social Security Act (42 U.S.C. 1396u–6(c)(2)) is amended—

(i) by redesignating subparagraph (D) as subparagraph (E); and

(ii) by inserting after subparagraph (C) the following new subparagraph:

''(D) The entity agrees to provide the Secretary and the Inspector General of the Department of Health and Human Services with such performance statistics (including the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities by the entity) as the Secretary or the Inspector General may request.''.

(B) EVALUATIONS AND ANNUAL REPORT.—Section 1936(e) of the Social Security Act (42 U.S.C. 1396u–7(e)) is amended—

(i) by redesignating paragraph (4) as paragraph (5); and

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

''(4) EVALUATIONS.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under the Program not less frequently than every 3 years.''.

(k) EXPANDED APPLICATION OF HARDSHIP WAIVERS FOR EXCLUSIONS.—Section 1128(c)(3)(B) of the Social Security Act (42 U.S.C. 1320a–7(c)(3)(B)) is amended by striking ''individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both'' and inserting ''beneficiaries (as defined in section 1128A(i)(5)) of that program''.

SEC. 5003. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION DATA BANK AND THE NATIONAL PRACTITIONER DATA BANK.

(a) INFORMATION REPORTED BY FEDERAL AGENCIES AND HEALTH PLANS.—Section 1128E of the Social Security Act (42 U.S.C. 1320a–7e) is amended—

(1) by striking subsection (a) and inserting the following:

''(a) IN GENERAL.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).'';

(2) by striking subsection (d) and inserting the following:

''(d) ACCESS TO REPORTED INFORMATION.—

''(1) AVAILABILITY.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b) information reported under section 1921(a).

''(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The

amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.'';

(3) by striking subsection (f) and inserting the following:

''(f) APPROPRIATE COORDINATION.—In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1921.''; and

(4) in subsection (g)—

(A) in paragraph (1)(A)—

(i) in clause (iii)—

(I) by striking ''or State'' each place it appears;

(II) by redesignating subclauses (II) and (III) as subclauses (III) and (IV), respectively; and

(III) by inserting after subclause (I) the following new subclause:

''(II) any dismissal or closure of the proceedings by reason of the provider, supplier, or practitioner surren-

dering their license or leaving the State or jurisdiction''; and

(ii) by striking clause (iv) and inserting the following:

''(iv) Exclusion from participation in a Federal health care program (as defined in section 1128B(f)).'';

(B) in paragraph (3)—

(i) by striking subparagraphs (D) and (E); and

(ii) by redesignating subparagraph (F) as subparagraph (D); and

(C) in subparagraph (D) (as so redesignated), by striking ''or State''.

(b) INFORMATION REPORTED BY STATE LAW OR FRAUD ENFORCEMENT AGENCIES.—Section 1921 of the Social Security Act (42 U.S.C. 1396r–2) is amended—

(1) in subsection (a)—

(A) in paragraph (1)—

(i) by striking ''SYSTEM.—The State'' and all that follows through the semicolon and inserting SYSTEM.—

''(A) LICENSING OR CERTIFICATION ACTIONS.—The State must have in effect a system of reporting the following information with re-

spect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by a State licensing or certification agency:'';

(ii) by redesignating subparagraphs (A) through (D) as clauses (i) through (iv), respectively, and indenting appropriately;

(iii) in subparagraph (A)(iii) (as so redesignated)—

(I) by striking ''the license of'' and inserting ''license or the right to apply for, or renew, a license by''; and

(II) by inserting ''nonrenewability,'' after ''voluntary surrender,''; and

(iv) by adding at the end the following new subparagraph:

''(B) OTHER FINAL ADVERSE ACTIONS.—The State must have in effect a system of reporting information with respect to any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier,

or practitioner by a State law or fraud enforcement agency.''; and

(B) in paragraph (2), by striking ''the authority described in paragraph (1)'' and inserting ''a State licensing or certification agency or State law or fraud enforcement agency'';

(2) in subsection (b)—

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

''(2) to State licensing or certification agencies and Federal agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners;'';

(B) in each of paragraphs (4) and (6), by inserting '', but only with respect to information provided pursuant to subsection (a)(1)(A)'' before the comma at the end;

(C) by striking paragraph (5) and inserting the following:

''(5) to State law or fraud enforcement agencies,'';

(D) by redesignating paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

''(7) to health plans (as defined in section 1128C(c));'';

(3) by redesignating subsection (d) as subsection (h), and by inserting after subsection (c) the following new subsections:

''(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

''(1) DISCLOSURE.—With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

''(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

''(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

''(2) CORRECTIONS.—Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any formal proceeding or final adverse action described in subsection (a), in such form and manner as the Secretary prescribes by regulation.

''(e) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

''(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any agency designated by the Secretary in subsection (b), shall be held liable in any civil action with respect to any reporting of information as required under this section, without knowledge of the falsity of the information contained in the report.

''(g) REFERENCES.—For purposes of this section:

''(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term 'State licensing or certification agency' includes any authority of a State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities.

''(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term 'State law or fraud enforcement agency' includes—

''(A) a State law enforcement agency; and

''(B) a State medicaid fraud control unit (as defined in section 1903(q)).

''(3) FINAL ADVERSE ACTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'final adverse action' includes—

''(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

''(ii) State criminal convictions related to the delivery of a health care item or service;

''(iii) exclusion from participation in State health care programs (as defined in section 1128(h));

''(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

''(v) any other adjudicated actions or decisions that the Secretary shall establish by regulation.

''(B) EXCEPTION.—Such term does not include any action with respect to a malpractice claim.''; and

(4) in subsection (h), as so redesignated, by striking ''The Secretary'' and all that follows through the period at the end and inserting ''In implementing this section, the Secretary shall provide for the maximum appropriate coordination with part B of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11131 et seq.) and section 1128E.''.

(c) CONFORMING AMENDMENT.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a–7c(a)(1)) is amended—

(1) in subparagraph (C), by adding ''and'' after the comma at the end;

(2) in subparagraph (D), by striking '', and'' and inserting a period; and

(3) by striking subparagraph (E).

(d) TRANSITION PROCESS; EFFECTIVE DATE.—

(1) IN GENERAL.—Effective on the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall implement a transition process under which, by not later than the end of the transi-

tion period described in paragraph (5), the Secretary shall cease operating the Healthcare Integrity and Protection Data Bank established under section 1128E of the Social Security Act (as in effect before the effective date specified in paragraph (6)) and shall transfer all data collected in the Healthcare Integrity and Protection Data Bank to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). During such transition process, the Secretary shall have in effect appropriate procedures to ensure that data collection and access to the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank are not disrupted.

(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out the amendments made by subsections (a) and (b).

(3) FUNDING.—

(A) AVAILABILITY OF FEES.—Fees collected pursuant to section 1128E(d)(2) of the Social Security Act prior to the effective date specified in paragraph (6) for the disclosure of information in the Healthcare Integrity and Protection Data Bank shall be available to the

Secretary, without fiscal year limitation, for payment of costs related to the transition process described in paragraph (1). Any such fees remaining after the transition period is complete shall be available to the Secretary, without fiscal year limitation, for payment of the costs of operating the National Practitioner Data Bank.

(B) AVAILABILITY OF ADDITIONAL FUNDS.—In addition to the fees described in subparagraph (A), any funds available to the Secretary or to the Inspector General of the Department of Health and Human Services for a purpose related to combating health care fraud, waste, or abuse shall be available to the extent necessary for operating the Healthcare Integrity and Protection Data Bank during the transition period, including systems testing and other activities necessary to ensure that information formerly reported to the Healthcare Integrity and Protection Data Bank will be accessible through the National Practitioner Data Bank after the end of such transition period.

(4) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the effective date specified in paragraph (6), the information described in subparagraph (B) shall be available from the National Practitioner Data Bank to the Secretary of Veterans Affairs without charge.

(B) INFORMATION DESCRIBED.—For purposes of subparagraph (A), the information described in this subparagraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs from the Healthcare Integrity and Protection Data Bank.

(5) TRANSITION PERIOD DEFINED.—For purposes of this subsection, the term ''transition period'' means the period that begins on the date of enactment of this Act and ends on the later of—

(A) the date that is 1 year after such date of enactment; or

(B) the effective date of the regulations promulgated under paragraph (2).

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 5004. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION.—

(1) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)(1)) is amended—

(A) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(B) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(2) PART B.—

(A) Section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)(B)) is amended—

(i) in subparagraph (B), in the flush language following clause (ii), by striking

''close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year)'' and inserting ''period ending 1 calendar year after the date of service''; and

(ii) by adding at the end the following new sentence: ''In applying subparagraph (B), the Secretary may specify exceptions to the 1 calendar year period specified in such subparagraph.''

(B) Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(i) in paragraph (1), by striking ''period of 3 calendar years'' and all that follows through the semicolon and inserting ''period ending 1 calendar year after the date of service;''; and

(ii) by adding at the end the following new sentence: ''In applying paragraph (1), the Secretary may specify exceptions to the 1 calendar year period specified in such paragraph.''

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2010.

(2) SERVICES FURNISHED BEFORE 2010.—In the case of services furnished before January 1, 2010, a bill or request for payment under section 1814(a)(1), 1842(b)(3)(B), or 1835(a) shall be filed not later that December 31, 2010.

SEC. 5005. PHYSICIANS WHO ORDER ITEMS OR SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by striking ''physician'' and inserting ''physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j)''.

(b) HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ''in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B),'' before ''or, in the case of services''.

(2) PART B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended in the matter preceding subparagraph (A) by inserting ", or in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or an eligible professional under section 1848(k)(3)(B)," after "a physician".

(c) APPLICATION TO OTHER ITEMS OR SERVICES.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be made by enrolled physicians and health professions) to all other categories of items or services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), including covered part D drugs as defined in section 1860D–2(e) of such Act (42 U.S.C. 1395w–102), that are ordered, prescribed, or referred by a physician enrolled under section 1866(j) of such Act (42 U.S.C. 1395cc(j)) or an eligible professional under section 1848(k)(3)(B) of such Act (42 U.S.C. 1395w–4(k)(3)(B)).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 5006. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph

''(9) The Secretary may revoke enrollment, for a period of not more than one year for each act, for a physician or supplier under section 1866(j) if such physician or supplier fails to maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.''.

(b) PROVIDERS OF SERVICES.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc) is further amended—

(1) in subparagraph (U), by striking at the end ''and'';

(2) in subparagraph (V), by striking the period at the end and adding ''; and''; and

(3) by adding at the end the following new subparagraph:

''(W) maintain and, upon request of the Secretary, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by the provider under this title, as specified by the Secretary.''.

(c) OIG PERMISSIVE EXCLUSION AUTHORITY.—Section 1128(b)(11) of the Social Security Act (42 U.S.C. 1320a–7(b)(11)) is amended by inserting '', ordering, referring for furnishing, or certifying the need for'' after ''furnishing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to orders, certifications, and referrals made on or after January 1, 2010.

SEC. 5007. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) PART A.—Section 1814(a)(2)(C) of such Act is amended—

(A) by striking ''and such services'' and inserting ''such services''; and

(B) by inserting after ''care of a physician'' the following: '', and, in the case of a certification made by a physician after January 1, 2010, prior to making such certification the physician must document that the physician himself or herself has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 1834(m), and other than with respect to encounters that are incident to services involved) with the individual within a reasonable timeframe as determined by the Secretary''.

(2) PART B.—Section 1835(a)(2)(A) of the Social Security Act is amended—

(A) by striking ''and'' before ''(iii)''; and

(B) by inserting after ''care of a physician'' the following: '', and (iv) in the case of a certification after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with

the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary''.

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding at the end the following: ''and shall require that such an order be written pursuant to the physician documenting that the physician has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual involved during the 6-month period preceding such written order, or other reasonable timeframe as determined by the Secretary''.

(c) APPLICATION TO OTHER AREAS UNDER MEDICARE.—The Secretary may apply the face-to-face encounter requirement described in the amendments made by subsections (a) and (b) to other items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such an decision would reduce the risk of waste, fraud, or abuse.

(d) APPLICATION TO MEDICAID.—The requirements pursuant to the amendments made by subsections (a) and (b) shall apply in the case of physicians making certifications for home health services under title XIX of the

Social Security Act in the same manner and to the same extent as such requirements apply in the case of physicians making such certifications under title XVIII of such Act.

SEC. 5008. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by section 5002(d)(2)(A), is amended—

(1) by inserting after paragraph (10) the following new paragraphs:

''(11) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

''(12) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;''; and

(2) in the first sentence (as so amended)—

(A) by striking ''or in cases under paragraph (9)'' and inserting ''in cases under paragraph (9)''; and

(B) by striking ''a material fact)'' and inserting ''a material fact, in cases under paragraph (11), $50,000 for each false record or statement, or in cases under paragraph (12), $15,000 for each day of the failure described in such paragraph)''.

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting ''timely'' before ''inspect''; and

(B) in subparagraph (B), by inserting ''timely'' before ''audit and inspect''.

(2) MARKETING VIOLATIONS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w—27(g)(1)) is amended—

(A) in subparagraph (F), by striking ''or'' at the end;

(B) by inserting after subparagraph (G) the following new subparagraphs:

''(H) except as provided under subparagraph (C) or (D) of section 1860D–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;

''(I) transfers an individual enrolled under this part from one plan to another without the prior consent of the individual or the designee of the individual or solely for the purpose of earning a commission;

''(J) fails to comply with marketing restrictions described in subsections (h) and (j) of section 1851 or applicable implementing regulations or guidance; or

''(K) employs or contracts with any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of this paragraph;''; and

(C) by adding at the end the following new sentence: ''The Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2), if the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such or-

ganization, has engaged in any conduct described in subparagraphs (A) through (K) of this paragraph.''.

(3) PROVISION OF FALSE INFORMATION.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is amended by inserting ''except with respect to a determination under subparagraph (E), an assessment of not more than the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,'' after ''for each such determination,''.

(c) OBSTRUCTION OF PROGRAM AUDITS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7(b)(2)) is amended—

(1) in the heading, by inserting ''OR AUDIT'' after ''INVESTIGATION''; and

(2) by striking ''investigation into'' and all that follows through the period and inserting ''investigation or audit related to—''

''(i) any offense described in paragraph (1) or in subsection (a); or

''(ii) the use of funds received, directly or indirectly, from any Federal health care

program (as defined in section 1128B(f)).''.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 5009. MEDICARE SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) DEVELOPMENT OF SELF-REFERRAL DISCLOSURE PROTOCOL.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1395nn) pursuant to a self-referral disclosure protocol (in this section referred to as an ''SRDP'').

The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) PUBLICATION ON INTERNET WEBSITE OF SRDP INFORMATION.—The Secretary of Health and Human Services shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) RELATION TO ADVISORY OPINIONS.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) REDUCTION IN AMOUNTS OWED.—The Secretary of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information related to the disclosure.

(4) Such other factors as the Secretary considers appropriate.

(c) REPORT.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a)(1), the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

SEC. 5010. ADJUSTMENTS TO THE MEDICARE DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES COMPETITIVE ACQUISITION PROGRAM.

(a) EXPANSION OF ROUND 2 OF THE DME COMPETITIVE BIDDING PROGRAM.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395w–3(a)(1)) is amended—

(1) in subparagraph (B)(i)(II), by striking ''70'' and inserting ''91''; and

(2) in subparagraph (D)(ii)—

(A) in subclause (I), by striking ''and'' at the end;

(B) by redesignating subclause (II) as subclause (III); and

(C) by inserting after subclause (I) the following new subclause:

''(II) the Secretary shall include the next 21 largest metropolitan statistical areas by total population (after those selected under subclause (I)) for such round; and''.

(b) REQUIREMENT TO EITHER COMPETITIVELY BID AREAS OR USE COMPETITIVE BID PRICES BY 2016.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395m(a)(1)(F)) is amended—

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

(2) in clause (ii)—

(A) by inserting ''(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii), shall)'' after ''may''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new clause:

''(iii) in the case of covered items furnished on or after January 1, 2016, the Secretary may continue to make such adjustments described in clause (ii) as, under such competitive acquisition programs, additional covered items are phased in or information is updated as contracts under section 1847 are recompeted in accordance with section 1847(b)(3)(B).''.

SEC. 5011. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) EXPANSION TO MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking ''that the records'' and inserting ''that—

''(A) the records'';

(B) by inserting ''and'' after the semicolon; and

(C) by adding at the end the following:

''(B) not later than December 31, 2010, the State shall—

''(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and

''(ii) provide assurances satisfactory to the Secretary that—

"(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

"(II) from such amounts recovered, payment—

"(aa) shall be made on a contingent basis for collecting overpayments; and

"(bb) may be made in such amounts as the State may specify for identifying underpayments;

"(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and

"(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

"(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient ad-

ministration of the State plan or a waiver of the plan;

''(bb) that section 1903(d) shall apply to amounts recovered under the program; and

''(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State medicaid fraud control unit; and''.

(2) COORDINATION; REGULATIONS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the

Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State's Medicaid program prior to December 31, 2010.

(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title'';

(2) in paragraph (2), by striking ''parts A and B'' and inserting ''this title'';

(3) in paragraph (3), by inserting ''(not later than December 31, 2010, in the case of contracts re-

lating to payments made under part C or D)'' after ''2010'';

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title''; and

(5) by adding at the end the following:

''(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

''(A) ensure that each MA plan under part C has an anti- fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(B) ensure that each prescription drug plan under part D has an anti- fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

"(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.".

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Subtitle B—Additional Medicaid Provisions

SEC. 5101. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is amended by inserting after "1128A," the following: "terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1128(c)(3)(B) and 1128(d)(3)(B)) partici-

pation of such individual or entity is terminated under title XVIII or any other State plan under this title,''.

SEC. 5102. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 5001(b), is amended by inserting after paragraph (75) the following:

''(76) provide that the State agency described in paragraph (9) exclude, with respect to a period, any individual or entity from participation in the program under the State plan if such individual or entity owns, controls, or manages an entity that (or if such entity is owned, controlled, or managed by an individual or entity that)—

''(A) has unpaid overpayments (as defined by the Secretary) under this title during such period determined by the Secretary or the State agency to be delinquent;

''(B) is suspended or excluded from participation under or whose participation is terminated under this title during such period; or

''(C) is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participa-

tion is terminated under this title during such period;''.

SEC. 5103. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 42 U.S.C. 1396a(a)), as amended by section 5102(a), is amended by inserting after paragraph (76), the following:

''(77) provide that any agent, clearinghouse, or other alternate payee (as defined by the Secretary) that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary; and''.

SEC. 5104. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after ''necessary'' the following: ''and including, for data submitted to the Secretary on or after January 1, 2010, data elements from the automated data system that the Secretary determines to be necessary for pro-

gram integrity, program oversight, and administration, at such frequency as the Secretary shall determine''.

(b) MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

SEC. 5105. PROHIBITION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396b(a)), as amended by section 5103, is amended by inserting after paragraph (77) the following new paragraph:

''(78) provide that the State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.''.

SEC. 5106. OVERPAYMENTS.

(a) EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—

(1) IN GENERAL.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) in the first sentence, by striking ''60 days'' and inserting ''1 year''; and

(ii) in the second sentence, by striking ''60 days'' and inserting ''1-year period''; and

(B) in subparagraph (D)—

(i) in inserting ''(i)'' after ''(D)''; and

(ii) by adding at the end the following:

''(ii) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity due to fraud within 1 year of discovery because there is not a final determination of the amount of the overpayment under an administrative or judicial process (as applicable), including as a result of a judgment being under appeal, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof) before the date that is 30 days after the date on which

a final judgment (including, if applicable, a final determination on an appeal) is made.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of enactment of this Act and apply to overpayments discovered on or after that date.

(b) CORRECTIVE ACTION.—The Secretary shall promulgate regulations that require States to correct Federally identified claims overpayments, of an ongoing or recurring nature, with new Medicaid Management Information System (MMIS) edits, audits, or other appropriate corrective action.

SEC. 5107. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.

Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)) is amended—

(1) in paragraph (1)(B)—

(A) in clause (ii), by striking ''and'' at the end;

(B) in clause (iii), by adding ''and'' after the semi-colon; and

(C) by adding at the end the following new clause:

''(iv) effective for claims filed on or after October 1, 2010, incorporate compat-

ible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);''; and

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

''(4) For purposes of paragraph (1)(B)(iv), the Secretary shall do the following:

''(A) Not later than September 1, 2010:

''(i) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) which are compatible to claims filed under this title.

''(ii) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to

items or services for which States provide medical assistance under this title and no national correct coding methodologies have been established under such Initiative with respect to title XVIII.

''(iii) Notify States of—

''(I) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

''(II) how States are to incorporate such methodologies into claims filed under this title.

''(B) Not later than March 1, 2011, submit a report to Congress that includes the notice to States under clause (iii) of subparagraph (A) and an analysis supporting the identification of the methodologies made under clauses (i) and (ii) of subparagraph (A).''.

SEC. 5108. GENERAL EFFECTIVE DATE.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle take effect on January 1, 2011, without re-

gard to whether final regulations to carry out such amendments and subtitle have been promulgated by that date.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this subtitle, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

TITLE VI—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SEC. 6001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1306, is amended by adding at the end the following:

"SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

''(a) IMPOSITION OF TAX.—If—

''(1) an employee is covered under any applicable employer-sponsored coverage of an employer at any time during a taxable period, and

''(2) there is any excess benefit with respect to the coverage,

there is hereby imposed a tax equal to 40 percent of the excess benefit.

''(b) EXCESS BENEFIT.—For purposes of this section—

''(1) IN GENERAL.—The term 'excess benefit' means, with respect to any applicable employer-sponsored coverage made available by an employer to an employee during any taxable period, the sum of the

excess amounts determined under paragraph (2) for months during the taxable period.

''(2) MONTHLY EXCESS AMOUNT.—The excess amount determined under this paragraph for any month is the excess (if any) of—

''(A) the aggregate cost of the applicable employer-sponsored coverage of the employee for the month, over

''(B) an amount equal to 1/12 of the annual limitation under paragraph (3) for the calendar year in which the month occurs.

''(3) ANNUAL LIMITATION.—For purposes of this subsection—

''(A) IN GENERAL.—The annual limitation under this paragraph for any calendar year is the dollar limit determined under subparagraph (C) for the calendar year.

''(B) APPLICABLE ANNUAL LIMITATION.—The annual limitation which applies for any month shall be determined on the basis of the type of coverage (as determined under subsection (f)(1)) provided to the employee by the employer as of the beginning of the month.

''(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (D)—

''(i) 2013.—In the case of 2013, the dollar limit under this subparagraph is—

''(I) in the case of an employee with self-only coverage, $8,000, and

''(II) in the case of an employee with coverage other than self-only coverage, $21,000.

''(ii) EXCEPTION FOR CERTAIN RETIRED EMPLOYEES AND EMPLOYEES ENGAGED IN HIGH-RISK PROFESSIONS.—In the case of an individual receiving retiree coverage who has attained age 55, and an employee (other than such an individual) who participates in a plan which covers employees engaged in a high-risk profession—

''(I) the dollar amount in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $1,850, and

''(II) the dollar amount in clause (i)(II) (determined after the application of such subparagraph) shall be increased by $5,000.

''(iii) SUBSEQUENT YEARS.—In the case of any calendar year after 2013, the dollar limit under this subparagraph is an amount equal to the sum of the applicable dollar amount in effect for the calendar year preceding such year under clause (i) and the dollar amount of any increase under clause (ii) as in effect for the calendar year preceding such year, except that each such amount shall be increased by an amount equal to the product of—

''(I) such amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for such year (determined by substitituting the calendar year that is 2 years before such year for '1992' in subparagraph (B) thereof), increased by 1 percentage point.

If the amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

''(D) TRANSITION RULE FOR STATES WITH HIGHEST COVERAGE COSTS.—

''(i) IN GENERAL.—If an employee is a resident of a high cost State on the first day of any month beginning in 2013, 2014, or 2015, the annual limitation under this paragraph for such month with respect to such employee shall be an amount equal to the applicable percentage of the annual limitation (determined without regard to this subparagraph or subparagraph (C)(ii)).

''(ii) APPLICABLE PERCENTAGE.—The applicable percentage is 120 percent for 2013, 110 percent for 2014, and 105 percent for 2015.

''(iii) HIGH COST STATE.—The term 'high cost State' means each of the 17 States which the Secretary of Health and Human Services, in consultation with the Secretary, estimates had the highest average cost during 2012 for employer-sponsored coverage under health plans. The Secretary's estimate shall be made on the basis of aggregate premiums paid in the State for such health plans, determined

using the most recent data available as of August 31, 2012.

''(c) LIABILITY TO PAY TAX.—

''(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

''(2) COVERAGE PROVIDER.—For purposes of this subsection, the term 'coverage provider' means each of the following:

''(A) HEALTH INSURANCE COVERAGE.—If the applicable employer-sponsored coverage consists of coverage under a group health plan which provides health insurance coverage, the health insurance issuer.

''(B) HSA CONTRIBUTIONS.—If the applicable employer-sponsored coverage consists of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the employer.

''(C) OTHER COVERAGE.—In the case of any other applicable employer-sponsored coverage, the person that administers the plan benefits.

''(3) APPLICABLE SHARE.—For purposes of this subsection, a coverage provider's applicable share of an excess benefit for any taxable period is the amount which bears the same ratio to the amount of such excess benefit as—

''(A) the cost of the applicable employer-sponsored coverage provided by the provider to the employee during such period, bears to

''(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.

''(4) RESPONSIBILITY TO CALCULATE TAX AND APPLICABLE SHARES.—

''(A) IN GENERAL.—Each employer shall—

''(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable share of such excess benefit for each coverage provider, and

''(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.

''(B) SPECIAL RULE FOR MULTIEMPLOYER PLANS.—In the case of applicable employer-sponsored coverage made available to employees through a multiemployer plan (as defined in section 414(f)), the plan sponsor shall make the calculations, and provide the notice, required under subparagraph (A).

''(d) APPLICABLE EMPLOYER-SPONSORED COVERAGE; COST.—For purposes of this section—

''(1) APPLICABLE EMPLOYER-SPONSORED COVERAGE.—

''(A) IN GENERAL.—The term 'applicable employer-sponsored coverage' means, with respect to any employee, coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

''(B) EXCEPTIONS.—The term 'applicable employer-sponsored coverage' shall not include—

"(i) any coverage (whether through insurance or otherwise) for disability or long-term care, or

"(ii) any coverage described in section 9832(c)(3) the payment for which is not excludable from gross income and for which a deduction under section 162(l) is not allowable.

"(C) COVERAGE INCLUDES EMPLOYEE PAID PORTION.—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

"(D) SELF-EMPLOYED INDIVIDUAL.—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to all or any portion the cost of the coverage.

"(E) GOVERNMENTAL PLANS INCLUDED.—Applicable employer-sponsored coverage shall include coverage under any group health plan

established and maintained for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

''(2) DETERMINATION OF COST.—

''(A) IN GENERAL.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 4980B(f)(4), except that in determining such cost, any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account. In the case of such coverage which provides coverage to retired employees, the employer may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as similarly situated beneficiaries.

''(B) HEALTH FSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 106(c)(2)), the cost of the coverage shall be equal to the sum of—

"(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

"(ii) the amount determined under subparagraph (A) with respect to any reimbursement under the arrangement in excess of the contributions described in clause (i).

"(C) HSAS.—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

"(D) ALLOCATION ON A MONTHLY BASIS.—If cost is determined on other than a monthly basis, the cost shall be allocated to months in a taxable period on such basis as the Secretary may prescribe.

"(e) PENALTY FOR FAILURE TO PROPERLY CALCULATE EXCESS BENEFIT.—

"(1) IN GENERAL.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to

the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

"(A) each coverage provider shall pay the tax on its applicable share (determined in the same manner as under subsection (c)(4)) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

"(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

"(2) LIMITATIONS ON PENALTY.—

"(A) PENALTY NOT TO APPLY WHERE FAILURE NOT DISCOVERED EXERCISING REASONABLE DILIGENCE.—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period for which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable

diligence would have known, that such failure existed.

"(B) PENALTY NOT TO APPLY TO FAILURES CORRECTED WITHIN 30 DAYS.—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

"(i) such failure was due to reasonable cause and not to willful neglect, and

"(ii) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

"(C) WAIVER BY SECRETARY.—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1), to the extent that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

"(f) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) COVERAGE DETERMINATIONS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), an employee shall be treated

as having self-only coverage with respect any applicable employer-sponsored coverage of an employer.

''(B) COVERAGE UNDER ESSENTIAL BENEFITS PACKAGE.—An employee shall be treated as having coverage other than self-only coverage only if the employee is enrolled in coverage other than self-only coverage in a group health plan which provides at least an essential benefits package (as defined in section 2242 of the Social Security Act).

''(2) EMPLOYEES ENGAGED IN HIGH-RISK PROFESSION.—The term 'employees engaged in a high-risk profession' means law enforcement officers, firefighters, members of a rescue squad or ambulance crew, and individuals engaged in the construction, mining, agriculture (not including food processing), forestry, and fishing industries.

''(3) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning given such term by section 5000(b)(1).

''(4) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—

''(A) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the

meaning given such term by section 9832(b)(1) (applied without regard to subparagraph (B) thereof, except as provided by the Secretary in regulations).

''(B) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning given such term by section 9832(b)(2).

''(5) PERSON THAT ADMINISTERS THE PLAN BENEFITS.—The term 'person that administers the plan benefits' shall include the plan sponsor if the plan sponsor administers benefits under the plan.

''(6) PLAN SPONSOR.—The term 'plan sponsor' has the meaning given such term in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(7) TAXABLE PERIOD.—The term 'taxable period' means the calendar year or such shorter period as the Secretary may prescribe. The Secretary may have different taxable periods for employers of varying sizes.

''(8) AGGREGATION RULES.—All employers treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer.

''(9) DENIAL OF DEDUCTION.—For denial of deduction for the tax imposed by this section, see section 275(a)(6).

''(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out this section.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code, as amended by section 1306, is amended by adding at the end the following new item:

''Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 6002. INCLUSION OF COST OF EMPLOYER-SPONSORED HEALTH COVERAGE ON W–2.

(a) IN GENERAL.—Section 6051(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking ''and'' at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting '', and'', and by adding after paragraph (13) the following new paragraph:

''(14) the aggregate cost (determined under rules similar to the rules of section 4980B(f)(4)) of applicable employer-sponsored coverage (as defined in section 4980I(d)(1)), except that this paragraph shall not apply to—

''(A) coverage to which paragraphs (11) and (12) apply, or

''(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SEC. 6003. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAS.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(b) ARCHER MSAS.—Subparagraph (A) of section 220(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: ''Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.''.

(d) EFFECTIVE DATES.—

(1) DISTRIBUTIONS FROM SAVINGS ACCOUNTS.—The amendments made by subsections (a) and (b) shall apply to amounts paid with respect to taxable years beginning after December 31, 2009.

(2) REIMBURSEMENTS.—The amendment made by subsection (c) shall apply to expenses incurred with respect to taxable years beginning after December 31, 2009.

SEC. 6004. INCREASE IN ADDITIONAL TAX ON DISTRIBUTIONS FROM HSAS NOT USED FOR QUALIFIED MEDICAL EXPENSES.

(a) IN GENERAL.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking ''10 percent'' and inserting ''20 percent''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to distributions made after December 31, 2010.

SEC. 6005. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

''(i) LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section, if a benefit is provided under a cafeteria plan through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 6006. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsections:

''(h) APPLICATION TO CORPORATIONS.—Notwithstanding any regulation prescribed by the Secretary before the date of the enactment of this subsection, for purposes of this section the term 'person' includes any corporation that is not an organization exempt from tax under section 501(a).

''(i) REGULATIONS.—The Secretary may prescribe such regulations and other guidance as may be appropriate or necessary to carry out the purposes of this section, including rules to prevent duplicative reporting of transactions.''.

(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041 of the Internal Revenue Code of 1986 is amended—

(1) by inserting ''amounts in consideration for property,'' after ''wages,'',

(2) by inserting ''gross proceeds,'' after ''emoluments, or other'', and

(3) by inserting ''gross proceeds,'' after ''setting forth the amount of such''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made after December 31, 2011.

SEC. 6007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) REQUIREMENTS TO QUALIFY AS SECTION 501(C)(3) CHARITABLE HOSPITAL ORGANIZATION.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (r) as subsection (s) and by inserting after subsection (q) the following new subsection:

''(r) ADDITIONAL REQUIREMENTS FOR CERTAIN HOSPITALS.—

''(1) IN GENERAL.—A hospital organization to which this subsection applies shall not be treated as described in subsection (c)(3) unless the organization—

''(A) meets the community health needs assessment requirements described in paragraph (3),

"(B) meets the financial assistance policy requirements described in paragraph (4),

"(C) meets the requirements on charges described in paragraph (5), and

"(D) meets the billing and collection requirement described in paragraph (6).

"(2) HOSPITAL ORGANIZATIONS TO WHICH SUBSECTION APPLIES.—

"(A) IN GENERAL.—This subsection shall apply to—

"(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

"(ii) any other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) (determined without regard to this subsection).

"(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than 1 hospital facility—

''(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

''(ii) shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

''(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

''(A) IN GENERAL.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

''(i) has conducted a community health needs assessment which meets the requirements of subparagraph (B) in such taxable year or in either of the 2 taxable years immediately preceding such taxable year,

''(ii) has adopted an implementation strategy to meet the community health needs identified through such assessment.

''(B) COMMUNITY HEALTH NEEDS ASSESSMENT.—A community health needs assessment meets the requirements of this paragraph if such community health needs assessment—

"(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health, and

"(ii) is made widely available to the public.

"(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

"(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

"(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care,

"(ii) the basis for calculating amounts charged to patients,

"(iii) the method for applying for financial assistance,

"(iv) in the case of an organization which does not have a separate billing and collections policy, the actions the organization may take in the event of non-payment,

including collections action and reporting to credit agencies, and

''(v) measures to widely publicize the policy within the community to be served by the organization.

''(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy requiring the organization to provide, without discrimination, care for emergency medical conditions (within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd)), or other medically necessary care, to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

''(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

''(A) limits amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than the lowest amounts charged to individuals who have insurance covering such care, and

''(B) prohibits the use of gross charges.

"(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions before the organization has made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

"(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this subsection, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6).".

(b) EXCISE TAX FOR FAILURES TO MEET HOSPITAL EXEMPTION REQUIREMENTS.—

(1) IN GENERAL.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

"SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000.".

(2) CONFORMING AMENDMENT.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

"Sec. 4959. Taxes on failures by hospital organizations.".

(c) MANDATORY REVIEW OF TAX EXEMPTION FOR HOSPITALS.—The Secretary of the Treasury or the Secretary's delegate shall review at least once every 3 years the community benefit activities of each hospital organization to which section 501(r) of the Internal Revenue Code of 1986 (as added by this section) applies.

(d) ADDITIONAL REPORTING REQUIREMENTS.—

(1) COMMUNITY HEALTH NEEDS ASSESSMENTS AND AUDITED FINANCIAL STATEMENTS.—Section 6033(b) of the Internal Revenue Code of 1986 (relating to certain organizations described in section 501(c)(3)) is amended by striking "and" at the end of paragraph (14), by redesignating paragraph (15) as paragraph (16), and by inserting after paragraph (14) the following new paragraph:

''(15) in the case of an organization to which the requirements of section 501(r) apply for the taxable year—

''(A) a description of how the organization is addressing the needs identified in each community health needs assessment conducted under section 501(r)(3) and a description of any such needs that are not being addressed together with the reasons why such needs are not being addressed, and

''(B) the audited financial statements of such organization (or, in the case of an organization the financial statements of which are included in a consolidated financial statement with other organizations, such consolidated financial statement).''.

(2) TAXES.—Section 6033(b)(10) of such Code is amended by striking ''and'' at the end of subparagraph (B), by inserting ''and'' at the end of subparagraph (C), and by adding at the end the following new subparagraph:

''(D) section 4959 (relating to taxes on failures by hospital organizations),''.

(e) REPORTS.—

(1) REPORT ON LEVELS OF CHARITY CARE.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate an annual report on the following:

(A) Information with respect to private tax-exempt, taxable, and government-owned hospitals regarding—

(i) levels of charity care provided,

(ii) bad debt expenses,

(iii) unreimbursed costs for services provided with respect to means-tested government programs, and

(iv) unreimbursed costs for services provided with respect to non-means tested government programs.

(B) Information with respect to private tax-exempt hospitals regarding costs incurred for community benefit activities.

(2) REPORT ON TRENDS.—

(A) STUDY.—The Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall conduct a study on trends in the information required to be reported under paragraph (1).

(B) REPORT.—Not later than 5 years after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, shall submit a report on the study conducted under subparagraph (A) to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and to the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

(2) COMMUNITY HEALTH NEEDS ASSESSMENT.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to taxable years beginning

after the date which is 2 years after the date of the enactment of this Act.

(3) EXCISE TAX.—The amendments made by subsection (b) shall apply to failures occurring after the date of the enactment of this Act.

SEC. 6008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar

year shall be equal to an amount that bears the same ratio to $2,300,000,000 as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

(2) SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the branded prescription drug sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate branded prescription drug sales during the calendar year that are:	The percentage of such sales taken into account is:
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $125,000,000.	10 percent
More than $125,000,000 but not more than $225,000,000.	40 percent
More than $225,000,000 but not more than $400,000,000.	75 percent
More than $400,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales on the basis

of reports submitted under subsection (g) and through the use of any other source of information available to the Secretary of the Treasury.

(c) TRANSFER OF FEES TO MEDICARE PART B TRUST FUND.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under subsection (a).

(d) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from branded prescription drug sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of

such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(e) BRANDED PRESCRIPTION DRUG SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''branded prescription drug sales'' means sales of branded prescription drugs to any specified government program or pursuant to coverage under any such program.

(2) BRANDED PRESCRIPTION DRUGS.—

(A) IN GENERAL.—The term ''branded prescription drug'' means—

(i) any prescription drug the application for which was submitted under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or

(ii) any biological product the license for which was submitted under section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(i), the term ''prescription drug'' means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(3) EXCLUSION OF ORPHAN DRUG SALES.—The term ''branded prescription drug sales'' shall not include sales of any drug or biological product with respect to which a credit was allowed for any taxable year under section 45C of the Internal Revenue Code of 1986. The preceding sentence shall not apply with respect to any such drug or biological product after the date on which such drug or biological product is approved by the Food and Drug Administration for marketing for any indication other than the treatment of the rare disease or condition with respect to which such credit was allowed.

(4) SPECIFIED GOVERNMENT PROGRAM.—The term ''specified government program'' means—

(A) the Medicare Part D program under part D of title XVIII of the Social Security Act,

(B) the Medicare Part B program under part B of title XVIII of the Social Security Act,

(C) the Medicaid program under title XIX of the Social Security Act,

(D) any program under which branded prescription drugs are procured by the Department of Veterans Affairs,

(E) any program under which branded prescription drugs are procured by the Department of Defense, or

(F) the TRICARE retail pharmacy program under section 1074g of title 10, United States Code.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary of the Treasury following the end of any calendar year, the Secretary of Health and Human Services, the Secretary of Veterans Affairs, and the Secretary of Defense shall report to the Secretary of the Treasury, in such manner as the Secretary of the Treasury prescribes, the total branded prescription drug sales for each covered entity with respect

to each specified government program under such Secretary's jurisdiction using the following methodology:

(1) MEDICARE PART D PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part D program, the product of—

(A) the per-unit ingredient cost, as reported to the Secretary of Health and Human Services by prescription drug plans and Medicare Advantage prescription drug plans, minus any per-unit rebate, discount, or other price concession provided by the covered entity, as reported to the Secretary of Health and Human Services by the prescription drug plans and Medicare Advantage prescription drug plans, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part D program.

(2) MEDICARE PART B PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the

Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit average sales price (as defined in section 1847A(c) of the Social Security Act) or the per-unit Part B payment rate for a separately paid branded prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the units and the allocated price for purposes of this section for those branded prescription drugs that are not separately payable or for which National Drug Codes are not reported.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered under the Medicaid program, the product of—

(A) the per-unit ingredient cost paid to pharmacies by States for the branded prescription drug dispensed to Medicaid beneficiaries, minus any per-unit rebate paid by the covered

entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(B) the number of units of the branded prescription drug paid for under the Medicaid program.

(4) DEPARTMENT OF VETERANS AFFAIRS PROGRAMS.—The Secretary of Veterans Affairs shall report, for each covered entity and for each branded prescription drug of the covered entity the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs for its beneficiaries.

(5) DEPARTMENT OF DEFENSE PROGRAMS AND TRICARE.—The Secretary of Defense shall report, for each covered entity and for each branded prescription drug of the covered entity, the sum of—

(A) the total amount paid for each such branded prescription drug procured by the Department of Defense for its beneficiaries, and

(B) for each such branded prescription drug dispensed under the TRICARE retail pharmacy program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program.

(h) SECRETARY.—For purposes of this section, the term ''Secretary'' includes the Secretary's delegate.

(i) GUIDANCE.—The Secretary of the Treasury shall publish guidance necessary to carry out the purposes of this section.

(j) APPLICATION OF SECTION.—This section shall apply to any branded prescription drug sales after December 31, 2008.

(k) CONFORMING AMENDMENT.—Section 1841(a) of the Social Security Act is amended by inserting ''or section 6008(c) of the America's Healthy Future Act of 2009'' after ''this part''.

SEC. 6009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $4,000,000,000 as—

(A) the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bear to

(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year.

(2) GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the gross receipts from medical device sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
Not more than $5,000,000	0 percent

With respect to a covered entity's aggregate gross receipts from medical device sales during the calendar year that are:	The percentage of gross receipts taken into account is:
More than $5,000,000 but not more than $25,000,000.	50 percent
More than $25,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any manufacturer or importer with gross receipts from medical device sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) MEDICAL DEVICE SALES.—For purposes of this section—

(1) IN GENERAL.—The term ''medical device sales'' means sales for use in the United States of any medical device, other than the sales of a medical device that—

(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or

(B) has been classified in class I under such section.

(2) UNITED STATES.—For purposes of paragraph (1), the term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term ''medical device'' means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(e) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(f) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of such covered entity during such calendar year.

(g) SECRETARY.—For purposes of this section, the term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section, including identification of medical devices described in subsection (d)(1)(A) and with respect to the treatment of gross receipts from sales of medical devices to another covered entity.

(i) APPLICATION OF SECTION.—This section shall apply to any medical device sales after December 31, 2008.

SEC. 6010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term ''annual payment date'' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $6,700,000,000 as—

(A) the covered entity's net premiums written during the preceding calendar year with respect to health insurance for any United States health risk, bear to

(B) the aggregate net premiums of all covered entities written during such preceding calendar year with respect to such health insurance.

(2) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term ''covered entity'' means any entity which

provides health insurance for any United States health risk.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks, or

(B) any governmental entity.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term ''United States health risk'' means the health risk of any individual who is—

(1) a United States citizen,

(2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or

(3) located in the United States, with respect to the period such individual is so located.

(e) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(f) REPORTING REQUIREMENT.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity's net premiums written during such calendar year with respect to health insurance for any United States health risk.

(g) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term ''United States'' means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(h) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section.

(i) APPLICATION OF SECTION.—This section shall apply to any net premiums written after December 31, 2008, with respect to health insurance for any United States health risk.

SEC. 6011. STUDY AND REPORT OF EFFECT ON VETERANS HEALTH CARE.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall conduct a study on the effect (if any) of the provisions of sections 6008, 6009, and 6010 on—

(1) the cost of medical care provided to veterans, and

(2) veterans' access to medical devices and branded prescription drugs.

(b) REPORT.—The Secretary of Veterans Affairs shall report the results of the study under subsection (a) to the Committee on Ways and Means of the House of

Representatives and to the Committee on Finance of the Senate not later than December 31, 2012.

SEC. 6012. ELIMINATION OF DEDUCTION FOR EXPENSES ALLOCABLE TO MEDICARE PART D SUBSIDY.

(a) IN GENERAL.—Section 139A of the Internal Revenue Code of 1986 is amended by striking the second sentence.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 6013. MODIFICATION OF ITEMIZED DEDUCTION FOR MEDICAL EXPENSES.

(a) IN GENERAL.—Subsection (a) of section 213 of the Internal Revenue Code of 1986 is amended by striking ''7.5 percent'' and inserting ''10 percent''.

(b) TEMPORARY WAIVER OF INCREASE FOR CERTAIN SENIORS.—Section 213 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(f) SPECIAL RULE FOR 2013, 2014, 2015, AND 2016.—In the case of a taxable year beginning after December 31, 2012, and ending before January 1, 2017, subsection (a) shall be applied with respect to a taxpayer by substituting '7.5 percent' for '10 percent' if such taxpayer

or such taxpayer's spouse has attained age 65 before the close of such taxable year.''.

(c) CONFORMING AMENDMENT.—Section 56(b)(1)(B) of the Internal Revenue Code of 1986 is amended by striking ''by substituting '10 percent' for '7.5 percent' '' and inserting ''without regard to subsection (f) of such section''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable year beginning after December 31, 2012.

SEC. 6014. LIMITATION ON EXCESSIVE REMUNERATION PAID BY CERTAIN HEALTH INSURANCE PROVIDERS.

(a) IN GENERAL.—Section 162(m) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(6) SPECIAL RULE FOR APPLICATION TO CERTAIN HEALTH INSURANCE PROVIDERS.—

''(A) IN GENERAL.—No deduction shall be allowed under this chapter—

''(i) in the case of applicable individual remuneration which is for any disqualified taxable year beginning after December 31, 2012, and which is attributable to services performed by an applicable indi-

vidual during such taxable year, to the extent that the amount of such remuneration exceeds $500,000, or

''(ii) in the case of deferred deduction remuneration for any taxable year beginning after December 31, 2012, for services performed by an applicable individual during any disqualified taxable year beginning after December 31, 2009, to the extent that the amount of such remuneration exceeds $500,000 reduced (but not below zero) by the sum of—

''(I) the applicable individual remuneration for such taxable year, plus

''(II) the portion of the deferred deduction remuneration for such services which was taken into account under this clause in a preceding taxable year.

''(B) DISQUALIFIED TAXABLE YEAR.—For purposes of this paragraph, the term 'disqualified taxable year' means, with respect to any employer, any taxable year for which such employer is a covered health insurance provider.

"(C) COVERED HEALTH INSURANCE PROVIDER.—For purposes of this paragraph—

"(i) IN GENERAL.—The term 'covered health insurance provider' means—

"(I) with respect to taxable years beginning after December 31, 2009, and before January 1, 2013, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and which receives premiums from providing health insurance coverage (as defined in section 9832(b)(1)), and

"(II) with respect to taxable years beginning after December 31, 2012, any employer which is a health insurance issuer (as defined in section 9832(b)(2)) and with respect to which not less than 25 percent of the gross premiums received from providing health insurance coverage (as defined in section 9832(b)(1)) is from essential health benefits coverage (as defined in section 5000A(f)(1)).

"(ii) AGGREGATION RULES.—Two or more persons who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 shall be treated as a single employer, except that in applying section 1563(a) for purposes of any such subsection, paragraphs (2) and (3) thereof shall be disregarded.

"(D) APPLICABLE INDIVIDUAL REMUNERATION.—For purposes of this paragraph, the term 'applicable individual remuneration' means, with respect to any applicable individual for any disqualified taxable year, the aggregate amount allowable as a deduction under this chapter for such taxable year (determined without regard to this subsection) for remuneration (as defined in paragraph (4)(D)) for services performed by such individual (whether or not during the taxable year). Such term shall not include any deferred deduction remuneration with respect to services performed during the disqualified taxable year.

"(E) DEFERRED DEDUCTION REMUNERATION.—For purposes of this paragraph, the term and 'deferred deduction remuneration'

means remuneration which would be applicable individual remuneration for services performed in a disqualified taxable year but for the fact that the deduction under this chapter (determined without regard to this paragraph) for such remuneration is allowable in a subsequent taxable year.

''(F) APPLICABLE INDIVIDUAL.—For purposes of this paragraph, the term 'applicable individual' means, with respect to any covered health insurance provider for any disqualified taxable year, any individual—

''(i) who is an officer, director, or employee in such taxable year, or

''(ii) who provides services for or on behalf of such covered health insurance provider during such taxable year.

''(G) COORDINATION.—Rules similar to the rules of subparagraphs (F) and (G) of paragraph (4) shall apply for purposes of this paragraph.

''(H) REGULATORY AUTHORITY.—The Secretary may prescribe such guidance, rules, or regulations as are necessary to carry out the purposes of this paragraph.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2009, with respect to services performed after such date.

Subtitle B—Other Provisions

SEC. 6021. EXCLUSION OF HEALTH BENEFITS PROVIDED BY INDIAN TRIBAL GOVERNMENTS.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 139C the following new section:

"SEC. 139D. INDIAN HEALTH CARE BENEFITS.

''(a) GENERAL RULE.—Except as otherwise provided in this section, gross income does not include the value of any qualified Indian health care benefit.

''(b) QUALIFIED INDIAN HEALTH CARE BENEFIT.—For purposes of this section, the term 'qualified Indian health care benefit' means—

''(1) any health service or benefit provided or purchased, directly or indirectly, by the Indian Health Service through a grant to or a contract or compact with an Indian tribe or tribal organization, or through a third-party program funded by the Indian Health Service,

''(2) medical care provided or purchased by, or amounts to reimburse for such medical care provided

by, an Indian tribe or tribal organization for, or to, a member of an Indian tribe, including a spouse or dependent of such a member,

''(3) coverage under accident or health insurance (or an arrangement having the effect of accident or health insurance), or an accident or health plan, provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe, include a spouse or dependent of such a member, and

''(4) any other medical care provided by an Indian tribe or tribal organization that supplements, replaces, or substitutes for a program or service relating to medical care provided by the Federal government to Indian tribes or members of such a tribe.

''(c) DEFINITIONS.—For purposes of this section—

''(1) INDIAN TRIBE.—The term 'Indian tribe' has the meaning given such term by section 45A(c)(6).

''(2) TRIBAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term by section 4(l) of the Indian Self-Determination and Education Assistance Act.

''(3) MEDICAL CARE.—The term 'medical care' has the same meaning as when used in section 213.

''(4) ACCIDENT OR HEALTH INSURANCE; ACCIDENT OR HEALTH PLAN.—The terms 'accident or health insurance' and 'accident or health plan' have the same meaning as when used in section 105.

''(5) DEPENDENT.—The term 'dependent' has the meaning given such term by section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof.

''(d) DENIAL OF DOUBLE BENEFIT.—Gross income of a beneficiary of any qualified Indian health care benefit shall include the amount of any such benefit which is not includible in gross income of such beneficiary, or for which a deduction is allowable to such beneficiary, under any other provision of this chapter.''.

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

''Sec. 139D. Indian health care benefits.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits and coverage provided after the date of the enactment of this Act.

(d) NO INFERENCE.—Nothing in the amendments made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

(1) benefits provided by an Indian tribe or tribal organization that are not within the scope of this section, and

(2) benefits provided prior to the date of the enactment of this Act.

SEC. 6022. ESTABLISHMENT OF SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans), as amended by this Act, is amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (i) the following new subsection:

''(j) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

''(1) IN GENERAL.—An eligible employer maintaining a simple cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement during such year.

''(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—

''(A) which is established and maintained by an eligible employer, and

''(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

''(3) CONTRIBUTIONS REQUIREMENTS.—

''(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

''(i) a uniform percentage (not less than 2 percent) of the employee's compensation for the plan year, or

''(ii) an amount which is not less than the lesser of—

''(I) 6 percent of the employee's compensation for the plan year, or

''(II) twice the amount of the salary reduction contributions of each qualified employee.

''(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EM-

PLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of contribution is greater than that with respect to an employee who is not a highly compensated or key employee.

''(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

''(D) DEFINITIONS.—For purposes of this paragraph—

''(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

''(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with re-

spect to a cafeteria plan, any employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

"(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 414(q).

"(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 416(i).

"(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

"(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

"(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

"(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

"(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph

(A)(i), an employer may elect to exclude under the plan employees—

"(i) who have not attained the age of 21 before the close of a plan year,

"(ii) who have less than 1 year of service with the employer as of any day during the plan year,

"(iii) who are covered under an agreement which the Secretary of Labor finds to be a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer, or

"(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clause (i) or (ii).

"(5) ELIGIBLE EMPLOYER.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 100 or fewer employees on business days

during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

''(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence throughout the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

''(C) GROWING EMPLOYERS RETAIN TREATMENT AS SMALL EMPLOYER.—

''(i) IN GENERAL.—If—

''(I) an employer was an eligible employer for any year (a 'qualified year'), and

''(II) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with

respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

''(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

''(D) SPECIAL RULES.—

''(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

''(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

''(6) APPLICABLE NONDISCRIMINATION REQUIREMENT.—For purposes of this subsection, the term 'applicable nondiscrimination requirement' means any requirement under subsection (b) of this section, section 79(d), section 105(h), or paragraph (2), (3), (4), or (8) of section 129(d).

''(7) COMPENSATION.—The term 'compensation' has the meaning given such term by section 414(s).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to years beginning after December 31, 2010.

SEC. 6023. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 48C the following new section:

''SEC. 48D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

''(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

''(b) QUALIFIED INVESTMENT.—

''(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the aggregate amount of the costs paid or incurred in such taxable year for expenses necessary for and

directly related to the conduct of a qualifying therapeutic discovery project.

''(2) LIMITATION.—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for the credit under this section.

''(3) EXCLUSIONS.—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any cost—

''(A) for remuneration for an employee described in section 162(m)(3),

''(B) for interest expenses,

''(C) for facility maintenance expenses,

''(D) which is identified as a service cost under section 1.263A-1(e)(4) of title 26, Code of Federal Regulations, or

''(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.

''(4) CERTAIN PROGRESS EXPENDITURE RULES MADE APPLICABLE.—In the case of costs described in paragraph (1) that are paid for property of a

character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

''(5) APPLICATION OF SUBSECTION.—An investment shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

''(c) DEFINITIONS.—

''(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—

''(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

''(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or

''(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

''(2) ELIGIBLE TAXPAYER.—

''(A) IN GENERAL.—The term 'eligible taxpayer' means a taxpayer which employs not more than 250 employees in all businesses of the taxpayer at the time of the submission of the application under subsection (d)(2).

''(B) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (m) or (o) of section 414, shall be so treated for purposes of this paragraph.

''(3) FACILITY MAINTENANCE EXPENSES.—The term 'facility maintenance expenses' means costs paid or incurred to maintain a facility, including—

''(A) mortgage or rent payments,

''(B) insurance payments,

''(C) utility and maintenance costs, and

''(D) costs of employment of maintenance personnel.

''(d) QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this section, the Secretary, in consultation with the Secretary of Health and Human Services, shall establish a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

''(B) LIMITATION.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

''(2) CERTIFICATION.—

''(A) APPLICATION PERIOD.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1).

''(B) TIME FOR REVIEW OF APPLICATIONS.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

"(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

"(3) SELECTION CRITERIA.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

"(A) shall take into consideration only those projects that show reasonable potential—

"(i) to result in new therapies—

"(I) to treat areas of unmet medical need, or

"(II) to prevent, detect, or treat chronic or acute diseases and conditions,

"(ii) to reduce long-term health care costs in the United States, or

"(iii) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1), and

''(B) shall take into consideration which projects have the greatest potential—

''(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and

''(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

''(4) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

''(e) SPECIAL RULES.—

''(1) BASIS ADJUSTMENT.—For purposes of this subtitle, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

''(2) DENIAL OF DOUBLE BENEFIT.—

''(A) BONUS DEPRECIATION.—A credit shall not be allowed under this section for any investment for which bonus depreciation is al-

lowed under section 168(k), 1400L(b)(1), or 1400N(d)(1).

"(B) DEDUCTIONS.—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subsection (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation the basis of which is reduced under paragraph (1), or which are described in section 280C(g).

"(C) CREDIT FOR RESEARCH ACTIVITIES.—

"(i) IN GENERAL.—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.

''(ii) EXPENSES INCLUDED IN DETERMINING BASE PERIOD RESEARCH EXPENSES.—Any expenses for any taxable year which are qualified research expenses (within the meaning of section 41(b)) shall be taken into account in determining base period research expenses for purposes of applying section 41 to subsequent taxable years.

''(f) COORDINATION WITH DEPARTMENT OF TREASURY LOANS.—In the case of any investment with respect to which the Secretary makes a loan under section 6023(e) of the America's Healthy Future Act of 2009—

''(1) DENIAL OF CREDIT.—No credit shall be determined under this section with respect to such investment for the taxable year in which such loan is made or any subsequent taxable year.

''(2) RECAPTURE OF CREDITS FOR PROGRESS EXPENDITURES MADE BEFORE LOAN.—If a credit was determined under this section with respect to such investment for any taxable year ending before such loan is made—

''(A) the tax imposed under subtitle A on the taxpayer for the taxable year in which such

loan is made shall be increased by so much of such credit as was allowed under section 38,

''(B) the general business carryforwards under section 39 shall be adjusted so as to recapture the portion of such credit which was not so allowed, and

''(C) the amount of such loan shall be determined without regard to any reduction in the basis of any property of a character subject to an allowance for depreciation by reason of such credit.''.

(b) INCLUSION AS PART OF INVESTMENT CREDIT.—Section 46 of the Internal Revenue Code of 1986 is amended—

(1) by adding a comma at the end of paragraph (2),

(2) by striking the period at the end of paragraph (5) and inserting '', and'', and

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

''(6) the qualifying therapeutic discovery project credit.''.

(c) CONFORMING AMENDMENTS.—

(1) Section 49(a)(1)(C) of the Internal Revenue Code of 1986 is amended—

(A) by striking ''and'' at the end of clause (iv),

(B) by striking the period at the end of clause (v) and inserting '', and'', and

(C) by adding at the end the following new clause:

''(vi) the basis of any property to which paragraph (1) of section 48D(e) applies which is part of a qualifying therapeutic discovery project under such section 48D.''.

(2) Section 280C of such Code is amended by adding at the end the following new subsection:

''(g) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—

''(1) IN GENERAL.—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—

''(A) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if the credit under section 41 or

section 45C were allowed with respect to such expenses for such taxable year, and

"(B) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

"(i) the amount disallowed as a deduction by reason of section 48D(e)(2)(B), and

"(ii) the amount of any basis reduction under section 48D(e)(1).

"(2) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—In the case of expenses described in paragraph (1)(A) taken into account in determining the credit under section 48D for the taxable year, if—

"(A) the amount of the portion of the credit determined under such section with respect to such expenses, exceeds

"(B) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)),

the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

"(3) CONTROLLED GROUPS.—Paragraph (3) of subsection (b) shall apply for purposes of this subsection.".

(d) CLERICAL AMENDMENT.—The table of sections for subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

"Sec. 48D. Qualifying therapeutic discovery project credit.".

(e) LOANS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(1) IN GENERAL.—Upon application, the Secretary of the Treasury shall, subject to the requirements of this subsection, provide a loan to each person who makes a qualified investment in a qualifying therapeutic discovery project in the amount of 50 percent of such investment. No loan shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010. The Secretary of the Treasury may by regulations prescribe terms for any loan made under this paragraph.

(2) APPLICATION.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification

under section 48D(d)(2) of the Internal Revenue Code of 1986 for a credit under such section for the taxable year of the applicant which begins in 2009 shall be considered to be an application for a loan under paragraph (1) for such taxable year.

(B) TAXABLE YEARS BEGINNING IN 2010.—An application for a loan under paragraph (1) for a taxable year beginning in 2010 shall be submitted—

(i) not earlier than the day after the last day of such taxable year, and

(ii) not later than the due date (including extensions) for filing the return of tax for such taxable year.

(C) INFORMATION TO BE SUBMITTED.—An application for a loan under paragraph (1) shall include such information and be in such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a loan under this subsection) under section 48D for the taxable year for the qualified investment with respect to which such application is made.

(3) TIME FOR PAYMENT OF LOAN PROCEEDS.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any loan under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such loan, or

(ii) the date the qualified investment for which the loan is being made is made.

(B) REGULATIONS.—In the case of investments of an ongoing nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term ''qualified investment'' means a qualified investment that is certified under section 48D(d) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making loans under this subsection, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986. In applying such rules, any increase in tax under

chapter 1 of such Code by reason of an investment ceasing to be a qualified investment shall be imposed on the person to whom the loan was made.

(B) SPECIAL RULES.—

(i) RECAPTURE OF EXCESSIVE LOAN AMOUNTS.—If the amount of a loan made under this subsection exceeds the amount allowable as a loan under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the loan relates had ceased to be a qualified investment immediately after such loan was made.

(ii) LOAN INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a loan made under paragraph (1), the identity of the person to whom such loan was made, or a description of the investment with respect to which such loan was made be treated as return information for purposes of section 6103 of the Internal Revenue Code of 1986.

(6) EXCEPTION FOR CERTAIN NON-TAXPAYERS.—The Secretary of the Treasury shall not make any loan under this subsection to—

(A) any Federal, State, or local government (or any political subdivision, agency, or instrumentality thereof),

(B) any organization described in section 501(c) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code,

(C) any entity referred to in paragraph (4) of section 54(j) of such Code, or

(D) any partnership or other pass-thru entity any partner (or other holder of an equity or profits interest) of which is described in subparagraph (A), (B) or (C).

In the case of a partnership or other pass-thru entity described in subparagraph (D), partners and other holders of any equity or profits interest shall provide to such partnership or entity such information as the Secretary of the Treasury may require to carry out the purposes of this paragraph.

(7) SECRETARY.—Any reference in this subsection to the Secretary of the Treasury shall be treated as including the Secretary's delegate.

(8) OTHER TERMS.—Any term used in this subsection which is also used in section 48D of the Internal Revenue Code of 1986 shall have the same meaning for purposes of this subsection as when used in such section.

(9) DENIAL OF DOUBLE BENEFIT.—No credit shall be allowed under section 46(6) of the Internal Revenue Code of 1986 by reason of section 48D of such Code for any investment for which a loan is awarded under this subsection.

(10) APPROPRIATIONS.—There is hereby appropriated to the Secretary of the Treasury such sums as may be necessary to carry out this subsection.

(11) TERMINATION.—The Secretary of the Treasury shall not make any loan to any person under this subsection unless the application of such person for such loan is received before January 1, 2013.

(f) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred after December 31, 2008, in taxable years beginning after such date.

Calendar No. 184

111TH CONGRESS
1ST SESSION

S. 1796

[Report No. 111–89]

A BILL

To provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

OCTOBER 19, 2009

Read twice and placed on the calendar