by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3259. Mr. UDALL of Colorado submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 396, between lines 8 and 9, insert the following:

SEC. 1___. STATE COURT INNOVATION PROJECT.

(a) GRANT.—

(1) IN GENERAL.—

(A) GRANT PROGRAM.—The Attorney General shall develop and implement a competitive grant program to improve the efficiency and lessen the costs and burdens of medical malpractice civil litigation for plaintiffs and defendants.

(B) ELEMENTS OF PROGRAM.—The grant program under subparagraph (A) shall be designed—

(i) to give State courts a mechanism for improving court rules and procedures, allowing parties to go to trial in more cost-effective ways and reducing the complexity and cost of litigation; and

(ii) to fund research and objective measurement, evaluation, and reporting of outcomes to identify innovative ways of promoting the resolution of medical malpractice cases in court or tried by jury in a more cost-effective and timely manner pursuant to clause (i).

(C) ELIGIBLE ENTITY.—To be eligible to receive a grant under subparagraph (A), an entity shall—

(i) be a nonprofit State court improvement organization that was incorporated or in existence before December 31, 2009, and which is experienced in developing State court improvement programs; and

(ii) submit to the Attorney General an application at such time, in such manner, and containing such information as the Attorney General may require.

(2) USE OF FUNDS.—A grant recipient under paragraph (1) shall use amounts awarded under the grant to conduct research and evaluations, develop rules and procedures designed to improve the efficiency and lessen the costs of medical malpractice litigation for plaintiffs and defendants, and to award subgrants to eligible entities to carry out activities—

(A) to conduct pilot projects;

(B) to increase the operating efficiency of State courts with respect to medical malpractice litigation;

(C) to conduct research to seek innovative ways to resolve medical malpractice litigation in State courts in a more cost-effective and timely manner; and

(D) to measures and report on outcomes with respect to activities funded under the subgrant.

(3) ELIGIBLE SUBGRANT ENTITY.—To be eligible to receive a subgrant under paragraph (2), an entity shall—

(A)(i) be a State or local governmental entity in a jurisdiction that permits jury trials for civil medical malpractice actions; or

(ii) be an academic institution; and

(B) submit an application at such time, in such manner, and containing such information as required by the recipient of the grant under paragraph (1), in accordance with any rules established by the Attorney General.

(4) REPORTING.—Not later than 2 years after receiving grant funds under this subsection, each grant recipient under paragraph (1) shall submit to the Attorney General a report that describes the activities conducted by the recipient under this section, including the activities of any subgrantees of such grant recipient under paragraph (2).

(b) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $10,000,000 to carry out this section.

SA 3260. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 522, between lines 2 and 3, insert the following:

SEC. 2603. PAYMENT FOR ILLEGAL UNAPPROVED DRUGS.

(a) FINDINGS.—Congress finds that each year, the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) pays millions of dollars in reimbursement for covered outpatient drugs that are not approved by the Food and Drug Administration under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) or an abbreviated new drug application under section 505(j) of such Act, or that such drug is not subject such section 505 or section 512 due to the application of section 201(p) of such Act (21 U.S.C. 321(p)).

(b) LISTING OF DRUGS AND DEVICES.—Section 510 of the Food, Drug and Cosmetic Act (21 U.S.C. 360) is amended—

(1) in subsection (j)(1)(B)—

(A) in clause (i), by inserting ''in the case of a drug, the authority under this Act that does not require such drug to be subject to section 505 and section 512,'' after ''labeling for such drug or device,''; and

(B) in clause (ii), by inserting '', in the case of a drug, the authority under this Act that does not require such drug to be subject to section 505 and section 512,'' after ''for such drug or device''; and

(2) in subsection (f)—

(A) by striking ''(f) The Secretary'' and inserting the following:

''(f) INSPECTION BY PUBLIC OF REGISTRATION.—

''(1) IN GENERAL.—The Secretary''; and

(B) by adding at the end the following:

''(2) LIST OF DRUGS THAT ARE NOT APPROVED UNDER SECTION 505 OR 512.—Not later than January 1, 2011, the Secretary shall make available to the public on the Internet website of the Food and Drug Administration a list that includes, for each drug described in subsection (j)(1)(B)—

''(A) the drug;

''(B) the person who listed such drug; and

''(C) the authority under this Act that does not require such drug to be subject to section 505 and section 512, as provided by such person in such list.''.

(c) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Section 1927 of the Social Security Act (42 U.S.C. 1396r-8) is amended by inserting at the end the following:

''(l) CONDITION.—Beginning January 1, 2011, no State shall make any payment under this section for any covered outpatient drug unless such State first verifies with the Food and Drug Administration that such covered outpatient drug has been approved by the Food and Drug Administration under a new drug application under section 505(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)) or an abbreviated new drug application under section 505(j) of such Act, or that such drug is not subject such section 505 or section 512 due to the application of section 201(p) of such Act (21 U.S.C. 321(p)). The Secretary shall have the authority to proscribe regulations to create an information sharing protocol to allow States to verify that a covered outpatient drug has been approved by the Food and Drug Administration.''.

SA 3261. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 722, after line 20, insert the following:

SEC. 3016. CULTURE OF SAFETY HOSPITAL ACCOUNTABILITY STUDY AND DEMONSTRATION PROGRAM.

(a) STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study that—

(A) examines existing activities and programs in hospitals for quality assurance, patient safety, and performance improvement and provides an analysis regarding best practices with respect to such activities and programs; and

(B) identifies best practices that should be replicated in hospitals to improve patient safety and quality of care, consistent with the provisions included under the quality assessment and performance improvement program, as required under the conditions of participation for hospitals under Medicare.

(2) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall prepare a report containing the results of the study conducted under paragraph (1). Such report shall be made available on the Internet website of the Centers for Medicare & Medicaid Services.

(b) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—The Secretary shall establish the Culture of Safety Hospital Accountability demonstration program to provide support for establishing partnerships and other cooperative approaches between hospitals, State health care agencies, and the Department of Health and Human Services to promote and implement the best practices identified under subsection (a), with the goal of improving the safety and quality of care provided to Medicare beneficiaries and enhance compliance with the conditions of participation for hospitals under Medicare.

(2) DURATION.—The demonstration program shall operate during a period of 3 years, beginning not later than 12 months after completion of the report described in subsection (a)(2).

(3) SCOPE.—

(A) STATES.—The Secretary shall select not less than 4 States, but not more than 6 States, to participate in the demonstration program.

(B) HOSPITALS.—The Secretary shall select not more than 24 hospitals, within the States

selected under subparagraph (A), to participate in the demonstration program. The hospitals selected under this subparagraph shall satisfy criteria, as developed by the Secretary, indicating a need for substantial improvement in quality of care and patient safety.

(4) APPLICATION.—A State or hospital that desires to participate in the demonstration program shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(5) IMPLEMENTATION.—

(A) TECHNICAL ASSISTANCE.—The Secretary shall provide participating hospitals with technical assistance in implementation of the best practices identified through the study under subsection (a).

(B) HOSPITAL SURVEYORS.—For each State participating in the demonstration program, the Secretary shall provide training to State surveyors that is designed to—

(i) enhance knowledge of the disciplines of patient safety, quality assessment, and performance improvement;

(ii) increase skill in evaluating compliance with quality assessment and performance improvement programs required under the conditions of participation for hospitals under Medicare; and

(iii) focus investigations of complaints regarding hospital care on the hospital's quality assessment and performance improvement program.

(6) EVALUATION.—For each State and hospital participating in the demonstration program, the Secretary shall evaluate the following:

(A) The level of implementation of the best practices identified under subsection (a) by the participating hospitals and whether adoption of such practices—

(i) improved quality and patient safety (including an analysis of changes in quality measures and other indicators of outcome and performance); and

(ii) resulted in a decrease in the seriousness or number of citations for deficiencies under the conditions of participation for hospitals under Medicare.

(B) The training provided to State surveyors and whether such training resulted in enhanced proficiency in evaluations of hospital quality assessment and performance improvement programs.

(7) REPORT.—Not later than 12 months after completion of the demonstration project, the Secretary shall submit to Congress a report containing an evaluation of the demonstration program, including—

(A) the findings of the evaluation under paragraph (6); and

(B) recommendations—

(i) in regard to whether the best practices identified under the demonstration program should be adopted by other hospitals, and how the Secretary can best promote adoption of such best practices;

(ii) in regard to whether the training for State surveyors developed under the demonstration program should be provided to all State surveyors; and

(iii) for such legislation and administrative action as the Secretary determines appropriate.

(8) WAIVER AUTHORITY.—The Secretary may waive such requirements under titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program.

(c) FUNDING.—For purposes of carrying out this section, 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) of $25,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2010 through 2017. Amounts transferred under the preceding sentence shall remain available until expended.

(d) ALTERNATIVE REMEDIES.—Section 1866(b) of the Social Security Act (42 U.S.C. 1395cc(b)) is amended by adding at the end the following new paragraph:

''(5)(A) The Secretary is authorized to promulgate regulations that establish enforcement remedies that are in addition to, or in lieu of, termination of an agreement under this section for hospitals or critical access hospitals for violations of health and safety requirements under this title. Such remedies may include directed plans of correction that are designed to—

''(i) ensure compliance with requirements under this title (including conditions of participation for hospitals or critical access hospitals);

''(ii) prevent recurrence of non-compliance with such requirements; and

''(iii) improve the internal structures and processes within the hospital or critical access hospital for provision of continuous quality and safety enhancement.

''(B) The regulations described under subparagraph (A) may be promulgated by the Secretary before, during, or after the evaluation described under section 3016(b)(6) of the Patient Protection and Affordable Care Act.''.

(e) NON-APPLICATION OF PAPERWORK REDUCTION ACT.—Chapter 35 of title 44, United States Code (commonly referred to as the 'Paperwork Reduction Act of 1995') shall not apply to this section.

(f) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROGRAM.—The term ''demonstration program'' means the Culture of Safety Hospital Accountability demonstration program conducted under this section.

(2) HOSPITAL.—The term ''hospital'' means—

(A) an institution described under section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)); or

(B) a critical access hospital (as described under section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)).

(3) MEDICARE.—The term ''Medicare'' means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

SA 3262. Mr. WHITEHOUSE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 796, between lines 5 and 6, insert the following:

SEC. 3028. VOLUNTARY ACCELERATED SHARED SAVINGS PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish the Voluntary Accelerated Shared Savings Program (referred to in this section as the ''shared savings program'') under which health care providers that voluntarily report on quality measures, adopt quality-improving protocols or strategies, and achieve quality benchmarks are eligible for a shared savings payment.

(2) DURATION.—The shared savings program shall be conducted during the following periods:

(A) The hospital readmission reduction program, as described under subsection (d), shall—

(i) begin on such date as determined appropriate by the Secretary for implementation of the program, but not later than 6 months after the date of enactment of this Act; and

(ii) end not later than October 1, 2012.

(B) The hospital-acquired conditions reduction program, as described under subsection (e), shall—

(i) begin on such date as determined appropriate by the Secretary for implementation of the program, but not later than 6 months after the date of enactment of this Act; and

(ii) shall end not later than October 1, 2015.

(b) ELIGIBILITY; PARTICIPATION REQUIREMENTS.—

(1) ELIGIBILITY.—A hospital described in section 1886(q)(5)(C) of the Social Security Act, as added by section 3025, shall be eligible to participate in the shared savings program.

(2) APPLICATION.—A provider seeking to participate in the shared savings program shall submit an application to the Secretary, in such manner and containing such information as the Secretary may require, that includes a detailed description of the methods through which the provider expects to—

(A) reduce readmissions or hospital-acquired condition rates, as applicable;

(B) reduce costs; and

(C) integrate and coordinate such quality improvement efforts with post-acute providers.

(3) PARTICIPATION REQUIREMENTS.—A participating provider shall be required to—

(A) report on quality measures (as determined by the Secretary under subsection (c));

(B) satisfy applicable benchmarks for such quality measures; and

(C) demonstrate savings (as described in subsection (f)).

(c) QUALITY AND OTHER REPORTING REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall determine appropriate measures to assess the quality of care furnished by participating providers, such as measures of—

(A) clinical processes and outcomes;

(B) patient and, where practicable, caregiver experience of care; and

(C) utilization rates.

(2) INCORPORATION OF MEASURES.—For purposes of the measures described under paragraph (1), the Secretary may incorporate measures established—

(A) under sections 1848(k) and 1886(b) of the Social Security Act; and

(B) pursuant to any provision of this Act or amendment made by this Act.

(3) REPORTING REQUIREMENT.—A participating provider shall submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the participating provider to report in order to evaluate the quality of care furnished by such provider.

(4) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by participating providers. The Secretary shall seek to improve the quality of care furnished by participating providers over time by specifying higher standards, new measures, or both for purposes of assessing such quality of care.

(d) HOSPITAL READMISSION REDUCTION PROGRAM.—

(1) HOSPITAL READMISSIONS RATE MEASURES.—For purposes of establishing measures under subsection (c) for the hospital readmission reduction program, the Secretary shall include measures for readmission rates established under 1886(b) of the Social Security Act (42 U.S.C. 1395ww(b)).

(2) BENCHMARK.—The Secretary shall establish a benchmark for reduction in the readmission rate for a hospital that is adjusted for geographic area, patient population characteristics, and such other factors as determined appropriate by the Secretary. The Secretary may establish a higher benchmark for hospitals with an annual readmission rate that is above the mean nationwide readmission rate.

(3) SHARED SAVINGS REQUIREMENTS.—A participating provider shall be eligible for a shared savings payment under subsection (f) if such provider—

(A) achieves the applicable benchmark established by the Secretary under paragraph (2); and

(B) has an annual readmission rate that is below the risk adjusted expected readmissions rate as determined under section 1886(q)(4)(C)(i)(II) of the Social Security Act (as added by section 3025).

(4) COMMUNITY-BASED ORGANIZATIONS.—The Secretary may permit a community-based organization, as described in section 3026(b)(1)(B), to receive shared savings payments under the hospital readmission reduction program if such an organization—

(A) satisfies the requirements described under section 3026; and

(B) is associated with a subsection (d) hospital (as described in section 3026(b)(1)(A)) that would be eligible for a shared savings payment under this section.

(e) HOSPITAL-ACQUIRED CONDITIONS REDUCTION PROGRAM.—

(1) HOSPITAL-ACQUIRED CONDITIONS RATE MEASURES.—For purposes of establishing measures under subsection (c) for the hospital-acquired conditions program, the Secretary shall establish measures that accurately determine rates of hospital-acquired conditions (as defined in section 1886(p) of the Social Security Act, as added by section 3008).

(2) REDUCTION IN HOSPITAL-ACQUIRED CONDITIONS BENCHMARK.—The Secretary shall establish a benchmark for reduction in the hospital-acquired conditions rate for a participating provider that is adjusted for geographic area, patient population characteristics, and such other factors as determined appropriate by the Secretary. The Secretary may establish a higher benchmark for hospitals with an annual hospital-acquired conditions rate that is above the mean nationwide hospital-acquired conditions rate.

(3) SHARED SAVINGS REQUIREMENTS.—A participating provider shall eligible for a shared savings payment under subsection (f) if such provider achieves the applicable benchmark established by the Secretary under paragraph (2).

(f) SHARED SAVINGS PAYMENTS.—

(1) IN GENERAL.—Under the shared savings program, payments shall continue to be made to participating providers 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 provider is eligible to receive payment for shared savings under paragraph (3) if—

(A) the provider meets quality performance standards established by the Secretary under subsection (c); and

(B) the provider meets the requirement under paragraph (2)(A).

(2) SAVINGS REQUIREMENT AND BENCHMARK.—

(A) DETERMINING SAVINGS.—Subject to subparagraph (C), in each year of the period under subsection (a)(2), a participating provider shall be eligible to receive payment for shared savings under paragraph (3) only if the estimated average per capita Medicare expenditures for such provider 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 subparagraph (B).

(B) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each period under subsection (a)(2) for each participating provider using the most recent available 3 years of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries served by the provider. 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.

(C) HIGHER BENCHMARK.—For purposes of subparagraph (A), the Secretary may require a greater percentage in savings below the benchmark established under subparagraph (B) for a participating provider with an annual readmission or hospital-acquired conditions rate, as applicable, that is above the mean nationwide rate (as described in subsections (e)(2) and (f)(2)).

(3) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (c), if a participating provider meets the requirements under paragraphs (1) and (2), 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, for the provider and such benchmark for the provider may be paid to the provider as shared savings and the remainder of such difference shall be retained by the Medicare program under title XVIII of the Social Security Act. The Secretary shall establish limits on the total amount of shared savings that may be paid to a participating provider under this paragraph.

(g) EARLY PARTICIPATION IN MEDICARE SHARED SAVINGS PROGRAM AND NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.—

(1) IN GENERAL.—For purposes of section 1866D of the Social Security Act (as added by section 3023) and section 1899 of such Act (as added by section 3022), the Secretary may establish a program to provide for early participation payments under such sections to eligible providers or groups of providers.

(2) ELIGIBILITY.—

(A) IN GENERAL.—Providers eligible for the early participation program under this subsection shall include—

(i) providers described under section 1866D(a)(2)(G) of the Social Security Act; and

(ii) providers that meet the requirements in section 1899(b) of such Act.

(B) WAIVER OF REQUIREMENTS.—Subject to subparagraph (C), for purposes of the early participation program under this subsection, the Secretary may waive—

(i) any requirements under section 1899 of the Social Security Act, except that the Secretary shall not waive—

(I) the requirements under subsection (b) of such section (with the exception of subparagraphs (B) and (D) of subsection (b)(2)); or

(II) the provisions under subsection (d) of such section.

(ii) any requirements under section 1866D of the Social Security Act, provided that the proposal submitted by the provider (as described under subparagraph (C)) adequately provides for—

(I) a plan for quality improvement that is consistent with subsection (c)(4) of such section; and

(II) a valid payment methodology that is consistent with subsection (c)(3) of such section.

(C) APPLICATION.—Providers seeking to participate in the early participation program under this section shall submit a proposal, in such manner and containing such information as the Secretary may require, that includes, for purposes of determining applicable payments under this section, a methodology for calculation of savings or determination of bundled payments.

(3) MEDICARE SHARED SAVINGS PROGRAM.—For purposes of section 1899 of the Social Security Act, a provider seeking to participate in the early participation program under this section shall, as part of the proposal described under paragraph (2)(C), provide a detailed plan for quality improvement that is consistent with the goals described under subsections (a) and (b)(3) of section 1899 of the Social Security Act.

(4) NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.—For purposes of section 1866D of the Social Security Act, a provider seeking to participate in the early participation program under this section shall, as part of the proposal described under paragraph (2)(C), provide a detailed plan in regard to the methods by which such provider will satisfy the objectives described under subsection (a)(1) of section 1866D of the Social Security Act, which shall include—

(A) a bundled payment methodology;

(B) methods by which quality of care will be improved; and

(C) a description of the conditions and services that are to be covered through the bundled payment.

(5) APPLICABLE PERIOD.—Any payments made to providers pursuant to early participation program under this section shall cease upon establishment of the programs described under sections 1866D and 1899 of the Social Security Act, except to the extent that providers are determined to be eligible for, and continue to participate in, the programs established under such sections.

SA 3263. Mr. BAUCUS (for himself, Ms. SNOWE, Mr. CARPER, Mrs. LINCOLN, and Mr. BENNET) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

TITLE ____—ALTERNATIVE TO MEDICAL TORT LITIGATION

SEC. __01. SHORT TITLE.

This title may be cited as the ''Fair and Reliable Medical Justice Act''.

SEC. __02. PURPOSES.

The purposes of this title are—

(1) to restore fairness and reliability to the medical justice system by fostering alternatives to current medical tort litigation that promote disclosure of health care errors and provide prompt, fair, and reasonable compensation to patients who are injured by health care errors;

(2) to promote patient safety through disclosure of health care errors; and

(3) to support and assist States in developing such alternatives.

SEC. __03. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended by this Act, is further amended by adding at the end the following:

"SEC. 399V–2. STATE DEMONSTRATION PROGRAMS TO EVALUATE ALTERNATIVES TO CURRENT MEDICAL TORT LITIGATION.

''(a) IN GENERAL.—The Secretary is authorized to award demonstration grants to States for the development, implementation, and evaluation of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. In awarding such grants, the Secretary shall ensure the diversity of the alternatives so funded.

''(b) DURATION.—The Secretary may award grants under subsection (a) for a period not to exceed 5 years.

''(c) CONDITIONS FOR DEMONSTRATION GRANTS.—

''(1) REQUIREMENTS.—Each State desiring a grant under subsection (a) shall develop an alternative to current tort litigation that—

''(A) allows for the resolution of disputes over injuries allegedly caused by health care providers or health care organizations; and

''(B) promotes a reduction of health care errors by encouraging the collection and analysis of patient safety data related to disputes resolved under subparagraph (A) by organizations that engage in efforts to improve patient safety and the quality of health care.

''(2) ALTERNATIVE TO CURRENT TORT LITIGATION.—Each State desiring a grant under subsection (a) shall demonstrate how the proposed alternative described in paragraph (1)(A)—

''(A) makes the medical liability system more reliable by increasing the availability of prompt and fair resolution of disputes;

''(B) encourages the efficient resolution of disputes;

''(C) encourages the disclosure of health care errors;

''(D) enhances patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events;

''(E) improves access to liability insurance;

''(F) fully informs patients about the differences in the alternative and current tort litigation;

''(G) provides patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other options, including litigation, outside the alternative;

''(H) would not conflict with State law at the time of the application in a way that would prohibit the adoption of an alternative to current tort litigation; and

''(I) would not limit or curtail a patient's existing legal rights, ability to file a claim in or access a State's legal system, or otherwise abrogate a patient's ability to file a medical malpractice claim.

''(3) SOURCES OF COMPENSATION.—Each State desiring a grant under subsection (a) shall identify the sources from and methods by which compensation would be paid for claims resolved under the proposed alternative to current tort litigation, which may include public or private funding sources, or a combination of such sources. Funding methods shall to the extent practicable provide financial incentives for activities that improve patient safety.

''(4) SCOPE.—

''(A) IN GENERAL.—Each State desiring a grant under subsection (a) shall establish a scope of jurisdiction (such as Statewide, designated geographic region, a designated area of health care practice, or a designated group of health care providers or health care organizations) for the proposed alternative to current tort litigation that is sufficient to evaluate the effects of the alternative. No scope of jurisdiction shall be established under this paragraph that is based on a health care payer or patient population.

''(B) NOTIFICATION OF PATIENTS.—A State shall demonstrate how patients would be notified that they are receiving health care services that fall within such scope, and the process by which they may opt out of or voluntarily withdraw from participating in the alternative. The decision of the patient whether to participate or continue participating in the alternative process shall be made at any time and shall not be limited in any way.

''(5) PREFERENCE IN AWARDING DEMONSTRATION GRANTS.—In awarding grants under subsection (a), the Secretary shall give preference to States—

''(A) that have developed the proposed alternative through substantive consultation with relevant stakeholders, including patient advocates, health care providers and health care organizations, attorneys with expertise in representing patients and health care providers, medical malpractice insurers, and patient safety experts;

''(B) that make proposals that are likely to enhance patient safety by detecting, analyzing, and helping to reduce medical errors and adverse events; and

''(C) that make proposals that are likely to improve access to liability insurance.

''(d) APPLICATION.—

''(1) IN GENERAL.—Each State desiring a grant under subsection (a) shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

''(2) REVIEW PANEL.—

''(A) IN GENERAL.—In reviewing applications under paragraph (1), the Secretary shall consult with a review panel composed of relevant experts appointed by the Comptroller General.

''(B) COMPOSITION.—

''(i) NOMINATIONS.—The Comptroller General shall solicit nominations from the public for individuals to serve on the review panel.

''(ii) APPOINTMENT.—The Comptroller General shall appoint, at least 9 but not more than 13, highly qualified and knowledgeable individuals to serve on the review panel and shall ensure that the following entities receive fair representation on such panel:

''(I) Patient advocates.

''(II) Health care providers and health care organizations.

''(III) Attorneys with expertise in representing patients and health care providers.

''(IV) Medical malpractice insurers.

''(V) State officials.

''(VI) Patient safety experts.

''(C) CHAIRPERSON.—The Comptroller General, or an individual within the Government Accountability Office designated by the Comptroller General, shall be the chairperson of the review panel.

''(D) AVAILABILITY OF INFORMATION.—The Comptroller General shall make available to the review panel such information, personnel, and administrative services and assistance as the review panel may reasonably require to carry out its duties.

''(E) INFORMATION FROM AGENCIES.—The review panel may request directly from any department or agency of the United States any information that such panel considers necessary to carry out its duties. To the extent consistent with applicable laws and regulations, the head of such department or agency shall furnish the requested information to the review panel.

''(e) REPORTS.—

''(1) BY STATE.—Each State receiving a grant under subsection (a) shall submit to the Secretary an annual report evaluating the effectiveness of activities funded with grants awarded under such subsection. Such report shall, at a minimum, include the impact of the activities funded on patient safety and on the availability and price of medical liability insurance.

''(2) BY SECRETARY.—The Secretary shall submit to Congress an annual compendium of the reports submitted under paragraph (1) and an analysis of the activities funded under subsection (a) that examines any differences that result from such activities in terms of the quality of care, number and nature of medical errors, medical resources used, length of time for dispute resolution, and the availability and price of liability insurance.

''(f) TECHNICAL ASSISTANCE.—

''(1) IN GENERAL.—The Secretary shall provide technical assistance to the States applying for or awarded grants under subsection (a).

''(2) REQUIREMENTS.—Technical assistance under paragraph (1) shall include—

''(A) guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events; and

''(B) the development, in consultation with States, of common definitions, formats, and data collection infrastructure for States receiving grants under this section to use in reporting to facilitate aggregation and analysis of data both within and between States.

''(3) USE OF COMMON DEFINITIONS, FORMATS, AND DATA COLLECTION INFRASTRUCTURE.—States not receiving grants under this section may also use the common definitions, formats, and data collection infrastructure developed under paragraph (2)(B).

''(g) EVALUATION.—

''(1) IN GENERAL.—The Secretary, in consultation with the review panel established under subsection (d)(2), shall enter into a contract with an appropriate research organization to conduct an overall evaluation of the effectiveness of grants awarded under subsection (a) and to annually prepare and submit a report to Congress. Such an evaluation shall begin not later than 18 months following the date of implementation of the first program funded by a grant under subsection (a).

''(2) CONTENTS.—The evaluation under paragraph (1) shall include—

''(A) an analysis of the effects of the grants awarded under subsection (a) with regard to the measures described in paragraph (3);

''(B) for each State, an analysis of the extent to which the alternative developed under subsection (c)(1) is effective in meeting the elements described in subsection (c)(2);

''(C) a comparison among the States receiving grants under subsection (a) of the effectiveness of the various alternatives developed by such States under subsection (c)(1);

''(D) a comparison, considering the measures described in paragraph (3), of States receiving grants approved under subsection (a) and similar States not receiving such grants; and

''(E) a comparison, with regard to the measures described in paragraph (3), of—

''(i) States receiving grants under subsection (a);

''(ii) States that enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, any cap on non-economic damages; and

''(iii) States that have enacted, prior to the date of enactment of the Patient Protection and Affordable Care Act, a requirement that the complainant obtain an opinion regarding the merit of the claim, although the substance of such opinion may have no bearing on whether the complainant may proceed with a case.

''(3) MEASURES.—The evaluations under paragraph (2) shall analyze and make comparisons on the basis of—

''(A) the nature and number of disputes over injuries allegedly caused by health care providers or health care organizations;

''(B) the nature and number of claims in which tort litigation was pursued despite the existence of an alternative under subsection (a);

''(C) the disposition of disputes and claims, including the length of time and estimated costs to all parties;

''(D) the medical liability environment;

''(E) health care quality;

''(F) patient safety in terms of detecting, analyzing, and helping to reduce medical errors and adverse events;

''(G) patient and health care provider and organization satisfaction with the alternative under subsection (a) and with the medical liability environment; and

''(H) impact on utilization of medical services, appropriately adjusted for risk.

''(4) FUNDING.—The Secretary shall reserve 5 percent of the amount appropriated in each fiscal year under subsection (k) to carry out this subsection.

''(h) MEDPAC AND MACPAC REPORTS.—

''(1) MEDPAC.—The Medicare Payment Advisory Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicare program under title XVIII of the Social Security Act, and its beneficiaries.

''(2) MACPAC.—The Medicaid and CHIP Payment and Access Commission shall conduct an independent review of the alternatives to current tort litigation that are implemented under grants under subsection (a) to determine the impact of such alternatives on the Medicaid or CHIP programs under titles XIX and XXI of the Social Security Act, and their beneficiaries.

''(3) REPORTS.—Not later than December 31, 2016, the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission shall each submit to Congress a report that includes the findings and recommendations of each respective Commission based on independent reviews conducted under paragraphs (1) and (2), including an analysis of the impact of the alternatives reviewed on the efficiency and effectiveness of the respective programs.

''(i) OPTION TO PROVIDE FOR INITIAL PLANNING GRANTS.—Of the funds appropriated pursuant to subsection (k), the Secretary may use a portion not to exceed $500,000 per State to provide planning grants to such States for the development of demonstration project applications meeting the criteria described in subsection (c). In selecting States to receive such planning grants, the Secretary shall give preference to those States in which State law at the time of the application would not prohibit the adoption of an alternative to current tort litigation.

''(j) DEFINITIONS.—In this section:

''(1) HEALTH CARE SERVICES.—The term 'health care services' means any services provided by a health care provider, or by any individual working under the supervision of a health care provider, that relate to—

''(A) the diagnosis, prevention, or treatment of any human disease or impairment; or

''(B) the assessment of the health of human beings.

''(2) HEALTH CARE ORGANIZATION.—The term 'health care organization' means any individual or entity which is obligated to provide, pay for, or administer health benefits under any health plan.

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means any individual or entity—

''(A) licensed, registered, or certified under Federal or State laws or regulations to provide health care services; or

''(B) required to be so licensed, registered, or certified but that is exempted by other statute or regulation.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, such sums as may be necessary to carry out this section for each of fiscal years 2011 through 2015.

''(l) CURRENT STATE EFFORTS TO ESTABLISH ALTERNATIVE TO TORT LITIGATION.—Nothing in this section shall be construed to limit any prior, current, or future efforts of any State to establish any alternative to tort litigation.

''(m) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as limiting states' authority over or responsibility for their state justice systems.''.

SA 3264. Mr. WYDEN (for himself, Mr. BROWN, Mr. SPECTER, Mr. KOHL, and Ms. COLLINS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 999, between lines 16 and 17, insert the following:

SEC. 3402. LIMITATION ON HOSPICE SPENDING.

Section 1814(i)(1)(C) of the Social Security Act, as amended by sections 3132 and 3401, is further amended—

(1) in each of clauses (ii)(VII) and (iii), by striking ''clause (iv)'' and inserting ''clauses (iv) and (v)'';

(2) in clause (iv)—

(A) in subclause (II)—

(i) by striking ''subject to clause (v),''; and

(ii) by striking ''0.5 percentage point'' and inserting ''0.25 percentage point''; and

(B) by striking the flush sentence following subclause (II); and

(3) by striking clause (v) and inserting the following new clauses:

''(v) After determining the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, with respect to fiscal years 2014 through 2019, if the Secretary determines there is excess hospice spending (as defined in clause (vi)) for the fiscal year, the Secretary shall reduce such percentage by the amount of such excess hospice spending. The application of this clause may not result in the market basket percentage increase under clause (ii)(VII) or (iii), as applicable, being less than 0.0 for a fiscal year.

''(vi) For purposes of clause (v), the term 'excess hospice spending' means—

''(I) for fiscal year 2014, the excess (expressed as a percentage) of—

''(aa) the aggregate amount of payments for hospice care under this title for fiscal year 2011; over

''(bb) the aggregate amount of such payments for fiscal year 2010 increased by the medical care component of the Consumer Price Index for fiscal year 2011, plus 3.0 percentage points; and

''(II) for fiscal year 2015 through 2019, the excess (expressed as a percentage) between—

''(aa) the aggregate amounts of such payments for the fiscal year 3 years prior to the fiscal year involved; over

''(bb) the aggregate amount of such payments for the fiscal year 4 years prior to the fiscal year involved increased by the medical care component of the Consumer Price Index for the fiscal year 3 years prior to the fiscal year involved, plus 3.0 percentage points.''.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 17, 2009, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON COMMERCE, SCIENCE, AND TRANSPORTATION

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet during the session of the Senate on December 17, 2009, in room 253 of the Russell Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on December 17, 2009, at 10 a.m., to conduct a hearing entitled ''Safeguarding the American Dream: Prospectus for Our Economic Future and Proposals to Secure It.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on December 17, 2009, at 2:15 p.m., in room 628 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on December 17, 2009, at 10 a.m., in SD–226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.