

1 (b) TABLE OF DIVISIONS, TITLES, AND SUB-
2 TITLES.—This Act is divided into divisions, titles, and
3 subtitles as follows:

DIVISION A—AFFORDABLE HEALTH CARE CHOICES

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED
HEALTH BENEFITS PLANS

Subtitle A—General Standards

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Subtitle D—Additional Consumer Protections

Subtitle E—Governance

Subtitle F—Relation to Other Requirements; Miscellaneous

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED
PROVISIONS

Subtitle A—Health Insurance Exchange

Subtitle B—Public Health Insurance Option

Subtitle C—Individual Affordability Credits

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Subtitle B—Employer Responsibility

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

Subtitle C—Disclosures to Carryout Health Insurance Exchange Subsidies

Subtitle D—Other Revenue Provisions

TITLE V—IMMEDIATE INVESTMENTS

DIVISION B—MEDICARE AND MEDICAID IMPROVEMENTS

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

Subtitle B—Provisions Related to Part B

Subtitle C—Provisions Related to Medicare Parts A and B

Subtitle D—Medicare Advantage Reforms

Subtitle E—Improvements to Medicare Part D

Subtitle F—Medicare Rural Access Protections

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

Subtitle B—Reducing Health Disparities

Subtitle C—Miscellaneous Improvements

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

Subtitle B.—Nursing Home Transparency

Subtitle C—Quality Measurements

Subtitle D—Physician Payments Sunshine Provisions

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse

Subtitle B—Enhanced Penalties for Fraud and Abuse

Subtitle C—Enhanced Program and Provider Protections

Subtitle D—Access to Information Needed to Prevent Fraud and Abuse

TITLE VII—MISCELLANEOUS PROVISIONS

TITLE VIII—MEDICAID AND CHIP

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

TITLE I—COMMUNITY HEALTH CENTERS

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

Subtitle B—Nursing Workforce

Subtitle C—Public Health Workforce

Subtitle D—Adapting Workforce to Evolving Health System Needs

TITLE III—PREVENTION AND WELLNESS

TITLE IV—QUALITY AND SURVEILLANCE

TITLE V—OTHER PROVISIONS

**DIVISION A—AFFORDABLE
HEALTH CARE CHOICES****SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION;
GENERAL DEFINITIONS.****(a) PURPOSE.—**

(1) **IN GENERAL.**—The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

(2) **BUILDING ON CURRENT SYSTEM.**—This division achieves this purpose by building on what works in today’s health care system, while repairing the aspects that are broken.

(3) INSURANCE REFORMS.—This division—

(A) enacts strong insurance market reforms;

(B) creates a new Health Insurance Exchange, with a public health insurance option alongside private plans;

(C) includes sliding scale affordability credits; and

(D) initiates shared responsibility among workers, employers, and the government;

1 so that all Americans have coverage of essential
2 health benefits.

3 (4) HEALTH DELIVERY REFORM.—This division
4 institutes health delivery system reforms both to in-
5 crease quality and to reduce growth in health spend-
6 ing so that health care becomes more affordable for
7 businesses, families, and government.

8 (b) TABLE OF CONTENTS OF DIVISION.—The table
9 of contents of this division is as follows:

Sec. 100. Purpose; table of contents of division; general definitions.

TITLE I—PROTECTIONS AND STANDARDS FOR QUALIFIED
HEALTH BENEFITS PLANS

Subtitle A—General Standards

Sec. 101. Requirements reforming health insurance marketplace.

Sec. 102. Protecting the choice to keep current coverage.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

Sec. 111. Prohibiting pre-existing condition exclusions.

Sec. 112. Guaranteed issue and renewal for insured plans.

Sec. 113. Insurance rating rules.

Sec. 114. Nondiscrimination in benefits.

Sec. 115. Ensuring adequacy of provider networks.

Sec. 116. Minimum medical loss ratio.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

Sec. 121. Coverage of essential benefits package.

Sec. 122. Essential benefits package defined.

Sec. 123. Health Benefits Advisory Committee.

Sec. 124. Process for adoption of recommendations; adoption of benefit stand-
ards.

Subtitle D—Additional Consumer Protections

Sec. 131. Requiring fair marketing practices by health insurers.

Sec. 132. Requiring fair grievance and appeals mechanisms.

Sec. 133. Requiring information transparency and plan disclosure.

Sec. 134. Application to qualified health benefits plans not offered through the
Health Insurance Exchange.

Sec. 135. Timely payment of claims.

Sec. 136. Standardized rules for coordination and subrogation of benefits.

Subtitle E—Governance

- Sec. 141. Health Choices Administration; Health Choices Commissioner.
- Sec. 142. Duties and authority of Commissioner.
- Sec. 143. Consultation and coordination.
- Sec. 144. Health Insurance Ombudsman.

Subtitle F—Relation to Other Requirements; Miscellaneous

- Sec. 151. Relation to other requirements.
- Sec. 152. Prohibiting discrimination in health care.

TITLE II—HEALTH INSURANCE EXCHANGE AND RELATED PROVISIONS

Subtitle A—Health Insurance Exchange

- Sec. 201. Establishment of Health Insurance Exchange; outline of duties; definitions.
- Sec. 202. Exchange-eligible individuals and employers.
- Sec. 203. Benefits package levels.
- Sec. 204. Contracts for the offering of Exchange-participating health benefits plans.
- Sec. 205. Outreach and enrollment of Exchange-eligible individuals and employers in Exchange-participating health benefits plan.
- Sec. 206. Other functions.
- Sec. 207. Health Insurance Exchange Trust Fund.
- Sec. 208. Optional operation of State-based health insurance exchanges.

Subtitle B—Public Health Insurance Option

- Sec. 221. Establishment and administration of a public health insurance option as an Exchange-qualified health benefits plan.
- Sec. 222. Premiums and financing.
- Sec. 223. Payment rates for items and services.
- Sec. 224. Modernized payment initiatives and delivery system reform.
- Sec. 225. Provider participation.
- Sec. 226. Application of fraud and abuse provisions.

Subtitle C—Individual Affordability Credits

- Sec. 241. Availability through Health Insurance Exchange.
- Sec. 242. Affordable credit eligible individual.
- Sec. 243. Affordable premium credit.
- Sec. 244. Affordability cost-sharing credit.
- Sec. 245. Income determinations.
- Sec. 246. No Federal payment for undocumented aliens.

TITLE III—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

- Sec. 301. Individual responsibility.

Subtitle B—Employer Responsibility

PART 1—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

- Sec. 311. Health coverage participation requirements.

- Sec. 312. Employer responsibility to contribute towards employee and dependent coverage.
- Sec. 313. Employer contributions in lieu of coverage.
- Sec. 314. Authority related to improper steering.

PART 2—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS

- Sec. 321. Satisfaction of Health Coverage Participation Requirements under the Employee Retirement Income Security Act of 1974.
- Sec. 322. Satisfaction of health coverage participation requirements under the Internal Revenue Code of 1986.
- Sec. 323. Satisfaction of Health Coverage Participation Requirements under the Public Health Service Act.
- Sec. 324. Additional rules relating to health coverage participation requirements.

TITLE IV—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Shared Responsibility

PART 1—INDIVIDUAL RESPONSIBILITY

- Sec. 401. Tax on individuals without acceptable health care coverage.

PART 2—EMPLOYER RESPONSIBILITY

- Sec. 411. Election to satisfy health coverage participation requirements.
- Sec. 412. Responsibilities of nonelecting employers.

Subtitle B—Credit for Small Business Employee Health Coverage Expenses

- Sec. 421. Credit for small business employee health coverage expenses.

Subtitle C—Disclosures to Carryout Health Insurance Exchange Subsidies

- Sec. 431. Disclosures to carryout health insurance exchange subsidies.

Subtitle D—Other Revenue Provisions

- Sec. 441. **【to be provided】**.

TITLE V—IMMEDIATE INVESTMENTS

- Sec. 501. Immediate investments.

1 (c) GENERAL DEFINITIONS.—Except as otherwise
2 provided, in this division:

3 (1) ACCEPTABLE COVERAGE.—The term “ac-
4 acceptable coverage” has the meaning given such term
5 in section 202(c)(2).

1 (2) BASIC PLAN.—The term “basic plan” has
2 the meaning given such term in section
3 203(c)(1)(A).

4 (3) COMMISSIONER.—The term “Commis-
5 sioner” means the Health Choices Commissioner es-
6 tablished under section 151.

7 (4) COST-SHARING.—The term “cost-sharing”
8 includes deductibles, coinsurance, copayments, and
9 similar charges but does not include premiums or
10 any network payment differential for covered serv-
11 ices or spending for non-covered services.

12 (5) DEPENDENT.—The term “dependent” has
13 the meaning given such term by the Commissioner
14 and includes a spouse.

15 (6) ENHANCED PLAN.—The term “enhanced
16 plan” has the meaning given such term in section
17 203(c)(1)(A).

18 (7) ESSENTIAL BENEFITS PACKAGE.—The term
19 “essential benefits package” is defined in section
20 122(a).

21 (8) FAMILY.—The term “family” means an in-
22 dividual and includes the individual’s dependents.

23 (9) FEDERAL POVERTY LEVEL; FPL.—The
24 terms “Federal poverty level” and “FPL” have the
25 meaning given the term “poverty line” in section

1 673(2) of the Community Services Block Grant Act
2 (42 U.S.C. 9902(2)), including any revision required
3 by such section.

4 (10) GROUP HEALTH PLAN.—The term “group
5 health plan” has the meaning given such term in
6 733(a)(1) of the Employee Retirement Income Secu-
7 rity Act of 1974, and also includes the following:

8 (A) FEDERAL AND STATE GOVERNMENTAL
9 PLANS.—Such a plan established or maintained
10 for its employees by the Government of the
11 United States, by the government of any State
12 or political subdivision thereof, or by any agen-
13 cy or instrumentality of any of the foregoing,
14 including a health benefits plan offered under
15 chapter 89 of title 5, United States Code.

16 (B) PLANS MAINTAINED BY MULTIPLE EN-
17 TITIES.—Such a plan established or maintained
18 by 2 or more employers or jointly by 1 or more
19 employers and 1 or more employee organiza-
20 tions, including such a plan established or
21 maintained under or pursuant to one or more
22 collective bargaining agreements.

23 (C) CHURCH PLANS.—Such a plan estab-
24 lished and maintained for its employees (or
25 their beneficiaries) by a church or by a conven-

1 tion or association of churches which is exempt
2 from tax under section 501 of the Internal Rev-
3 enue Code of 1986.

4 (11) HEALTH BENEFITS PLAN.—The terms
5 “health benefits plan” means health insurance cov-
6 erage and a group health plan and includes the pub-
7 lic health insurance option.

8 (12) HEALTH INSURANCE COVERAGE; HEALTH
9 INSURANCE ISSUER.—The terms “health insurance
10 coverage” and “health insurance issuer” have the
11 meanings given such terms in section 2791 of the
12 Public Health Service Act.

13 (13) HEALTH INSURANCE EXCHANGE.—The
14 term “Health Insurance Exchange” means the
15 Health Insurance Exchange established under sec-
16 tion 201.

17 (14) MEDICAID.—The term “Medicaid” means
18 a State plan under title XIX of the Social Security
19 Act (whether or not the plan is operating under a
20 waiver under section 1115 of such Act).

21 (15) MEDICARE.—The term “Medicare” means
22 the health insurance programs under title XVIII of
23 the Social Security Act.

24 (16) PLAN SPONSOR.—The term “plan spon-
25 sor” has the meaning given such term in section

1 3(16)(B) of the Employee Retirement Income Secu-
2 rity Act of 1974.

3 (17) PLAN YEAR.—The term “plan year”
4 means—

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

7 (B) with respect to another health benefits
8 plan, a 12-month period as specified by the
9 Commissioner.

10 (18) PREMIUM PLAN; PREMIUM-PLUS PLAN.—
11 The terms “premium plan” and “premium-plus
12 plan” have the meanings given such terms in sub-
13 paragraphs (A) and (B), respectively, of section
14 203(c)(1).

15 (19) QHBP OFFERING ENTITY.—The terms
16 “QHBP offering entity” means, with respect to a
17 health benefits plan that is—

18 (A) a group health plan, the plan sponsor
19 in relation to such group health plan, except
20 that, in the case of a plan maintained jointly by
21 1 or more employers and 1 or more employee
22 organizations and with respect to which an em-
23 ployer is the primary source of financing, such
24 term means such employer;

1 (B) health insurance coverage, the health
2 insurance issuer offering the coverage;

3 (C) the public health insurance option, the
4 Secretary of Health and Human Services;

5 (D) a non-Federal governmental plan (as
6 defined in section 2791(d) of the Public Health
7 Service Act), the State or political subdivision
8 of a State which establishes or maintains such
9 plan; or

10 (E) a Federal governmental plan (as de-
11 fined in section 2791(d) of the Public Health
12 Service Act), the appropriate Federal official.

13 (20) QUALIFIED HEALTH BENEFITS PLAN.—
14 The term “qualified health benefits plan” means a
15 health benefits plan that meets the requirements for
16 such a plan under title I and includes the public
17 health insurance option.

18 (21) PUBLIC HEALTH INSURANCE OPTION.—
19 The term “public health insurance option” means
20 the public health insurance option as provided under
21 subtitle B of title II.

22 (22) SERVICE AREA; PREMIUM RATING AREA.—
23 The terms “service area” and “premium rating
24 area” mean with respect to health insurance cov-
25 erage—

1 (A) offered other than through the Health
2 Insurance Exchange, such an area as estab-
3 lished by the QHBP offering entity of such cov-
4 erage in accordance with applicable State law;
5 and

6 (B) offered through the Health Insurance
7 Exchange, such an area as established by such
8 entity in accordance with applicable State law
9 and applicable rules of the Commissioner for
10 Exchange-participating health benefits plans.

11 (23) STATE.—The term “State” has the mean-
12 ing given such term for purposes of the Medicaid
13 program, but only includes, with respect to subtitle
14 C of title II, the 50 States and the District of Co-
15 lumbia.

16 (24) STATE MEDICAID AGENCY.—The term
17 “State Medicaid agency” means, with respect to a
18 Medicaid plan, the single State agency responsible
19 for administering such plan under title XIX of the
20 Social Security Act.

21 (25) Y1, Y2, ETC.—The terms “Y1” , “Y2”,
22 “Y3”, “Y4”, “Y5”, and similar subsequently num-
23 bered terms, mean 2013 (or such earlier year as the
24 President may determine with respect to the applica-

1 tion of titles I, II, and III of this division) and sub-
2 sequent years, respectively.

3 (d) REFERENCES TO ERISA.—With respect to any
4 term defined in subsection (b) with reference to the Em-
5 ployee Retirement Income Security Act of 1974, such ref-
6 erence shall be applied without regard to paragraph (1)
7 of section 4(b) of such Act (relating to governmental
8 plans) and paragraph (2) of such section 4(b) (relating
9 to church plans).

10 **TITLE I—PROTECTIONS AND**
11 **STANDARDS FOR QUALIFIED**
12 **HEALTH BENEFITS PLANS**

13 **Subtitle A—General Standards**

14 **SEC. 101. REQUIREMENTS REFORMING HEALTH INSUR-**
15 **ANCE MARKETPLACE.**

16 (a) PURPOSE.—The purpose of this title is to estab-
17 lish standards to ensure that new health insurance cov-
18 erage and group health plans that are offered meet essen-
19 tial standards guaranteeing access to affordable coverage,
20 essential benefits, and other consumer protections.

21 (b) REQUIREMENTS FOR QUALIFIED HEALTH BENE-
22 FITS PLANS.—A health benefits plan shall not be a quali-
23 fied health benefits plan under this division unless the
24 plan meets the applicable requirements of the following
25 subtitles for the type of plan and plan year involved:

1 (1) Subtitle B (relating to guaranteeing access
2 to coverage).

3 (2) Subtitle C (relating to guaranteeing access
4 to essential benefits).

5 (3) Subtitle D (relating to ensuring consumer
6 protection), to the extent made applicable to quali-
7 fied health benefits plans under section 134.

8 (c) TERMINOLOGY.—In this division:

9 (1) ENROLLMENT IN GROUP HEALTH PLANS.—
10 An individual shall be treated as being “enrolled” in
11 a group health plan if the individual is a participant
12 or beneficiary in such plan.

13 (2) INDIVIDUAL GROUP HEALTH INSURANCE
14 COVERAGE.—The terms “individual health insurance
15 coverage” and “group health insurance coverage”
16 mean health insurance coverage offered in the indi-
17 vidual market or large or small group market, re-
18 spectively, as defined in section 2791 of the Public
19 Health Service Act.

20 **SEC. 102. PROTECTING THE CHOICE TO KEEP CURRENT**
21 **COVERAGE.**

22 (a) GRANDFATHERED HEALTH INSURANCE COV-
23 ERAGE DEFINED.—Subject to the succeeding provisions of
24 this section, for purposes of establishing acceptable cov-
25 erage under this division, the term “grandfathered health

1 insurance coverage” means individual health insurance
2 coverage that is offered and in force and effect before the
3 first day of Y1 (as defined in section 100(c)) if the fol-
4 lowing conditions are met:

5 (1) LIMITATION ON NEW ENROLLMENT.—

6 (A) IN GENERAL.—Except as provided in
7 this paragraph, the individual health insurance
8 issuer offering such coverage does not enroll
9 any individual in such coverage if the effective
10 date of coverage is on or after the first day of
11 Y1.

12 (B) DEPENDENT COVERAGE PER-
13 MITTED.—Subparagraph (A) shall not affect
14 the subsequent enrollment of a dependent of an
15 individual who is covered as of such first day.

16 (2) LIMITATION ON CHANGES IN TERMS OR
17 CONDITIONS.—Subject to paragraph (3), the issuer
18 does not change any of its terms or conditions, in-
19 cluding benefits and cost-sharing, from those in ef-
20 fect as of the day before the first day of Y1.

21 (3) RESTRICTIONS ON PREMIUM INCREASES.—
22 The issuer cannot vary in an individual market pol-
23 icy by any factor other than area (as defined by the
24 Commissioner).

1 (b) GRACE PERIOD FOR CURRENT GROUP HEALTH
2 PLANS.—

3 (1) GRACE PERIOD.—

4 (A) IN GENERAL.—The Commissioner
5 shall establish a grace period whereby, by the
6 end of the 5-year period beginning with Y1, a
7 group health plan in operation as of the day be-
8 fore the first day of Y1 must meet the same re-
9 quirements as apply to a qualified health bene-
10 fits plan under section 101, including the min-
11 imum benefit package requirement under sec-
12 tion 121.

13 (B) EXCEPTION FOR LIMITED BENEFITS
14 PLANS.—Subparagraph (A) shall not apply to a
15 group health plan in which the coverage con-
16 sists only of one or more of the following:

17 (i) Any coverage described in section
18 3001(a)(1)(B)(ii)(IV) of division B of the
19 American Recovery and Reinvestment Act
20 of 2009 (PL 111–5).

21 (ii) Excepted benefits (as defined in
22 section 733(c) of the Employee Retirement
23 Income Security Act of 1974), including
24 coverage under a dread disease policy de-

1 scribed in paragraph (3)(A) of such sec-
2 tion.

3 (iii) A health flexible spending ar-
4 rangement (as defined in section 106(e)(2)
5 of the Internal Revenue Code of 1986).

6 (iv) Such other limited benefits as the
7 Commissioner may specify.

8 (2) TRANSITIONAL TREATMENT AS ACCEPT-
9 ABLE COVERAGE.—During the grace period specified
10 in paragraph (1), a group health plan that is de-
11 scribed in such paragraph shall be treated as accept-
12 able coverage under this division.

13 (c) LIMITATION ON INDIVIDUAL HEALTH INSURANCE
14 COVERAGE.—

15 (1) IN GENERAL.—Individual health insurance
16 coverage shall not qualify as acceptable coverage
17 under this division for purposes of section 59B of
18 the Internal Revenue Code of 1986 unless the cov-
19 erage is grandfathered health insurance coverage or
20 is coverage offered as an Exchange-participating
21 health benefits plan.

22 (2) SEPARATE, EXCEPTED COVERAGE PER-
23 MITTED.—Nothing in paragraph (1) shall prevent
24 the offering, other than through the Health Insur-
25 ance Exchange, of excepted benefits (as defined in

1 section 2791(c) of the Public Health Service Act) so
2 long as it is offered and priced separately from
3 health insurance coverage.

4 **Subtitle B—Standards Guaranteing Access to Affordable Cov-**
5 **teeing Access to Affordable Cov-**
6 **erage**

7 **SEC. 111. PROHIBITING PRE-EXISTING CONDITION EXCLU-**
8 **SIONS.**

9 A qualified health benefits plan may not impose any
10 pre-existing condition exclusion (as defined in section
11 2701(b)(1)(A) of the Public Health Service Act) or other-
12 wise impose any limit or condition on the coverage under
13 the plan with respect to an individual or dependent of an
14 individual based on any health status-related factors (as
15 defined in section 2791(d)(9) of the Public Health Service
16 Act) in relation to the individual or dependent.

17 **SEC. 112. GUARANTEED ISSUE AND RENEWAL FOR IN-**
18 **SURED PLANS.**

19 The requirements of sections 2711 and 2712 of the
20 Public Health Service Act, relating to guaranteed avail-
21 ability and renewability of group health insurance cov-
22 erage in the small group market shall apply effective the
23 first day of Y1 to all health insurance coverage, whether
24 offered to individuals through the Health Insurance Ex-
25 change or through any group health plan in the same

1 manner as such sections apply to health insurance cov-
2 erage offered in the small group market and for purposes
3 of applying such section 2712, rescissions of coverage shall
4 be treated in the same manner as non-renewals of cov-
5 erage.

6 **SEC. 113. INSURANCE RATING RULES.**

7 The premium rate charged for an insured qualified
8 health benefits plan may not vary except as follows:

9 (1) LIMITED AGE VARIATION PERMITTED.—By
10 age (within such age categories as the Commissioner
11 shall specify) so long as the ratio of the highest such
12 premium to the lowest such premium does not ex-
13 ceed the ratio of 2 to 1.

14 (2) BY AREA.—By premium rating area (as
15 permitted by State insurance regulators or, in the
16 case of Exchange-participating health benefits plans,
17 as specified by the Commissioner under section
18 203(a)(7) in consultation with such regulators).

19 (3) BY FAMILY ENROLLMENT.—By family en-
20 rollment (such as variations within categories and
21 compositions of families) so long as the ratio of the
22 premium for family enrollment (or enrollments) to
23 the premium for individual enrollment is uniform, as
24 specified under State law and consistent with rules
25 of the Commissioner.

1 **SEC. 114. NONDISCRIMINATION IN BENEFITS.**

2 A qualified health benefits plan shall comply with
3 standards established by the Commissioner to prohibit dis-
4 crimination in health benefits or benefit structures for
5 qualifying health benefits plans, to the extent such stand-
6 ards are not inconsistent with sections 702 of Employee
7 Retirement Income Security Act of 1974 and 2702 of the
8 Public Health Service Act.

9 **SEC. 115. ENSURING ADEQUACY OF PROVIDER NETWORKS.**

10 (a) IN GENERAL.—A qualified health benefits plan
11 that uses a provider network for items and services shall
12 meet such standards respecting provider networks as the
13 Commissioner may establish to assure the adequacy of
14 such networks in ensuring enrollee access to such items
15 and services and transparency in the cost-sharing differen-
16 tials between in-network coverage and out-of-network cov-
17 erage.

18 (b) PROVIDER NETWORK DEFINED.—In this divi-
19 sion, the term “provider network” means the providers
20 with respect to which covered benefits, treatments, and
21 services are available under a health benefits plan.

22 **SEC. 116. MINIMUM MEDICAL LOSS RATIO.**

23 The QHBP offering entity shall provide that for any
24 plan year in which a qualified health benefits plan the en-
25 tity offers has a medical loss ratio (as defined by the Com-
26 missioner consistent with section 1851(p)(5) of the Social

1 Security Act) that is less than 85 percent, the QHBP of-
2 fering entity offering such plan shall provide for rebates
3 to enrollees of payment sufficient to meet such loss ratio.

4 **Subtitle C—Standards Guaranteing Access to Essential Bene-**
5 **fits**
6

7 **SEC. 121. COVERAGE OF ESSENTIAL BENEFITS PACKAGE.**

8 (a) IN GENERAL.—A qualified health benefits plan
9 shall provide coverage that at least meets the benefit
10 standards adopted under section 124 for the essential ben-
11 efits package described in section 122 for the plan year
12 involved.

13 (b) CHOICE OF COVERAGE.—

14 (1) NON-EXCHANGE-PARTICIPATING HEALTH
15 BENEFITS PLANS.—In the case of a qualified health
16 benefits plan that is not an Exchange-participating
17 health benefits plan, such plan may offer such cov-
18 erage in addition to the essential benefits package as
19 the QHBP offering entity may specify.

20 (2) EXCHANGE-PARTICIPATING HEALTH BENE-
21 FITS PLANS.—In the case of an Exchange-partici-
22 pating health benefits plan, such plan is required
23 under section 203(b) to provide specified levels of
24 benefits and, in the case of a plan offering a pre-

1 mium-plus level of benefits, provide additional bene-
2 fits.

3 (3) CONTINUATION OF OFFERING OF SEPARATE
4 EXCEPTED BENEFITS COVERAGE.—Nothing in this
5 division shall be construed as affecting the offering
6 of health benefits in the form of excepted benefits
7 described in section 2791(c) of the Public Health
8 Service Act if such benefits are offered under a sep-
9 arate policy, contract, or certificate of insurance.

10 (c) NO LIMITS ON COVERAGE UNRELATED TO CLIN-
11 ICAL APPROPRIATENESS.—A qualified health benefits
12 plan may not impose any limit (other than cost-sharing)
13 unrelated to clinical appropriateness on the coverage of
14 the health care items and services.

15 **SEC. 122. ESSENTIAL BENEFITS PACKAGE DEFINED.**

16 (a) IN GENERAL.—In this division, the term “essen-
17 tial benefits package” means health benefits coverage,
18 consistent with standards adopted under section 124 to
19 ensure the provision of quality health care and financial
20 security, that—

21 (1) provides payment for the items and services
22 described in subsection (b) in accordance with gen-
23 erally accepted standards of medical or other appro-
24 priate clinical or professional practice;

1 (2) limits cost-sharing for such covered health
2 care items and services in accordance with such ben-
3 efit standards, consistent with subsection (c);

4 (3) does not impose any annual or lifetime limit
5 on the coverage of covered health care items and
6 services; and

7 (4) complies with section 114(c) (relating to
8 network adequacy).

9 (b) **MINIMUM SERVICES TO BE COVERED.**—The
10 items and services described in this subsection are the fol-
11 lowing:

12 (1) Hospitalization.

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

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

17 (4) Such services, equipment, and supplies inci-
18 dent to the services of a physician's or a health pro-
19 fessional's delivery of care in institutional settings,
20 physician offices, patients' homes or place of resi-
21 dence, or other settings, as appropriate.

22 (5) Prescription drugs.

23 (6) Rehabilitative and habilitative services.

24 (7) Mental health and substance use disorder
25 services.

1 (8) Preventive services, including those services
2 recommended with a grade of A or B by the United
3 States Preventive Services Task Force and those
4 vaccines recommended for use by the Director of the
5 Centers for Disease Control and Prevention.

6 (9) Maternity benefits.

7 (10) Well baby and well child care and oral
8 health, vision, and hearing services, equipment, and
9 supplies at least for children under 21 years of age.

10 (c) REQUIREMENTS RELATING TO COST-SHARING
11 AND MINIMUM ACTUARIAL VALUE.—

12 (1) NO COST-SHARING FOR PREVENTIVE SERV-
13 ICES.—There shall be no cost-sharing under the es-
14 sential benefits package for preventive items and
15 services (as specified under the benefit standards),
16 including well baby and well child care.

17 (2) ANNUAL LIMITATION.—

18 (A) ANNUAL LIMITATION.—The cost-shar-
19 ing incurred under the essential benefits pack-
20 age with respect to an individual (or family) for
21 a year does not exceed the applicable level spec-
22 ified in subparagraph (B).

23 (B) APPLICABLE LEVEL.—The applicable
24 level specified in this subparagraph for Y1 is
25 \$5,000 for an individual and \$10,000 for a

1 family. Such levels shall be increased (rounded
2 to the nearest \$100) for each subsequent year
3 by the annual percentage increase in the Con-
4 sumer Price Index for All Urban Consumers
5 (United States city average) applicable to such
6 year.

7 (C) USE OF COPAYMENTS.—In establishing
8 cost-sharing levels for basic, enhanced, and pre-
9 mium plans under this subsection, the Commis-
10 sioner shall, to the maximum extent possible,
11 use only copayments and not coinsurance.

12 (3) MINIMUM ACTUARIAL VALUE.—

13 (A) IN GENERAL.—The cost-sharing under
14 the essential benefits package shall be designed
15 to provide a level of coverage that is designed
16 to provide benefits that are actuarially equiva-
17 lent to approximately 70 percent of the full ac-
18 tuarial value of the benefits provided under the
19 reference benefits package described in sub-
20 paragraph (B) if there were no cost-sharing im-
21 posed under the plan.

22 (B) REFERENCE BENEFITS PACKAGE DE-
23 SCRIBED.—The reference benefits package de-
24 scribed in this subparagraph is the essential
25 benefits package.

1 **SEC. 123. HEALTH BENEFITS ADVISORY COMMITTEE.**

2 (a) ESTABLISHMENT.—

3 (1) IN GENERAL.—There is established a pri-
4 vate-public advisory committee which shall be a
5 panel of medical and experts to be known as the
6 Health Benefits Advisory Committee to recommend
7 covered benefits and an essential benefits package.

8 (2) CHAIR.—The Surgeon General shall be a
9 member and the chair of the Health Benefits Advi-
10 sory Committee.

11 (3) MEMBERSHIP.—The Health Benefits Advi-
12 sory Committee shall be composed of the following
13 members, in addition to the Surgeon General:

14 (A) 9 members who are not Federal em-
15 ployees or officers and who are appointed by
16 the President.

17 (B) 9 members who are not Federal em-
18 ployees or officers and who are appointed by
19 the Comptroller General of the United States in
20 a manner similar to the manner in which the
21 Comptroller General appoints members to the
22 Medicare Payment Advisory Commission under
23 section 1805(c) of the Social Security Act.

24 (C) Such even number of members (not to
25 exceed 8) who are Federal employees and offi-
26 cers, as the President may appoint.

1 Such initial appointments shall be made not later
2 than 60 days after the date of the enactment of this
3 Act.

4 (4) PARTICIPATION.—The membership of the
5 Health Benefits Advisory Committee shall at least
6 reflect providers, consumer representatives, employ-
7 ers, labor, health insurance issuers, experts in health
8 care financing and delivery, individuals knowledge-
9 able about disparities relating to race, ethnicity, and
10 disabilities, representatives of relevant governmental
11 agencies. and at least one practicing physician or
12 other health professional and an expert on children’s
13 health and shall represent a balance among various
14 sectors of the health care system so that no single
15 sector unduly influences the recommendations of
16 such Committee.

17 (b) DUTIES.—

18 (1) RECOMMENDATIONS ON BENEFIT STAND-
19 ARDS.—The Health Benefits Advisory Committee
20 shall recommend to the Secretary of Health and
21 Human Services (in this subtitle referred to as the
22 “Secretary”) benefit standards (as defined in para-
23 graph (4)), and periodic updates to such standards.
24 In developing such recommendations, the Committee
25 shall take into account innovation in health care and

1 ensure that essential benefits coverage does not lead
2 to rationing of health care.

3 (2) DEADLINE.—The Health Benefits Advisory
4 Committee shall recommend initial benefit standards
5 to the Secretary not later than 1 year after the date
6 of the enactment of this Act.

7 (3) PUBLIC INPUT.—The Health Benefits Advi-
8 sory Committee shall allow for public input as a part
9 of developing recommendations under this sub-
10 section.

11 (4) BENEFIT STANDARDS DEFINED.—In this
12 subtitle, the term “benefit standards” means stand-
13 ards respecting—

14 (A) the essential benefits package de-
15 scribed in section 122, including covered treat-
16 ments and items and services within benefit
17 classes; and

18 (B) the cost-sharing levels for enhanced
19 plans and premium plans (as provided under
20 section 203(c)) consistent with paragraphs (5)
21 and (6).

22 (5) LEVELS OF COST-SHARING FOR ENHANCED
23 AND PREMIUM PLANS.—

24 (A) ENHANCED PLAN.—The level of cost-
25 sharing for enhanced plans shall be designed so

1 that such plans have benefits that are actuari-
2 ally equivalent to approximately 85 percent of
3 the actuarial value of the benefits provided
4 under the reference benefits package described
5 in section 122(c)(3)(B).

6 (B) PREMIUM PLAN.—The level of cost-
7 sharing for premium plans shall be designed so
8 that such plans have benefits that are actuari-
9 ally equivalent to approximately 95 percent of
10 the actuarial value of the benefits provided
11 under the reference benefits package described
12 in section 122(c)(3)(B).

13 (c) OPERATIONS.—

14 (1) PER DIEM PAY.—Each member shall receive
15 travel expenses, including per diem in accordance
16 with applicable provisions under subchapter I of
17 chapter 57 of title 5, United States Code and shall
18 otherwise serve without additional pay.

19 (2) APPLICATION OF FACA.—The Federal Advi-
20 sory Committee Act (5 U.S.C. App.), other than sec-
21 tion 14, shall apply to the Health Benefits Advisory
22 Committee.

23 (d) PUBLICATION.—The Secretary shall provide for
24 publication in the Federal Register and the posting on the
25 Internet website of the Department of Health and Human

1 Services of all recommendations made by the Health Ben-
2 efits Advisory Committee under this section.

3 **SEC. 124. PROCESS FOR ADOPTION OF RECOMMENDA-**
4 **TIONS; ADOPTION OF BENEFIT STANDARDS.**

5 (a) PROCESS FOR ADOPTION OF RECOMMENDA-
6 TIONS.—

7 (1) REVIEW OF RECOMMENDED STANDARDS.—

8 Not later than 45 days after the date of receipt of
9 benefit standards recommended under section 123
10 (including such standards as modified under para-
11 graph (2)(B)), the Secretary shall review such
12 standards and shall determine whether to propose
13 adoption of such standards.

14 (2) DETERMINATION TO ADOPT STANDARDS.—

15 If the Secretary determines—

16 (A) to propose adoption of benefit stand-
17 ards so recommended, the Secretary shall, by
18 regulation under section 553 of title 5, United
19 States Code, determine whether to adopt such
20 standards; or

21 (B) not to propose adoption of such stand-
22 ards, the Secretary shall notify the Health Ben-
23 efits Advisory Committee in writing of such de-
24 termination and the reasons for not proposing
25 the adoption of such recommendation and pro-

1 vide the Committee with a further opportunity
2 to modify its previous recommendations and
3 submit new recommendations to the Secretary
4 on a timely basis.

5 (3) CONTINGENCY.—If, because of the applica-
6 tion of paragraph (2)(B), the Secretary would other-
7 wise be unable to propose initial adoption of such
8 recommended standards by the deadline specified in
9 subsection (b)(1), the Secretary shall, by regulation
10 under section 553 of title 5, United States Code,
11 propose adoption of initial benefit standards by such
12 deadline.

13 (4) PUBLICATION.—The Secretary shall provide
14 for publication in the Federal Register of all deter-
15 minations made by the Secretary under this sub-
16 section.

17 (b) ADOPTION OF STANDARDS.—

18 (1) INITIAL STANDARDS.—Not later than 18
19 months after the date of the enactment of this Act,
20 the Secretary shall, through the rulemaking process
21 consistent with subsection (a), adopt an initial set of
22 benefit standards.

23 (2) PERIODIC UPDATING STANDARDS.—Under
24 subsection (a), the Secretary shall provide for the

1 periodic updating of the benefit standards previously
2 adopted under this section.

3 (3) REQUIREMENT.—The Secretary may not
4 adopt any benefit standards for a essential benefits
5 package or for level of benefits that are inconsistent
6 with the requirements for such a package or level of
7 benefits under section 122 and 123(b)(5).

8 **Subtitle D—Additional Consumer** 9 **Protections**

10 **SEC. 131. REQUIRING FAIR MARKETING PRACTICES BY** 11 **HEALTH INSURERS.**

12 The Commissioner shall establish uniform marketing
13 standards that all QHBP offering entities shall meet.

14 **SEC. 132. REQUIRING FAIR GRIEVANCE AND APPEALS** 15 **MECHANISMS.**

16 (a) IN GENERAL.—A QHBP offering entity shall pro-
17 vide for timely grievance and appeals mechanisms as the
18 Commissioner shall establish.

19 (b) INTERNAL CLAIMS AND APPEALS PROCESS.—
20 Under a qualified health benefits plan the QHBP offering
21 entity shall provide an internal claims and appeals process
22 that initially incorporates the claims and appeals proce-
23 dures (including urgent claims) set forth at section
24 2560.503-1 of title 29, Code of Federal Regulations, as
25 published on Nov 21, 2000 (65 Fed. Reg. 70246) and

1 shall update such process in accordance with any stand-
2 ards that the Commissioner may establish.

3 (c) EXTERNAL REVIEW PROCESS.— The Commis-
4 sioner shall establish an external review process (including
5 procedures for expedited reviews of urgent claims) that
6 provides for an impartial, independent, and de novo review
7 of denied claims under this division. The Commissioner
8 may authorize the application of State law external review
9 processes that meet such standards.

10 (d) CONSTRUCTION.—Nothing in this section or
11 under part 7 of subtitle B of title I of the Employee Re-
12 tirement Income Security Act of 1974 shall be construed
13 as affecting the availability of judicial review under State
14 law for adverse decisions under subsection (b) or (c), sub-
15 ject to section 151.

16 **SEC. 133. REQUIRING INFORMATION TRANSPARENCY AND**
17 **PLAN DISCLOSURE.**

18 (a) IN GENERAL.—A qualified health benefits plan
19 shall comply with standards established by the Commis-
20 sioner for the accurate and timely disclosure of plan docu-
21 ments, plan terms and conditions, claims payment policies,
22 practices, and amounts, periodic financial disclosure, and
23 other information as determined appropriate by the Com-
24 missioner. The Commissioner shall require that such dis-
25 closure be provided in plain language.

1 (b) CONTRACTING REIMBURSEMENT.—A qualified
2 health benefits plan shall comply with standards estab-
3 lished by the Commissioner to ensure transparency to each
4 health care provider relating to reimbursement arrange-
5 ments between such plan and such provider.

6 (c) ADVANCE NOTICE OF PLAN CHANGES.—A
7 change in a qualified health benefits plan shall not be
8 made without such reasonable and timely advance notice
9 to enrollees of such change.

10 **SEC. 134. APPLICATION TO QUALIFIED HEALTH BENEFITS**
11 **PLANS NOT OFFERED THROUGH THE**
12 **HEALTH INSURANCE EXCHANGE.**

13 The requirements of the previous provisions of this
14 subtitle shall apply to qualified health benefits plans that
15 are not being offered through the Health Insurance Ex-
16 change only to the extent specified by the Commissioner.

17 **SEC. 135. TIMELY PAYMENT OF CLAIMS.**

18 A QHBP offering entity shall comply with the re-
19 quirements of section 1857(f) of the Social Security Act
20 with respect to a qualified health benefits plan it offers
21 in the same manner an Medicare Advantage organization
22 is required to comply with such requirements with respect
23 to a Medicare Advantage plan it offers under part C of
24 Medicare, except that the Commissioner may reduce the

1 time period permitted for prompt payment of claims as
2 feasible.

3 **SEC. 136. STANDARDIZED RULES FOR COORDINATION AND**
4 **SUBROGATION OF BENEFITS.**

5 The Commissioner shall establish standards for the
6 coordination of benefits and reimbursement of payments
7 in cases involving individual and multiple plan coverage.

8 **Subtitle E—Governance**

9 **SEC. 141. HEALTH CHOICES ADMINISTRATION; HEALTH**
10 **CHOICES COMMISSIONER.**

11 (a) IN GENERAL.—There is hereby established, as an
12 independent agency in the executive branch of the Govern-
13 ment, a Health Choices Administration (in this division
14 referred to as the “Administration”).

15 (b) COMMISSIONER.—

16 (1) IN GENERAL.—The Administration shall be
17 headed by a Health Choices Commissioner (in this
18 division referred to as the “Commissioner”) who
19 shall be appointed by the President, by and with the
20 advice and consent of the Senate.

21 (2) COMPENSATION; ETC.—The provisions of
22 paragraphs (2), (5) and (7) of subsection (a) (relat-
23 ing to compensation, terms, general powers, rule-
24 making, and delegation) of section 702 of the Social
25 Security Act (42 U.S.C. 902) shall apply to the

1 Commissioner and the Administration in the same
2 manner as such provisions apply to the Commis-
3 sioner of Social Security and the Social Security Ad-
4 ministration.

5 **SEC. 142. DUTIES AND AUTHORITY OF COMMISSIONER.**

6 (a) DUTIES.—The Commissioner is responsible for
7 carrying out the following functions under this division:

8 (1) QUALIFIED PLAN STANDARDS.—The estab-
9 lishment of qualified health benefits plan standards
10 under this title I, including the enforcement of such
11 standards in coordination with State insurance regu-
12 lators and the Secretaries of Labor and the Treas-
13 ury.

14 (2) HEALTH INSURANCE EXCHANGE.—The es-
15 tablishment and operation of a Health Insurance
16 Exchange under subtitle A of title II.

17 (3) INDIVIDUAL AFFORDABILITY CREDITS.—
18 The administration of individual affordability credits
19 under subtitle C of title II.

20 (4) ADDITIONAL FUNCTIONS.—Such additional
21 functions as may be specified in this division.

22 (b) DATA COLLECTION.—The Commissioner shall
23 collect data for purposes of carrying out the Commis-
24 sioner's duties, including for purposes of promoting qual-
25 ity and value and addressing disparities in health care and

1 may share such data with the Secretary of Health and
2 Human Services.

3 (c) SANCTIONS AUTHORITY.—

4 (1) IN GENERAL.—In the case that the Com-
5 missioner determines that a QHBP offering entity
6 violates a requirement of this title, the Commis-
7 sioner may, in coordination with State insurance
8 regulators and the Secretary of Labor, provide, in
9 addition to any other remedies authorized by law,
10 for any of the remedies described in paragraph (2).

11 (2) REMEDIES.—The remedies described in this
12 paragraph, with respect to a qualified health benefits
13 plan offered by a QHBP offering entity, are—

14 (A) civil money penalties of not more than
15 the amount that would be applicable under
16 similar circumstances for similar violations
17 under section 1857(g) of the Social Security
18 Act;

19 (B) suspension of enrollment of individuals
20 under such plan after the date the Commis-
21 sioner notifies the entity of a determination
22 under paragraph (1) and until the Commis-
23 sioner is satisfied that the basis for such deter-
24 mination has been corrected and is not likely to
25 recur; or

1 (C) in the case of an Exchange-partici-
2 pating health benefits plan, suspension of pay-
3 ment to the entity under the Health Insurance
4 Exchange for individuals enrolled in such plan
5 after the date the Commissioner notifies the en-
6 tity of a determination under paragraph (1)
7 and until the Secretary is satisfied that the
8 basis for such determination has been corrected
9 and is not likely to recur.

10 **SEC. 143. CONSULTATION AND COORDINATION.**

11 (a) CONSULTATION.—In carrying out the Commis-
12 sioner's duties under this division, the Commissioner, as
13 appropriate, shall consult at least with the following:

14 (1) The National Association of Insurance
15 Commissioners, State attorneys general, and State
16 insurance regulators, including concerning the
17 standards for insured qualified health benefits plans
18 under this title and enforcement of such standards.

19 (2) Appropriate State agencies, specifically con-
20 cerning the administration of individual affordability
21 credits under subtitle C of title II and the offering
22 of Exchange-participating health benefits plans, in-
23 cluding Medicaid, to Medicaid eligible individuals
24 under subtitle A of such title.

25 (3) Other appropriate Federal agencies.

1 (4) Indian tribes and tribal organizations.

2 (b) COORDINATION.—In carrying out the functions of
3 the Commissioner, including with respect to the enforce-
4 ment of the provisions of this division, the Commissioner
5 shall work in coordination with existing Federal and State
6 entities to the maximum extent feasible consistent with
7 this division and in a manner that prevents conflicts of
8 interest in duties and ensures effective enforcement.

9 **SEC. 144. HEALTH INSURANCE OMBUDSMAN.**

10 (a) IN GENERAL.—The Commissioner shall appoint
11 within the Health Choices Administration a Qualified
12 Health Benefits Plan Ombudsman who shall have exper-
13 tise and experience in the fields of health care and edu-
14 cation of (and assistance to) individuals.

15 (b) DUTIES.—The Qualified Health Benefits Plan
16 Ombudsman shall—

17 (1) receive complaints, grievances, and requests
18 for information submitted by individuals;

19 (2) provide assistance with respect to com-
20 plaints, grievances, and requests referred to in para-
21 graph (1), including—

22 (A) helping individuals determine the rel-
23 evant information needed to seek an appeal of
24 a decision or determination;

1 (B) assistance to such individuals with any
2 problems arising from disenrollment from such
3 a plan;

4 (C) assistance to such individuals in choos-
5 ing a qualified health benefits plan in which to
6 enroll; and

7 (D) assistance to such individuals in pre-
8 senting information under subtitle C (relating
9 to affordability credits); and

10 (3) submit annual reports to Congress and the
11 Commissioner that describe the activities of the Om-
12 budsman and that include such recommendations for
13 improvement in the administration of this division as
14 the Ombudsman determines appropriate. The Om-
15 budsman shall not serve as an advocate for any in-
16 creases in payments or new coverage of services, but
17 may identify issues and problems in payment or cov-
18 erage policies.

19 **Subtitle F—Relation to Other** 20 **Requirements; Miscellaneous**

21 **SEC. 151. RELATION TO OTHER REQUIREMENTS.**

22 (a) IN GENERAL.—In the case of—

23 (1) health insurance coverage, whether or not
24 offered in connection with a group health plan, not
25 offered through the Health Insurance Exchange and

1 in the case of a group health plan, the requirements
2 of this title do not supercede any requirements appli-
3 cable under titles XXII and XXVII of the Public
4 Health Service Act, parts 6 and 7 of subtitle B of
5 title I of the Employee Retirement Income Security
6 Act of 1974, or under State law except insofar as
7 such requirements prevent the application of a re-
8 quirement of this title; or

9 (2) health insurance coverage, whether or not
10 offered in connection with a group health plan, of-
11 fered through the Health Insurance Exchange—

12 (A) the requirements of this title do not
13 supercede any requirements (including require-
14 ments relating to genetic information non-
15 discrimination and mental health) applicable
16 under title XXVII of the Public Health Service
17 Act or under State law except insofar as such
18 requirements prevents the application of a re-
19 quirement of this division, as determined by the
20 Commissioner; and .

21 (B) State laws relating to private rights of
22 action with remedies shall apply.

23 (b) CONSTRUCTION.—In the case of coverage de-
24 scribed in subsection (a)(2), nothing in such subsection
25 shall be construed as preventing the application of State

1 laws creating private rights of action with remedies with
2 respect to any requirements referred to in such subsection.
3 Nothing in this section shall be construed as affecting the
4 application of section 514 of the Employee Retirement In-
5 come Security Act of 1974.

6 **SEC. 152. PROHIBITING DISCRIMINATION IN HEALTH CARE.**

7 (a) IN GENERAL.—Except as otherwise explicitly per-
8 mitted by this Act, all health care and related services (in-
9 cluding insurance coverage and public health activities)
10 covered by this Act shall be provided without regard to
11 personal characteristics extraneous to the provision of
12 high quality health care or related services.

13 (b) IMPLEMENTATION.—To implement the require-
14 ment set forth in subsection (a), the Secretary of Health
15 and Human Services shall, not later than 18 months after
16 the date of the enactment of this Act, promulgate such
17 regulations as are necessary or appropriate to insure that
18 all health care and related services (including insurance
19 coverage and public health activities) covered by this Act
20 are provided (whether directly or through contractual, li-
21 censing, or other arrangements) without regard to per-
22 sonal characteristics extraneous to the provision of high
23 quality health care or related services.

1 **TITLE II—HEALTH INSURANCE**
2 **EXCHANGE AND RELATED**
3 **PROVISIONS**

4 **Subtitle A—Health Insurance**
5 **Exchange**

6 **SEC. 201. ESTABLISHMENT OF HEALTH INSURANCE EX-**
7 **CHANGE; OUTLINE OF DUTIES; DEFINITIONS.**

8 (a) ESTABLISHMENT.—There is established within
9 the Health Choices Administration and under the direc-
10 tion of the Commissioner a Health Insurance Exchange
11 in order to facilitate access of individuals and employers,
12 through a transparent process, to a variety of choices of
13 affordable, quality health insurance coverage, including a
14 public health insurance option.

15 (b) OUTLINE OF DUTIES OF COMMISSIONER.—In ac-
16 cordance with this subtitle and in coordination with appro-
17 priate Federal and State officials as provided under sec-
18 tion 153(a), the Commissioner shall—

19 (1) under section 204 establish standards for,
20 accept bids from, and negotiate and enter into con-
21 tracts with QHBP offering entities for the offering
22 of health benefits plans through the Health Insur-
23 ance Exchange, with different levels of benefits re-
24 quired under section 203, and including with respect
25 to oversight and enforcement;

1 (2) under section 205 facilitate outreach and
2 enrollment in such plans of Exchange-eligible indi-
3 viduals and employers described in section 204; and

4 (3) conduct such activities related to the Health
5 Insurance Exchange as required, including operation
6 of a risk pooling mechanism and consumer protec-
7 tions under section 206.

8 (c) EXCHANGE-PARTICIPATING HEALTH BENEFITS
9 PLAN DEFINED.—In this division, the term “Exchange-
10 participating health benefits plan” means a qualified
11 health benefits plan that is offered through the Health In-
12 surance Exchange.

13 **SEC. 202. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOY-**
14 **ERS.**

15 (a) ACCESS TO COVERAGE.—In accordance with this
16 section, all individuals are eligible to obtain coverage
17 through enrollment in an Exchange-participating health
18 benefits plan offered through the Health Insurance Ex-
19 change unless such individuals are enrolled in another
20 qualified health benefits plan or other acceptable coverage.

21 (b) DEFINITIONS.—In this division:

22 (1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The
23 term “Exchange-eligible individual” means an indi-
24 vidual who is eligible under this section to be en-
25 rolled through the Health Insurance Exchange in an

1 Exchange-participating health benefits plan and,
2 with respect to family coverage, includes dependents
3 of such individuals.

4 (2) EXCHANGE-ELIGIBLE EMPLOYER.—The
5 term “Exchange-eligible employer” means an em-
6 ployer that is eligible under this section to enroll
7 through the Health Insurance Exchange employees
8 of the employer (and their dependents) in Exchange-
9 eligible health benefits plans.

10 (3) EMPLOYMENT-RELATED DEFINITIONS.—
11 The terms “employer”, “employee”, “full-time em-
12 ployee”, and “part-time employee” have the mean-
13 ings given such terms by the Commissioner for pur-
14 poses of this division.

15 (c) TRANSITION.—Individuals and employers shall
16 only be eligible to enroll or participate in the Health Insur-
17 ance Exchange in accordance with the following transition
18 schedule:

19 (1) FIRST YEAR.—In Y1 (as defined in section
20 100(c))—

21 (A) individuals described in subsection
22 (d)(1); and

23 (B) smallest employers described in sub-
24 section (e)(1).

25 (2) SECOND YEAR.—In Y2—

1 (A) individuals and employers described in
2 paragraph (1); and

3 (B) smaller employers described in sub-
4 section (e)(2).

5 (3) THIRD AND SUBSEQUENT YEARS.—In Y3
6 and subsequent years—

7 (A) individuals and employers described in
8 paragraph (2); and

9 (B) larger employers as permitted by the
10 Commissioner under subsection (e)(3).

11 (d) INDIVIDUALS.—

12 (1) INDIVIDUAL DESCRIBED.—Subject to the
13 succeeding provisions of this subsection, an indi-
14 vidual described in this paragraph is an individual
15 who—

16 (A) except as provided in paragraph (3)
17 and (4), does not have coverage described in
18 subparagraphs (C) through (F) of paragraph
19 (2); or

20 (B) except as provided in paragraph (4),
21 does not have coverage as a full-time employee
22 (or as a dependent of such an employee) under
23 a group health plan if the coverage and an em-
24 ployer contribution under the plan meet the re-
25 quirements of section 312.

1 For purposes of subparagraph (B), in the case of an
2 individual who is self-employed, has at least 1 em-
3 ployee, and who meets the requirements of section
4 312, such individual shall be deemed a full-time em-
5 ployee described in such clause.

6 (2) ACCEPTABLE COVERAGE.—For purposes of
7 this division, the term “acceptable coverage” means
8 any of the following:

9 (A) QUALIFIED HEALTH BENEFITS PLAN
10 COVERAGE.—Coverage under a qualified health
11 benefits plan.

12 (B) GRANDFATHERED HEALTH INSURANCE
13 COVERAGE; COVERAGE UNDER CURRENT GROUP
14 HEALTH PLAN.—Coverage under a grand-
15 fathered health insurance coverage (as defined
16 in subsection (a) of section 102) or under a
17 current group health plan (described in sub-
18 section (b) of such section).

19 (C) MEDICARE.—Coverage under part A of
20 title XVIII of the Social Security Act.

21 (D) MEDICAID.—Coverage for medical as-
22 sistance under title XIX of the Social Security
23 Act.

24 (E) MEMBERS OF THE ARMED FORCES
25 AND DEPENDENTS (INCLUDING TRICARE).—

1 Coverage under chapter 55 of title 10, United
2 States Code, including similar coverage fur-
3 nished under section 1781 of title 38 of such
4 Code.

5 (F) VA.—Coverage under the veteran’s
6 health care program under chapter 17 of title
7 38, United States Code, but only if the cov-
8 erage for the individual involved is determined
9 by the Commissioner in coordination with the
10 Secretary of Treasury to be not less than a level
11 specified by the Commission, in coordination
12 with such Secretary, based on the individual’s
13 priority for services as provided under section
14 1705(a) of such title.

15 (G) OTHER COVERAGE.—Such other health
16 benefits coverage, such as a State health bene-
17 fits risk pool, as the Commissioner, in coordina-
18 tion with the Secretary of the Treasury, recog-
19 nizes for purposes of this subsection.

20 The Commissioner shall make determinations under
21 this paragraph in coordination with the Secretary of
22 the Treasury.

23 (3) TREATMENT OF MEDICAID ELIGIBLE INDI-
24 VIDUALS.—

1 (A) CERTAIN NON-TRADITIONAL MEDICAID
2 ELIGIBLE INDIVIDUALS ALLOWED.—An indi-
3 vidual who is a non-traditional Medicaid eligible
4 individual in a State may be an Exchange-eli-
5 gible individual if the individual was enrolled in
6 a qualified health benefits plan, grandfathered
7 health insurance coverage, or current group
8 health plan during the 6 months before the in-
9 dividual became a non-traditional Medicaid eli-
10 gible individual.

11 (B) ALL MEDICAID ELIGIBLE INDIVID-
12 UALS.—An individual who is a Medicaid eligible
13 individual (not described in subparagraph (A))
14 in a State may be an Exchange-eligible indi-
15 vidual beginning with Y5 if—

16 (i) the State—

17 (I) requests such treatment for
18 the group including such individual;
19 and

20 (II) demonstrates to the satisfac-
21 tion of the Secretary of Health and
22 Human Services, in the case of tradi-
23 tional Medicaid eligible individuals,
24 the ability to offer wrap-around serv-
25 ices to such individuals in such group

1 in accordance with section 1943(e)(1)
2 of the Social Security Act; and

3 (ii) the Commissioner determines,
4 using standards applied under paragraph
5 (3)(A)(ii)(I), that the Health Insurance
6 Exchange has the capacity to support the
7 participation of individuals in the group re-
8 quested under clause (i)(I).

9 (4) CONTINUED ELIGIBILITY PERMITTED.—

10 (A) IN GENERAL.—Except as provided in
11 subparagraph (B), once an individual qualifies
12 as an Exchange-eligible individual under this
13 subsection (including as an employee or depend-
14 ent of an employee of an Exchange-eligible em-
15 ployer) and enrolls under an Exchange-partici-
16 pating health benefits plan through the Health
17 Insurance Exchange, the individual shall con-
18 tinue to be treated as an Exchange-eligible indi-
19 vidual until the individual is no longer enrolled
20 with an Exchange-participating health benefits
21 plan.

22 (B) EXCEPTIONS.—

23 (i) IN GENERAL.—Subparagraph (A)
24 shall not apply to an individual once the
25 individual becomes eligible for coverage—

1 (I) under part A of the Medicare
2 program;

3 (II) under the Medicaid program
4 as a Medicaid eligible individual, ex-
5 cept as permitted under paragraph
6 (3) or clause (ii); or

7 (III) in such other circumstances
8 as the Commissioner may provide.

9 (ii) TRANSITION PERIOD.—In the case
10 described in clause (i)(II), the Commis-
11 sioner shall permit the individual to con-
12 tinue treatment under subparagraph (A)
13 until such time (not to exceed 12 months)
14 as the Commissioner determines it is ad-
15 ministratively feasible, consistent with
16 minimizing disruption in the individual's
17 access to health care.

18 (e) EMPLOYERS.—

19 (1) SMALLEST EMPLOYER.—Subject to para-
20 graph (4), smallest employers described in this para-
21 graph are employers with 10 or fewer employees.

22 (2) SMALLER EMPLOYERS.—Subject to sub-
23 paragraph (B) and paragraph (4), smaller employers
24 described in this paragraph are employers that are

1 not smallest employers described in paragraph (1)
2 and have 20 or fewer employees.

3 (3) LARGER EMPLOYERS.—

4 (A) IN GENERAL.—Beginning with Y3, the
5 Commissioner may permit employers not de-
6 scribed in paragraph (1) or (2) to be Exchange-
7 eligible employers.

8 (B) PHASE-IN.—In applying subparagraph
9 (A), the Commissioner may phase-in the appli-
10 cation of such subparagraph based the number
11 of full-time employees of an employer and such
12 other considerations as the Commissioner
13 deems appropriate.

14 (4) CONTINUING ELIGIBILITY.—Once an em-
15 ployer is permitted to be an Exchange-eligible em-
16 ployer under this subsection and enrolls employees
17 through the Health Insurance Exchange, the em-
18 ployer shall continue to be treated as an Exchange-
19 eligible employer for each subsequent plan year re-
20 gardless of the number of employees involved unless
21 and until the employer meets the requirement of sec-
22 tion 311(a) through paragraph (1) of such section
23 by offering a group health plan and not through of-
24 fering Exchange-participating health benefits plan.

1 (5) EMPLOYER PARTICIPATION AND CONTRIBU-
2 TIONS.—

3 (A) SATISFACTION OF EMPLOYER RESPON-
4 SIBILITY.—For any year in which an employer
5 is an Exchange-eligible employer, such employer
6 may meet the requirements of section 312 with
7 respect to employees of such employer by offer-
8 ing such employees the option of enrolling with
9 Exchange-participating health benefits plans
10 through the Health Insurance Exchange con-
11 sistent with the provisions of subtitle B of title
12 III.

13 (B) EMPLOYEE CHOICE.—Any employee
14 offered Exchange-participating health benefits
15 plans by the employer of such employee under
16 subparagraph (A) may choose any such cov-
17 erage. Such choice shall apply, with respect to
18 family coverage, to the dependents of such em-
19 ployee.

20 (6) AFFILIATED GROUPS.—Any employer which
21 is part of a group of employers who are treated as
22 a single employer under subsection (b), (c), (m), or
23 (o) of section 414 of the Internal Revenue Code of
24 1986 shall be treated, for purposes of this subtitle,
25 as a single employer.

1 (7) OTHER COUNTING RULES.—The Commis-
2 sioner shall establish rules relating to how employees
3 are counted for purposes of carrying out this sub-
4 section.

5 (f) SPECIAL SITUATION AUTHORITY.—The Commis-
6 sioner shall have the authority to establish such rules as
7 may be necessary to deal with special situations with re-
8 gard to uninsured individuals participating as Exchange-
9 eligible individuals and employers, such as transition peri-
10 ods for individuals and employers who gain, or lose, Ex-
11 change-eligible participation status, and to establish grace
12 periods for premium payment.

13 (g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—
14 The Commissioner shall provide for periodic surveys of
15 Exchange-eligible individuals and employers concerning
16 satisfaction of such individuals and employers with the
17 Health Insurance Exchange and Exchange-participating
18 health benefits plans.

19 **SEC. 203. BENEFITS PACKAGE LEVELS.**

20 (a) IN GENERAL.—The Commissioner shall specify
21 the benefits to be made available under Exchange-partici-
22 pating health benefits plans during each plan year, con-
23 sistent with part 1 of subtitle C of title I and this section.

24 (b) LIMITATION ON HEALTH BENEFITS PLANS OF-
25 FERED BY OFFERING ENTITIES.—The Commissioner may

1 not enter into a contract with a QHBP offering entity
2 under section 204(c) for the offering of an Exchange-par-
3 ticipating health benefits plan, unless the following re-
4 quirements are met:

5 (1) REQUIRED OFFERING OF BASIC PLAN.—The
6 entity offers one basic plan for each service area.

7 (2) OPTIONAL OFFERING OF ENHANCED
8 PLAN.—The entity may offer one enhanced plan for
9 each service area.

10 (3) OPTIONAL OFFERING OF PREMIUM PLAN.—
11 If and only if the entity offers a enhanced plan for
12 a service area, the entity may offer one premium
13 plan for such area.

14 (4) OPTIONAL OFFERING OF PREMIUM-PLUS
15 PLAN.—If and only if the entity offers a premium
16 plan for a service area, the entity may offer one or
17 more premium-plus plans for such area.

18 All such plans may be offered under a single contract with
19 the Commissioner.

20 (c) SPECIFICATION OF BENEFIT LEVELS FOR
21 PLANS.—

22 (1) IN GENERAL.—The Commissioner shall es-
23 tablish the following standards consistent with this
24 subsection and title I:

1 (A) BASIC, ENHANCED, AND PREMIUM
2 PLANS.—Standards for 3 basic levels of Ex-
3 change-participating health benefits plans,
4 basic, enhanced, and premium (in this division
5 referred to as a “basic plan”, “enhanced plan”,
6 and “premium plan”, respectively).

7 (B) PREMIUM-PLUS PLAN BENEFITS.—
8 Standards for additional benefits that may be
9 offered, consistent with this subsection and sub-
10 title C of title I, under a premium plan (such
11 a plan referred to in this division as a “pre-
12 mium-plus plan”) .

13 (2) BASIC PLAN.—

14 (A) IN GENERAL.—A basic plan shall offer
15 the essential benefits package required under
16 title I for a qualified health benefits plan.

17 (B) TIERED COST-SHARING FOR AFFORD-
18 ABLE CREDIT ELIGIBLE INDIVIDUALS.—In the
19 case of an affordable credit eligible individual
20 enrolled in an Exchange-participating health
21 benefits plan, the benefits under a basic plan
22 are modified to provide for the reduced cost-
23 sharing for the income tier applicable to the in-
24 dividual under section 244(c).

1 (3) ENHANCED PLAN.—A enhanced plan shall
2 offer, in addition to the level of benefits under the
3 basic plan, a lower level of cost-sharing as provided
4 under title I consistent with section 123(b)(5)(A).

5 (4) PREMIUM PLAN.—A premium plan shall
6 offer, in addition to the level of benefits under the
7 basic plan, a lower level of cost-sharing as provided
8 under title I consistent with section 123(b)(5)(B).

9 (5) PREMIUM-PLUS PLAN.—A premium-plus
10 plan is a premium plan that also provides additional
11 benefits, such as adult oral health and vision care,
12 approved by the Commissioner. The portion of the
13 premium that is attributable to such additional ben-
14 efits shall be separately specified.

15 (6) RANGE OF PERMISSIBLE VARIATION IN
16 COST-SHARING.—The Commissioner shall establish a
17 permissible range of variation of cost-sharing for
18 basic, enhanced, and premium plans, except with re-
19 spect to any benefit for which there is no cost-shar-
20 ing permitted under the essential benefits package.
21 Such variation shall permit a variation of not more
22 than plus (or minus) 10 percent in cost-sharing with
23 respect to each benefit category specified under sec-
24 tion 122, so that, for example, with respect to a
25 standard that provides for 20 percent coinsurance,

1 the permissible variation would be between 18 and
2 22 percent coinsurance.

3 (d) TREATMENT OF STATE BENEFIT MANDATES.—
4 Insofar as a State requires a health insurance issuer offer-
5 ing health insurance coverage to include benefits beyond
6 the essential benefits package, such requirements shall
7 continue to apply to an Exchange-participating health
8 benefits plan, but only, under rules established by the
9 Commissioner, if the State has entered into an arrange-
10 ment satisfactory to the Commissioner to reimburse the
11 Commissioner for the amount of any net increase in af-
12 fordability premium credits under subtitle C as a result
13 of an increase in premium in basic plans as a result of
14 application of such requirements.

15 **SEC. 204. CONTRACTS FOR THE OFFERING OF EXCHANGE-**
16 **PARTICIPATING HEALTH BENEFITS PLANS.**

17 (a) CONTRACTING DUTIES.—In carrying out section
18 201(b)(1) and consistent with this subtitle:

19 (1) OFFERING ENTITY AND PLAN STAND-
20 ARDS.—The Commissioner shall—

21 (A) establish standards necessary to imple-
22 ment the requirements of this title and title I
23 for—

1 (i) QHBP offering entities for the of-
2 fering of an Exchange-participating health
3 benefits plan; and

4 (ii) for Exchange-participating health
5 benefits plans ; and

6 (B) certify QHBP offering entities and
7 qualified health benefits plans as meeting such
8 standards and requirements of this title and
9 title I for purposes of this subtitle.

10 (2) SOLICITING AND NEGOTIATING BIDS; CON-
11 TRACTS.—The Commissioner shall—

12 (A) solicit bids from QHBP offering enti-
13 ties for the offering of Exchange-participating
14 health benefits plans;

15 (B) based upon a review of such bids, ne-
16 gotiate with such entities for the offering of
17 such plans; and

18 (C) enter into contracts with such entities
19 for the offering of such plans under terms (con-
20 sistent with this title) negotiated between the
21 Exchange and such entities.

22 (3) FAR NOT APPLICABLE.—The provisions of
23 the Federal Acquisition Regulation shall not apply to
24 contracts between the Commissioner and QHBP of-

1 fering entities for the offering of Exchange-partici-
2 pating health benefits plans under this title.

3 (b) STANDARDS FOR QHBP OFFERING ENTITIES TO
4 OFFER EXCHANGE-PARTICIPATING HEALTH BENEFITS
5 PLANS.—The standards established under subsection
6 (a)(1)(A) shall require that, in order for a QHBP offering
7 entity to offer an Exchange-participating health benefits
8 plan, the entity must meet the following requirements:

9 (1) LICENSED.—The entity shall be licensed to
10 offer health insurance coverage under State law for
11 each State in which it is offering such coverage.

12 (2) DATA REPORTING.—The entity shall pro-
13 vide for the reporting of such information as the
14 Commissioner may specify, including information
15 necessary to administer the risk pooling mechanism
16 described in section 206(b).

17 (3) IMPLEMENTING AFFORDABILITY CRED-
18 ITS.—The entity shall provide for implementation of
19 the affordability credits provided for enrollees under
20 subtitle C, including the reduction in cost-sharing
21 under section 244(c).

22 (4) ENROLLMENT.—The entity shall accept all
23 enrollments under this subtitle, subject to such ex-
24 ceptions (such as capacity limitations) in accordance

1 with the Federal requirements under title I for a
2 qualified health benefits plan.

3 (5) WRAP-AROUND COVERAGE FOR MEDICAID
4 ELIGIBLE INDIVIDUALS.—Beginning in Y5, the enti-
5 ty shall provide, and be reimbursed by Medicaid for,
6 wrap-around services to Medicaid eligible individuals
7 (as defined in section 205(e)(5)) who elect to enroll
8 in an Exchange-participating health benefits plan of-
9 fered by the entity, in accordance with terms speci-
10 fied by the Commissioner in the Medicaid memo-
11 randum of understanding (as defined in section
12 205(e)(4)).

13 (6) POOLING PARTICIPATION.—The entity shall
14 participate in such pooling mechanism as the Com-
15 missioner establishes under section 206(b).

16 (7) ESSENTIAL COMMUNITY PROVIDERS.—With
17 respect to the basic plan offered by the entity, the
18 entity shall contract with essential community pro-
19 viders, as specified by the Commissioner. The Com-
20 missioner shall specify the extent to which and man-
21 ner in which the previous sentence shall apply in the
22 case of a basic plan with respect to which the Com-
23 missioner determines provides substantially all bene-
24 fits through a health maintenance organization, as

1 defined in section 2791(b)(3) of the Public Health
2 Service Act.

3 (8) CULTURALLY AND LINGUISTICALLY APPRO-
4 PRIATE SERVICES AND COMMUNICATIONS.—The en-
5 tity shall provide for culturally and linguistically ap-
6 propriate communication and health services.

7 (9) ADDITIONAL REQUIREMENTS.—The entity
8 shall comply with other applicable requirements of
9 this title, as specified by the Commissioner, includ-
10 ing standards regarding billing and collection prac-
11 tices for premiums and related grace periods.

12 (c) CONTRACTS.—

13 (1) BID APPLICATION.—To be eligible to enter
14 into a contract under this section, a QHBP offering
15 entity shall submit to the Commissioner a bid at
16 such time, in such manner, and containing such in-
17 formation as the Commissioner may require.

18 (2) TERM.—Each contract with a QHBP offer-
19 ing entity under this section shall be for a term of
20 not less than one year, but may be made automati-
21 cally renewable from term to term in the absence of
22 notice of termination by either party.

23 (3) ENFORCEMENT OF NETWORK ADEQUACY.—
24 In the case of a health benefits plan that uses a pro-
25 vider network, the contract under this section with

1 the QHBP offering entity of such plan shall provide
2 that if—

3 (A) the Commissioner determines that
4 such provider network does not meet such
5 standards as the Commissioner shall establish
6 under section 114; and

7 (B) an individual enrolled in such plan re-
8 ceives an item or service from a provider that
9 is not within such network;

10 then any cost-sharing for such item or service shall
11 be equal to the amount of such cost-sharing that
12 would be imposed if such item or service was fur-
13 nished by a provider within such network.

14 (4) OVERSIGHT AND ENFORCEMENT RESPON-
15 SIBILITIES.—The Commissioner shall establish proc-
16 esses to oversee, monitor, and enforce applicable re-
17 quirements of this title with respect to QHBP offer-
18 ing entities offering Exchange-participating health
19 benefits plans and such plans, including the mar-
20 keting of such plans. Such processes shall include
21 the following:

22 (A) GRIEVANCE AND COMPLAINT MECHA-
23 NISMS.—The Commissioner shall establish, in
24 coordination with State insurance regulators, a
25 process under which Exchange-eligible individ-

1 uals and employers may file complaints con-
2 cerning violations of such standards.

3 (B) ENFORCEMENT.—In carrying out au-
4 thorities under this division relating to the
5 Health Insurance Exchange, the Commissioner
6 may impose the type of intermediate sanctions
7 described in section 152(e).

8 (C) TERMINATION.—

9 (i) IN GENERAL.—The Commissioner
10 may terminate a contract with a QHBP of-
11 fering entity under this section for the of-
12 fering of an Exchange-participating health
13 benefits plan if such entity fails to comply
14 with the applicable requirements of this
15 title. Any determination by the Commis-
16 sioner to terminate a contract shall be
17 made in accordance with formal investiga-
18 tion and compliance procedures established
19 by the Commissioner under which—

20 (I) the Commissioner provides
21 the entity with the reasonable oppor-
22 tunity to develop and implement a
23 corrective action plan to correct the
24 deficiencies that were the basis of the
25 Commissioner's determination; and

1 (II) the Commissioner provides
2 the entity with reasonable notice and
3 opportunity for hearing (including the
4 right to appeal an initial decision) be-
5 fore terminating the contract.

6 (ii) EXCEPTION FOR IMMINENT AND
7 SERIOUS RISK TO HEALTH.—Clause (i)
8 shall not apply if the Commissioner deter-
9 mines that a delay in termination, result-
10 ing from compliance with the procedures
11 specified in such subparagraph prior to
12 termination, would pose an imminent and
13 serious risk to the health of individuals en-
14 rolled under the qualified health benefits
15 plan of the QHBP offering entity.

16 (D) CONSTRUCTION.—Nothing in this sub-
17 section shall be construed as preventing the ap-
18 plication of other sanctions under subtitle F of
19 title I with respect to an entity for a violation
20 of such a requirement.

21 **SEC. 205. OUTREACH AND ENROLLMENT OF EXCHANGE-EL-**
22 **IGIBLE INDIVIDUALS AND EMPLOYERS IN EX-**
23 **CHANGE-PARTICIPATING HEALTH BENEFITS**
24 **PLAN.**

25 (a) IN GENERAL.—

1 (1) **OUTREACH.**—The Commissioner shall con-
2 duct outreach activities consistent with subsection
3 (d), including through use of appropriate entities as
4 described in paragraph (4) of such subsection, to in-
5 form and educate individuals and employers about
6 the Health Insurance Exchange and Exchange-par-
7 ticipating health benefits plan options. Such out-
8 reach shall include outreach specific to vulnerable
9 populations, such as children, individuals with dis-
10 abilities, individuals with mental illness, and individ-
11 uals with other cognitive impairments.

12 (2) **ELIGIBILITY.**—The Commissioner shall
13 make timely determinations of whether individuals
14 and employers are Exchange-eligible individuals and
15 employers (as defined in section 202).

16 (3) **ENROLLMENT.**—The Commissioner shall es-
17 tablish and carry out an enrollment process for Ex-
18 change-eligible individuals and employers, including
19 at community locations, in accordance with sub-
20 section (b).

21 (b) **ENROLLMENT PROCESS.**—

22 (1) **IN GENERAL.**—The Commissioner shall es-
23 tablish a process consistent with this title for enroll-
24 ments in Exchange-participating health benefits
25 plans. Such process shall provide for enrollment

1 through means such as the mail, by telephone, elec-
2 tronically, and in person.

3 (2) ENROLLMENT PERIODS.—

4 (A) OPEN ENROLLMENT PERIOD.—The
5 Commissioner shall establish an annual open
6 enrollment period during which an Exchange-el-
7 igible individual or employer may elect to enroll
8 in an Exchange-participating health benefits
9 plan for the following plan year and an enroll-
10 ment period for affordability credits under sub-
11 title C. Such periods shall be during September
12 through November of each year, or such other
13 time that would maximize timeliness of income
14 verification for purposes of such subtitle. The
15 open enrollment period shall not be less than 30
16 days.

17 (B) SPECIAL ENROLLMENT.—The Com-
18 missioner shall also provide for special enroll-
19 ment periods to take into account special cir-
20 cumstances of individuals and employers, such
21 as an individual who—

22 (i) loses acceptable coverage;

23 (ii) experiences a change in marital or
24 other dependent status;

1 (iii) moves outside the service area of
2 the Exchange-participating health benefits
3 plan in which the individual is enrolled; or
4 (iv) experiences a significant change
5 in income.

6 (C) ENROLLMENT INFORMATION.—The
7 Commissioner shall provide for the broad dis-
8 semination of information to prospective enroll-
9 ees on the enrollment process, including before
10 each open enrollment period. In carrying out
11 the previous sentence, the Commissioner may
12 work with other appropriate entities to facilitate
13 such provision of information.

14 (3) AUTOMATIC ENROLLMENT FOR NON-MED-
15 ICAID ELIGIBLE INDIVIDUALS.—

16 (A) IN GENERAL.—The Commissioner
17 shall provide for a process under which individ-
18 uals who are Exchange-eligible individuals de-
19 scribed in subparagraph (B), (C), or (D) are
20 automatically enrolled under an appropriate Ex-
21 change-participating health benefits plan. Such
22 process may involve a random assignment or
23 some other form of assignment that takes into
24 account the health care providers used by the

1 individual involved or such other relevant fac-
2 tors as the Commissioner may specify.

3 (B) SUBSIDIZED INDIVIDUALS DE-
4 SCRIBED.—An individual described in this sub-
5 paragraph is an Exchange-eligible individual
6 who is either of the following:

7 (i) AFFORDABILITY CREDIT ELIGIBLE
8 INDIVIDUALS.—The individual—

9 (I) has applied for, and been de-
10 termined eligible for, affordability
11 credits under subtitle C;

12 (II) has not opted out from re-
13 ceiving such affordability credit; and

14 (III) does not otherwise enroll in
15 another Exchange-participating health
16 benefits plan.

17 (ii) INDIVIDUALS ENROLLED IN A
18 TERMINATED PLAN.—The individual is en-
19 rolled in an Exchange-participating health
20 benefits plan that is terminated (during or
21 at the end of a plan year) and who does
22 not otherwise enroll in another Exchange-
23 participating health benefits plan.

24 (c) COVERAGE INFORMATION AND ASSISTANCE.—

1 (1) COVERAGE INFORMATION.—The Commis-
2 sioner shall provide for the broad dissemination of
3 information on Exchange-participating health bene-
4 fits plans offered under this title. Such information
5 shall be provided in a comparative manner, and shall
6 include information on benefits, premiums, cost-
7 sharing, quality, provider networks, and consumer
8 satisfaction.

9 (2) CONSUMER ASSISTANCE WITH CHOICE.—To
10 provide assistance to Exchange-eligible individuals
11 and employers, the Commissioner shall—

12 (A) provide for the operation of a toll-free
13 telephone hotline to respond to requests for as-
14 sistance and maintain an Internet website
15 through which individuals may obtain informa-
16 tion on coverage under Exchange-participating
17 health benefits plans and file complaints;

18 (B) develop and disseminate information to
19 Exchange-eligible enrollees on their rights and
20 responsibilities; and

21 (C) assist Exchange-eligible individuals in
22 selecting Exchange-participating health benefits
23 plans and obtaining benefits through such
24 plans.

1 (3) EFFECTIVE CULTURALLY AND LINGUIS-
2 TICALLY APPROPRIATE COMMUNICATION.—In car-
3 rying out this subsection, the Commissioner shall es-
4 tablish effective methods for communicating in plain
5 language and a culturally and linguistically appro-
6 priate manner.

7 (4) USE OF OTHER ENTITIES.—In carrying out
8 this subsection, the Commissioner may work with
9 other appropriate entities to facilitate the dissemina-
10 tion of information described in such paragraphs
11 and to provide assistance as described in paragraph
12 (2).

13 (d) SPECIAL DUTIES RELATED TO MEDICAID AND
14 CHIP.—

15 (1) COVERAGE FOR CERTAIN NEWBORNS.—In
16 the case of a child born in the United States, for
17 any portion during the first year of life for which the
18 child is not otherwise covered under acceptable cov-
19 erage, the child shall be deemed—

20 (A) to be a non-traditional Medicaid eligi-
21 ble individual (as defined in subsection (e)(5))
22 for purposes of this division and Medicaid;

23 (B) to have elected to enroll in Medicaid
24 through the application of paragraph (4) and
25 subparagraph (C); and

1 (C) to be an affordable credit eligible indi-
2 vidual described in section 242(a)(2) and to be
3 described in section 1902(a)(10)(A)(i)(IX) of
4 the Social Security Act.

5 (2) CHIP TRANSITION.—A child who, as of the
6 day before the first day of Y1, is eligible for child
7 health assistance under title XXI of the Social Secu-
8 rity Act is deemed as of such first day to be Ex-
9 change-eligible individual unless the individual is a
10 traditional Medicaid eligible individual as of such
11 day.

12 (3) AUTOMATIC ENROLLMENT OF MEDICAID EL-
13 IGIBLE INDIVIDUALS INTO MEDICAID.—The Com-
14 missioner shall provide for a process under which an
15 individual who is a Medicaid eligible individual, is an
16 Exchange-eligible individual, and has not elected to
17 enroll in an Exchange-participating health benefits
18 plan is automatically enrolled under Medicaid.

19 (e) CHOICE OF MEDICAID COVERAGE FOR MEDICAID
20 ELIGIBLE INDIVIDUALS.—

21 (1) IN GENERAL.—As part of the enrollment
22 process under subsection (b), the Commissioner shall
23 provide the option, in the case of a non-traditional
24 Medicaid eligible individual described in section
25 202(d)(3)(A) who is an Exchange-eligible individual

1 and in the case of another Medicaid eligible indi-
2 vidual who is an Exchange-eligible individual pursu-
3 ant to section 202(d)(3)(B), for the individual to
4 elect to enroll under Medicaid instead of under an
5 Exchange-participating health benefits plan. Such an
6 individual may change such election during an en-
7 rollment period under subsection (b)(2).

8 (2) NON-TRADITIONAL MEDICAID ELIGIBLE IN-
9 DIVIDUALS.—In the case of a non-traditional Med-
10 icaid eligible individual who elects to enroll under
11 Medicaid under paragraph (1), the Commissioner
12 shall enroll the individual under the State Medicaid
13 plan in accordance with the Medicaid memorandum
14 of understanding under paragraph (4).

15 (3) TRADITIONAL ELIGIBLE INDIVIDUALS.—Be-
16 ginning in Y5 in the case of a traditional Medicaid
17 eligible individual who is not enrolled under Med-
18 icaid and who elects to enroll under Medicaid under
19 paragraph (1), the individual shall be covered under
20 Medicaid in one of the following manners (as se-
21 lected and specified in such memorandum):

22 (A) ENROLLMENT AS FOR NON-
23 TRADITIONALS.—The Commissioner shall effect
24 the individual's enrollment in Medicaid in the
25 manner specified in paragraph (2) for a non-

1 traditional Medicaid eligible individual. In the
2 case of such an enrollment, the State shall pro-
3 vide for the same periodic redetermination of
4 eligibility under Medicaid as would otherwise
5 apply if the individual had directly applied for
6 medical assistance to the State Medicaid agen-
7 cy.

8 (B) PRESUMPTIVE ELIGIBILITY.—

9 (i) IN GENERAL.—The Commissioner
10 shall effect the individual's temporary en-
11 rollment in Medicaid during a presumptive
12 eligibility period (specified in such memo-
13 randum consistent with clause (ii)) and
14 shall provide the State Medicaid agency
15 with information on the individual's income
16 used in making the determination that the
17 individual is a traditional Medicaid eligible
18 individual.

19 (ii) PRESUMPTIVE ELIGIBILITY PE-
20 RIOD.—The presumptive eligibility period
21 specified in such memorandum for pur-
22 poses of this subparagraph shall be similar
23 to the presumptive eligibility period de-
24 scribed in section 1920(b)(1) of the Social
25 Security Act except that the deadline for

1 application for medical assistance described
2 in subparagraph (B)(ii) of such section
3 shall not be earlier than the last day of the
4 month that begins 60 days following the
5 month during which the Commissioner
6 makes the determination that the indi-
7 vidual is a traditional Medicaid eligible in-
8 dividual.

9 (4) COORDINATED ENROLLMENT WITH STATE
10 THROUGH MEMORANDUM OF UNDERSTANDING.—
11 The Commissioner shall enter into a memorandum
12 of understanding with each State (each in this divi-
13 sion referred to as a “Medicaid memorandum of un-
14 derstanding”) with respect to coordinating enroll-
15 ment of individuals in Exchange-participating health
16 benefits plans and under the State’s Medicaid pro-
17 gram consistent with this section and to otherwise
18 coordinate the implementation of the provisions of
19 this division with respect to the Medicaid program.
20 Such memorandum shall permit the exchange of in-
21 formation consistent with the limitations described
22 in section 1902(a)(7) of the Social Security Act.

23 (5) MEDICAID ELIGIBLE INDIVIDUALS.—For
24 purposes of this division:

1 (A) MEDICAID ELIGIBLE INDIVIDUAL.—
2 The term “Medicaid eligible individual” means
3 an individual who is eligible for medical assist-
4 ance under Medicaid.

5 (B) TRADITIONAL MEDICAID ELIGIBLE IN-
6 DIVIDUAL.—The term “traditional Medicaid eli-
7 gible individual” means a Medicaid eligible indi-
8 vidual other than an individual who is—

9 (i) a Medicaid eligible individual by
10 reason of the application of subclause
11 (VIII) or (IX) section 1902(a)(10)(A)(i) of
12 the Social Security Act; or

13 (ii) a childless adult not described in
14 section 1902(a)(10)(A) or (C) of such Act
15 (as in effect as of the day before the date
16 of the enactment of this Act).

17 (C) NON-TRADITIONAL MEDICAID ELIGI-
18 BLE INDIVIDUAL.—The term “non-traditional
19 Medicaid eligible individual” means a Medicaid
20 eligible individual who is not a traditional Med-
21 icaid eligible individual.

22 **SEC. 206. OTHER FUNCTIONS.**

23 (a) COORDINATION OF AFFORDABILITY CREDITS.—
24 The Commissioner shall coordinate the distribution of af-
25 fordability premium and cost-sharing credits under sub-

1 title C to QHBP offering entities offering Exchange-participating health benefits plans.

3 (b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHBP offering entities offering Exchange-participating health benefits plans of premiums collected for such plans that takes into account (in a manner specified by the Commissioner) the differences in the risk characteristics of individuals and employers enrolled under the different Exchange-participating health benefits plans offered by such entities so as to minimize the impact of adverse selection of enrollees among the plans offered by such entities.

14 (c) SPECIAL INSPECTOR GENERAL FOR THE HEALTH INSURANCE EXCHANGE.—

16 (1) ESTABLISHMENT.—There is hereby established the Office of the Special Inspector General for the Health Insurance Exchange.

19 (2) APPOINTMENT AND REMOVAL OF SPECIAL INSPECTOR GENERAL.—

21 (A) IN GENERAL.—The President shall appoint, by and with the advice and consent of the Senate, a Special Inspector General for the Health Insurance Exchange (in this subsection referred to as the “Special Inspector General”)

1 to head the Office of the Special Inspector Gen-
2 eral for the Health Insurance Exchange.

3 (B) CONSIDERATIONS IN APPOINTMENT.—

4 The appointment of the Special Inspector Gen-
5 eral shall be made on the basis of integrity and
6 demonstrated ability in accounting, auditing, fi-
7 nancial analysis, law, management analysis,
8 public administration, or investigations.

9 (C) TIMING OF APPOINTMENT.—The nomi-
10 nation of an individual as Special Inspector
11 General shall be made as soon as practicable
12 after the establishment of the program under
13 this subtitle.

14 (D) REMOVAL.—The Special Inspector
15 General may be removed from office in accord-
16 ance with the provisions of section 3(b) of the
17 Inspector General Act of 1978 (5 U.S.C. App.).

18 (E) POLITICAL ACTIVITIES.—For purposes
19 of section 7324 of title 5, United States Code,
20 the Special Inspector General shall not be con-
21 sidered an employee who determines policies to
22 be pursued by the United States in the nation-
23 wide administration of Federal law.

24 (F) PAY.—The annual rate of basic pay of
25 the Special Inspector General shall be the an-

1 nual rate of basic pay for an Inspector General
2 under section 3(e) of the Inspector General Act
3 of 1978 (5 U.S.C. App.).

4 (3) DUTIES.—

5 (A) IN GENERAL.—The Special Inspector
6 General shall—

7 (i) conduct, supervise, and coordinate
8 audits, evaluations and investigations of
9 the Health Insurance Exchange to protect
10 the integrity of the Health Insurance Ex-
11 change, as well as the health and welfare
12 of participants in the Exchange;

13 (ii) establish, maintain, and oversee
14 such systems, procedures, and controls as
15 the Special Inspector General considers ap-
16 propriate to discharge the duty under
17 clause (i); and

18 (iii) have the duties and responsibil-
19 ities of inspectors general under the In-
20 spector General Act of 1978

21 (B) REPORTING PROBLEMS.—The Office
22 of the Special Inspector General has a responsi-
23 bility to report both to the Administrator and
24 to the Congress regarding program and man-

1 agement problems and recommendations to cor-
2 rect them.

3 (4) POWERS AND AUTHORITIES.—In carrying
4 out the duties specified in subsection (c), the Special
5 Inspector General shall have the authorities provided
6 in section 6 of the Inspector General Act of 1978.

7 (5) PERSONNEL, FACILITIES, AND OTHER RE-
8 SOURCES.—

9 (A) EMPLOYEES AND OFFICERS.—The
10 Special Inspector General may select, appoint,
11 and employ such officers and employees as may
12 be necessary for carrying out the duties of the
13 Special Inspector General, subject to the provi-
14 sions of title 5, United States Code and the
15 provisions of chapter 51 and subchapter III of
16 chapter 53 of such title.

17 (B) SERVICES.—The Special Inspector
18 General may obtain services as authorized by
19 section 3109 of title 5, United States Code, at
20 daily rates not to exceed the equivalent rate
21 prescribed for grade GS-15 of the General
22 Schedule by section 5332 of such title.

23 (C) CONTRACTS.—The Special Inspector
24 General may enter into contracts and other ar-
25 rangements for audits, studies, analyses, and

1 other services with public agencies and with pri-
2 vate persons, and make such payments as may
3 be necessary to carry out the duties of the In-
4 spector General.

5 (D) ASSISTANCE FROM OTHER FEDERAL
6 ENTITIES.—

7 (i) IN GENERAL.—Upon request of
8 the Special Inspector General for informa-
9 tion or assistance from any department,
10 agency, or other entity of the Federal Gov-
11 ernment, the head of such entity shall, in-
12 sofar as is practicable and not in con-
13 travention of any existing law, furnish such
14 information or assistance to the Special In-
15 spector General, or an authorized designee.

16 (ii) REPORT TO CONGRESS.—When-
17 ever information or assistance requested by
18 the Special Inspector General is, in the
19 judgment of the Special Inspector General,
20 unreasonably refused or not provided, the
21 Special Inspector General shall report the
22 circumstances to the appropriate commit-
23 tees of Congress without delay.

24 (6) REPORTS.—Not later than one year after
25 the confirmation of the Special Inspector General,

1 and annually thereafter, the Special Inspector Gen-
2 eral shall submit to the appropriate committees of
3 Congress a report summarizing the activities of the
4 Special Inspector General during the one year period
5 ending on the date such report is submitted.

6 (7) FUNDING.—Of the amounts made available
7 to the Commissioner, \$[____],000,000 shall be
8 available to the Special Inspector General to carry
9 out this section and shall remain available until ex-
10 pended.

11 (8) TERMINATION.—The Office of the Special
12 Inspector General shall terminate five years after
13 the date of the enactment of this Act.

14 **SEC. 207. HEALTH INSURANCE EXCHANGE TRUST FUND.**

15 (a) ESTABLISHMENT OF HEALTH INSURANCE EX-
16 CHANGE TRUST FUND.—There is created within the
17 Treasury of the United States a trust fund to be known
18 as the “Health Insurance Exchange Trust Fund” (in this
19 section referred to as the “Trust Fund”), consisting of
20 such amounts as may be appropriated or credited to the
21 Trust Fund under this section or any other provision of
22 law.

23 (b) PAYMENTS FROM TRUST FUND.—The Commis-
24 sioner shall pay from time to time from the Trust Fund
25 such amounts as the Commissioner determines are nec-

1 essary to make payments to operate the Health Insurance
2 Exchange, including payments under subtitle C (relating
3 to affordability credits).

4 (c) TRANSFERS TO TRUST FUND.—

5 (1) DEDICATED PAYMENTS.—There is hereby
6 appropriated to the Trust Fund amounts equivalent
7 to the following:

8 (A) TAXES ON INDIVIDUALS NOT OBTAIN-
9 ING ACCEPTABLE COVERAGE.—The amounts re-
10 ceived in the Treasury under section 59B of the
11 Internal Revenue Code of 1986 (relating to re-
12 quirement of health insurance coverage for indi-
13 viduals).

14 (B) EMPLOYMENT TAXES ON EMPLOYERS
15 NOT PROVIDING ACCEPTABLE COVERAGE.—The
16 amounts received in the Treasury under section
17 3111(c) of the Internal Revenue Code of 1986
18 (relating to employers electing to not provide
19 health benefits).

20 (C) EXCISE TAX ON FAILURES TO MEET
21 CERTAIN HEALTH COVERAGE REQUIRE-
22 MENTS.—The amounts received in the Treasury
23 under section 4980H(b) (relating to excise tax
24 with respect to failure to meet health coverage
25 participation requirements).

1 (2) APPROPRIATIONS TO COVER GOVERNMENT
2 CONTRIBUTIONS.—There are authorized to be appro-
3 priated from time to time, out of any moneys in the
4 Treasury not otherwise appropriated, to the Trust
5 Fund, an amount equivalent to the amount of pay-
6 ments made from the Trust Fund under subsection
7 (b) plus such amounts as are necessary reduced by
8 the amounts deposited under paragraph (1).

9 (d) APPLICATION OF CERTAIN RULES.—Rules simi-
10 lar to the rules of subchapter B of chapter 98 of the Inter-
11 nal Revenue Code of 1986 shall apply with respect to the
12 Trust Fund.

13 **SEC. 208. OPTIONAL OPERATION OF STATE-BASED HEALTH**
14 **INSURANCE EXCHANGES.**

15 (a) IN GENERAL.—If—

16 (1) a State (or group of States, subject to the
17 approval of the Commissioner) applies to the Com-
18 missioner for approval of a State-based Health In-
19 surance Exchange to operate in the State (or group
20 of States); and

21 (2) the Commissioner approves such State-
22 based Health Insurance Exchange,
23 then, subject to subsections (c) and (d), the State-based
24 Health Insurance Exchange shall operate, instead of the

1 Health Insurance Exchange, with respect to such State
2 (or group of States).

3 (b) REQUIREMENTS FOR APPROVAL.—The Commis-
4 sioner may not approve a State-based Health Insurance
5 Exchange under this section unless the following require-
6 ments are met:

7 (1) The State-based Health Insurance Ex-
8 change must demonstrate the capacity to and pro-
9 vide assurances satisfactory to the Commissioner
10 that the State-based Health Insurance Exchange will
11 carry out the functions specified for the Health In-
12 surance Exchange in the State (or States) involved,
13 including—

14 (A) contracting with QHBP offering enti-
15 ties for the offering of Exchange-participating
16 health benefits plan, which satisfy the stand-
17 ards and requirements of this title and title I;

18 (B) enrolling Exchange-eligible individuals
19 and employers in such State in such plans; and

20 (C) the establishment of sufficient local of-
21 fices to meet the needs of Exchange-eligible in-
22 dividuals and employers.

23 (2) There is no more than one Health Insur-
24 ance Exchange operating with respect to any one
25 State.

1 (3) Such other requirements as the Commis-
2 sioner may specify.

3 (c) CEASING OPERATION.—

4 (1) IN GENERAL.—A State-based Health Insur-
5 ance Exchange may, at the option of each State in-
6 volved, and only after providing timely and reason-
7 able notice to the Commissioner, cease operation as
8 such an Exchange, in which case the Health Insur-
9 ance Exchange shall operate, instead of such State-
10 based Health Insurance Exchange, with respect to
11 such State (or States).

12 (2) TERMINATION; HI EXCHANGE RESUMPTION
13 OF FUNCTIONS.—The Commissioner may terminate
14 the approval (for some or all functions) of a State-
15 based Health Insurance Exchange under this section
16 if the Commissioner determines that such Exchange
17 no longer meets the requirements of subsection (b)
18 or is no longer capable of carrying out such func-
19 tions in accordance with the requirements of this
20 subtitle. In lieu of terminating such approval, the
21 Commissioner may temporarily assume some or all
22 functions of the State-based Health Insurance Ex-
23 change until such time as the Commissioner deter-
24 mines the State-based Health Insurance Exchange
25 meets such requirements of subsection (b) and is ca-

1 pable of carrying out such functions in accordance
2 with the requirements of this subtitle.

3 (3) EFFECTIVENESS.—The ceasing or termi-
4 nation of a State-based Health Insurance Exchange
5 under this subsection shall be effective in such time
6 and manner as the Commissioner shall specify.

7 (d) RETENTION OF AUTHORITY.—

8 (1) AUTHORITY RETAINED.—Enforcement au-
9 thorities of the Commissioner shall be retained by
10 the Commissioner.

11 (2) DISCRETION TO RETAIN ADDITIONAL AU-
12 THORITY.—The Commissioner may specify functions
13 of the Health Insurance Exchange that—

14 (A) may not be performed by a State-
15 based Health Insurance Exchange under this
16 section; or

17 (B) may be performed by the Commis-
18 sioner and by such a State-based Health Insur-
19 ance Exchange.

20 (e) REFERENCES.—In the case of a State-based
21 Health Insurance Exchange, except as the Commissioner
22 may otherwise specify under subsection (d), any references
23 in this subtitle to the Health Insurance Exchange or to
24 the Commissioner in the area in which the State-based
25 Health Insurance Exchange operates shall be deemed a

1 reference to the State-based Health Insurance Exchange
2 and the head of such Exchange, respectively.

3 (f) FUNDING.—In the case of a State-based Health
4 Insurance Exchange, there shall be assistance provided for
5 the operation of such Exchange.

6 **Subtitle B—Public Health** 7 **Insurance Option**

8 **SEC. 221. ESTABLISHMENT AND ADMINISTRATION OF A** 9 **PUBLIC HEALTH INSURANCE OPTION AS AN** 10 **EXCHANGE-QUALIFIED HEALTH BENEFITS** 11 **PLAN.**

12 (a) ESTABLISHMENT.—Not later than Y1, the Sec-
13 retary of Health and Human Services (in this subtitle re-
14 ferred to as the “Secretary”) shall provide for the offering
15 of an Exchange-participating health benefits plan (in this
16 division referred to as the “public health insurance op-
17 tion”) that ensures choice, competition, and stability of
18 affordable, high quality coverage throughout the United
19 States in accordance with this subtitle.

20 (b) OFFERING AS AN EXCHANGE-PARTICIPATING
21 HEALTH BENEFITS PLAN.—

22 (1) EXCLUSIVE TO THE EXCHANGE.—The pub-
23 lic health insurance option shall only be made avail-
24 able through the Health Insurance Exchange.

1 (2) ENSURING A LEVEL PLAYING FIELD.—Con-
2 sistent with this subtitle, the public health insurance
3 option shall comply with requirements that are ap-
4 plicable under this title to an Exchange-participating
5 health benefits plan, including requirements related
6 to benefits, benefit levels, provider networks, notices,
7 consumer protections, and cost sharing.

8 (3) PROVISION OF BENEFIT LEVELS.—The pub-
9 lic health insurance option—

10 (A) shall offer basic, enhanced, and pre-
11 mium plans; and

12 (B) may offer premium-plus plans.

13 (c) ADMINISTRATIVE CONTRACTING.—The Secretary
14 may enter into contracts for the purpose of performing
15 administrative functions (including functions described in
16 subsection (a)(4) of section 1874A of the Social Security
17 Act) with respect to the public health insurance option in
18 the same manner as the Secretary may enter into con-
19 tracts under subsection (a)(1) of such section. The Sec-
20 retary has the same authority with respect to the public
21 health insurance option as the Secretary has under sub-
22 sections (a)(1) and (b) of section 1874A of the Social Se-
23 curity Act with respect to title XVIII of such Act. Con-
24 tracts under this subsection shall not involve the transfer
25 of insurance risk to such entity.

1 (d) OMBUDSMAN.—The Secretary shall establish an
2 office of the ombudsman for the public health insurance
3 option which shall have duties with respect to the public
4 health insurance option similar to the duties of the Medi-
5 care Beneficiary Ombudsman under section 1808(c)(2) of
6 the Social Security Act.

7 (e) DATA COLLECTION.—The Secretary shall collect
8 such data as may be required to establish premiums and
9 payment rates for the public health insurance option and
10 for other purposes under this subtitle, including to im-
11 prove quality and to reduce racial and ethnic disparities
12 in health care.

13 (f) TREATMENT OF PUBLIC HEALTH INSURANCE OP-
14 TION.—With respect to the public health insurance option,
15 the Secretary shall be treated as a QHBP offering entity
16 offering an Exchange-participating health benefits plan.

17 (g) ACCESS TO FEDERAL COURTS.—The provisions
18 of Medicare (and related provisions of title II of the Social
19 Security Act) relating to access of Medicare beneficiaries
20 to Federal courts for the enforcement of rights under
21 Medicare, including with respect to amounts in con-
22 troversy, shall apply to the public health insurance option
23 and individuals enrolled under such option under this title
24 in the same manner as such provisions apply to Medicare
25 and Medicare beneficiaries.

1 **SEC. 222. PREMIUMS AND FINANCING.**

2 (a) ESTABLISHMENT OF PREMIUMS.—

3 (1) IN GENERAL.—The Secretary shall establish
4 geographically-adjusted premium rates for the public
5 health insurance option in a manner—

6 (A) that complies with the premium rules
7 established by the Commissioner under section
8 113 for Exchange-participating health benefit
9 plans; and

10 (B) at a level sufficient to fully finance the
11 costs of—

12 (i) health benefits provided by the
13 public health insurance option; and

14 (ii) administrative costs related to op-
15 erating the public health insurance option.

16 (2) CONTINGENCY MARGIN.—In establishing
17 premium rates under paragraph (1), the Secretary
18 shall include an appropriate amount for a contin-
19 gency margin.

20 (b) ACCOUNT.—

21 (1) ESTABLISHMENT.—There is established in
22 the Treasury of the United States an Account for
23 the receipts and disbursements attributable to the
24 operation of the public health insurance option, in-
25 cluding the start-up funding under paragraph (2).
26 Section 1854(g) of the Social Security Act shall

1 apply to receipts described in the previous sentence
2 in the same manner as such section applies to pay-
3 ments or premiums described in such section.

4 (2) START-UP FUNDING.—In order to provide
5 for the establishment of the public health insurance
6 option before the collection of premiums, there is
7 hereby appropriated to the Secretary out of any
8 funds in the Treasury not otherwise appropriated,
9 \$[*to be specified*]. Nothing in this section shall be
10 construed as authorizing any additional appropria-
11 tions to the Account, other than such amounts as
12 are otherwise provided with respect to other Ex-
13 change-participating health benefits plans.

14 **SEC. 223. PAYMENT RATES FOR ITEMS AND SERVICES.**

15 (a) RATES ESTABLISHED BY SECRETARY.—

16 (1) IN GENERAL.—The Secretary shall establish
17 payment rates for the public health insurance option
18 for services and health care providers consistent with
19 this section and may change such payment rates in
20 accordance with section 224.

21 (2) INITIAL PAYMENT RULES.—

22 (A) IN GENERAL.—Except as provided in
23 subparagraph (B) and subsection (b)(1), during
24 Y1, Y2, and Y3, the Secretary shall base the
25 payment rates under this section for services

1 and providers described in paragraph (1) on the
2 payment rates for similar services and providers
3 under parts A and B of Medicare.

4 (B) EXCEPTIONS.—

5 (i) PRACTITIONERS' SERVICES.—Pay-
6 ment rates for practitioners' services other-
7 wise established under the fee schedule
8 under section 1848 of the Social Security
9 Act shall be applied without regard to the
10 provisions under subsection (f) of such sec-
11 tion and the update under subsection
12 (d)(4) under such section for a year as ap-
13 plied under this paragraph shall be not less
14 than 1 percent.

15 (ii) ADJUSTMENTS.—The Secretary
16 may determine the extent to which Medi-
17 care adjustments applicable to base pay-
18 ment rates under parts A and B of Medi-
19 care shall apply under this subtitle.

20 (3) FOR NEW SERVICES.—The Secretary shall
21 modify payment rates described in paragraph (2) in
22 order to accommodate payments for services, such as
23 well-child visits, that are not otherwise covered
24 under Medicare.

1 (4) PRESCRIPTION DRUGS.—Payment rates
2 under this section for prescription drugs that are not
3 paid for under part A or part B of Medicare shall
4 be at rates negotiated by the Secretary.

5 (b) INCENTIVES FOR PARTICIPATING PROVIDERS.—

6 (1) INITIAL INCENTIVE PERIOD.—

7 (A) IN GENERAL.—The Secretary shall
8 provide, in the case of services described in sub-
9 paragraph (B), for payment rates that are 5
10 percent greater than the rates established under
11 subsection (a).

12 (B) SERVICES DESCRIBED.—The services
13 described in this subparagraph are items and
14 professional services furnished during Y1, Y2,
15 and Y3, under the public health insurance op-
16 tion by a physician or other health care practi-
17 tioner who participates in both Medicare and
18 the public health insurance option.

19 (C) SPECIAL RULES.—A pediatrician and
20 any other health care practitioner who is a type
21 of practitioner that does not typically partici-
22 pate in Medicare (as determined by the Sec-
23 retary) shall also be eligible for the increased
24 payment rates under subparagraph (A).

1 (2) SUBSEQUENT PERIODS.— Beginning with
2 Y4 and for subsequent years, the Secretary may ad-
3 just such rates in order to promote payment accu-
4 racy, to ensure adequate beneficiary access to pro-
5 viders, or to promote affordability and the efficient
6 delivery of medical care.

7 (c) ADMINISTRATIVE PROCESS FOR SETTING
8 RATES.—Chapter 5 of title 5, United States Code shall
9 apply to the process for the initial establishment of pay-
10 ment rates under this section but not to the specific meth-
11 odology for establishing such rates or the calculation of
12 such rates.

13 (d) CONSTRUCTION.—Nothing in this subtitle shall
14 be construed as limiting the Secretary’s authority to cor-
15 rect for payments that are excessive or deficient, taking
16 into account the amounts paid for similar health care pro-
17 viders and services under other Exchange-participating
18 health benefits plans.

19 (e) CONSTRUCTION.—Nothing in this subtitle shall be
20 construed as affecting the authority of the Secretary to
21 establish payment rates, including payments to provide for
22 the more efficient delivery of services, such as the initia-
23 tives provided for under section 224.

24 (f) LIMITATIONS ON REVIEW.—There shall be no ad-
25 ministrative or judicial review of a payment rate or meth-

1 odology established under this section or under section
2 224.

3 **SEC. 224. MODERNIZED PAYMENT INITIATIVES AND DELIV-**
4 **ERY SYSTEM REFORM.**

5 (a) IN GENERAL.—For plan years beginning with Y1,
6 the Secretary may utilize innovative payment mechanisms
7 and policies to determine payments for items and services
8 under the public health insurance option. The payment
9 mechanisms and policies under this section may include
10 patient-centered medical home and other care manage-
11 ment payments, accountable care organizations, value-
12 based purchasing, bundling of services, differential pay-
13 ment rates, performance or utilization based payments,
14 partial capitation, and direct contracting with providers.

15 (b) REQUIREMENTS FOR INNOVATIVE PAYMENTS.—
16 The Secretary shall design and implement the payment
17 mechanisms and policies under this section in a manner
18 that—

19 (1) seeks to—

20 (A) improve health outcomes;

21 (B) reduce health disparities (including ra-
22 cial and ethnic disparities);

23 (C) address geographic variation in the
24 provision of health services; or

25 (D) prevent or manage chronic illness; and

1 (2) promotes care that is integrated, patient-
2 centered, quality, and efficient.

3 (c) ENCOURAGING THE USE OF HIGH VALUE SERV-
4 ICES.—To the extent allowed by the benefit standards ap-
5 plied to all Exchange-participating health benefits plans,
6 the public health insurance option may modify cost shar-
7 ing and payment rates to encourage the use of services
8 that promote health and value.

9 (d) NON-UNIFORMITY PERMITTED.—Nothing in this
10 subtitle shall prevent the Secretary from varying payments
11 based on different payment structure models (such as ac-
12 countable care organizations and medical homes) under
13 the public health insurance option for different geographic
14 areas.

15 **SEC. 225. PROVIDER PARTICIPATION.**

16 (a) IN GENERAL.—The Secretary shall establish con-
17 ditions of participation for health care providers under the
18 public health insurance option.

19 (b) LICENSURE OR CERTIFICATION.—The Secretary
20 shall not allow a health care provider to participate in the
21 public health insurance option unless such provider is ap-
22 propriately licensed or certified under State law.

23 (c) LIMITATION ON BALANCE BILLING.—In the case
24 of a health care provider that furnishes items or services
25 to an individual enrolled under the public health insurance

1 option for which payment may be made under such option,
2 the provider may not impose charges for such items or
3 services (in relation to the payment rate under the option
4 for such items and services) that exceed the charges that
5 may be made for such items and services (in relation to
6 the payment rate for such items and services under Medi-
7 care) or for similar items and services (in the case of items
8 and services not covered under Medicare).

9 (d) EXCLUSION OF CERTAIN PROVIDERS.—The Sec-
10 retary shall exclude from participation under the public
11 health insurance option a health care provider that is ex-
12 cluded from participation in a Federal health care pro-
13 gram (as defined in section 1128B(f) of the Social Secu-
14 rity Act).

15 **SEC. 226. APPLICATION OF FRAUD AND ABUSE PROVI-**
16 **SIONS.**

17 (a) IN GENERAL.—The provisions of titles XI and
18 XVIII of the Social Security Act relating to program in-
19 tegrity, sanctions (including exclusion authority, civil mon-
20 etary penalties, payment denials, other penalties), and
21 other authority to prevent and prosecute waste, fraud, and
22 abuse shall apply with respect to the public health insur-
23 ance option (and health care providers and entities with
24 respect to such option) in the same manner as such provi-

1 sions apply with respect to Medicare (and related pro-
2 viders and entities).

3 (b) **ADDITIONAL PROGRAMS.**—Other provisions of
4 law (other than criminal law provisions) identified by the
5 Secretary by regulation, in consultation with the Inspector
6 General of the Department of Health and Human Serv-
7 ices, that impose sanctions with respect to waste, fraud,
8 and abuse under Medicare shall also apply to the public
9 health insurance option.

10 **Subtitle C—Individual** 11 **Affordability Credits**

12 **SEC. 241. AVAILABILITY THROUGH HEALTH INSURANCE EX-** 13 **CHANGE.**

14 (a) **IN GENERAL.**—Subject to the succeeding provi-
15 sions of this subtitle, in the case of an affordable credit
16 eligible individual enrolled in an Exchange-participating
17 health benefits plan—

18 (1) the individual shall be eligible for, in accord-
19 ance with this subtitle, affordability credits con-
20 sisting of—

21 (A) an affordability premium credit under
22 section 243 to be applied against the premium
23 for the Exchange-participating health benefits
24 plan in which the individual is enrolled; and

1 (B) an affordability cost-sharing credit
2 under section 244 to be applied as a reduction
3 of the cost-sharing otherwise applicable to such
4 plan; and

5 (2) the Commissioner shall pay the QHBP of-
6 fering entity that offers such plan from the Health
7 Insurance Exchange Account the aggregate amount
8 of affordability credits for all affordadble credit eligi-
9 ble individuals enrolled in such plan.

10 (b) APPLICATION.—

11 (1) IN GENERAL.—An Exchange eligible indi-
12 vidual may apply to the Commissioner through the
13 Health Insurance Exchange or through another enti-
14 ty under an arrangement made with the Commis-
15 sioner, in a form and manner specified by the Com-
16 missioner, to be determined to be an affordable cred-
17 it eligible individual and to be provided affordability
18 credits under this subtitle. The Commissioner shall
19 establish a process whereby, on the basis of informa-
20 tion otherwise available, individuals may be deemed
21 to be affordable credit eligible individuals.

22 (2) USE OF STATE MEDICAID AGENCIES.—If
23 the Commissioner determines that a State has the
24 capacity to make a determination of eligibility for af-
25 fordability credits under this subtitle and under the

1 same standards as used by the Commissioner, under
2 the Medicaid memorandum of understanding (as de-
3 fined in section 205(c)(4))—

4 (A) the State is authorized to conduct such
5 determinations for any Exchange-eligible indi-
6 vidual who requests such a determination; and

7 (B) the Commissioner shall reimburse the
8 State for the costs of conducting such deter-
9 minations.

10 (c) USE OF AFFORDABILITY CREDITS.—

11 (1) IN GENERAL.—In Y1 and Y2 an affordable
12 credit eligible individual may use an affordability
13 credit only with respect to a basic plan.

14 (2) FLEXIBILITY IN PLAN ENROLLMENT AU-
15 THORIZED.—Beginning with Y3, the Commissioner
16 shall establish a process to allow an affordability
17 credit to be used for enrollees in enhanced or pre-
18 mium plans. In the case of an affordable credit eligi-
19 ble individual who enrolls in an enhanced or pre-
20 mium plan, the individual shall be responsible for
21 any difference between the premium for such plan
22 and the affordable credit amount otherwise applica-
23 ble if the individual had enrolled in a basic plan.

24 (d) ACCESS TO DATA.—In carrying out this subtitle,
25 the Commissioner is authorized to request from the Sec-

1 retary of the Treasury consistent with section 6103 of the
2 Internal Revenue Code of 1986 such information as may
3 be required to carry out this subtitle.

4 (e) NO CASH REBATES.—In no case shall an afford-
5 able credit eligible individual receive any cash payment as
6 a result of the application of this subtitle.

7 **SEC. 242. AFFORDABLE CREDIT ELIGIBLE INDIVIDUAL.**

8 (a) DEFINITION.—

9 (1) IN GENERAL.—For purposes of this divi-
10 sion, the term “affordable credit eligible individual”
11 means, subject to subsection (b), an individual who
12 is lawfully present in a State in the United States
13 (other than as a nonimmigrant described in section
14 101(a)(15) of the Immigration and Nationality
15 Act)—

16 (A) who is enrolled under an Exchange-
17 participating health benefits plan and is not en-
18 rolled under such plan as an employee (or de-
19 pendent of an employee) through an employer
20 qualified health benefits plan that has elected
21 the play option under section 311(a); and

22 (B) with family income below 400 percent
23 of the Federal poverty level for a family of the
24 size involved.

1 (2) TREATMENT OF FAMILY.—Except as the
2 Commissioner may otherwise provide, members of
3 the same family who are affordable credit eligible in-
4 dividuals shall be treated as a single affordable cred-
5 it individual eligible for the applicable credit for such
6 a family under this subtitle.

7 (b) LIMITATIONS ON EMPLOYEE AND DEPENDENT
8 DISQUALIFICATION.—

9 (1) APPLICATION BEFORE Y5.—Before Y5, sub-
10 ject to paragraphs (2) and (3), the term “affordable
11 credit eligible individual” does not include a full-time
12 employee of an employer if the employer offers the
13 employee coverage (for the employee and depend-
14 ents) as a full-time employee under a group health
15 plan if the coverage and employer contribution under
16 the plan meet the requirements of section 312.

17 (2) ADDITIONAL EXCEPTIONS.—The Commis-
18 sioner shall establish such exceptions and special
19 rules in the case described in paragraph (1) as may
20 be appropriate in the case of a divorced or separated
21 individual or such a dependent of an employee who
22 would otherwise be an affordable credit eligible indi-
23 vidual.

24 (3) EXCEPTION.—Beginning in Y2, in the case
25 of full-time employees for which the annual cost of

1 the employee premium for coverage under a group
2 health plan would exceed 10 percent of family in-
3 come, paragraph (1) shall not apply.

4 (c) INCOME DEFINED.—

5 (1) IN GENERAL.—In this title, the term “in-
6 come” means adjusted gross income (as defined in
7 section 62 of the Internal Revenue Code of 1986).

8 (2) STUDY OF INCOME DISREGARDS.—The
9 Commissioner shall conduct a study that examines
10 the application of income disregards for purposes of
11 this subtitle. Not later than the first day of Y2, the
12 Commissioner shall submit to Congress a report on
13 such study and shall include such recommendations
14 as the Commissioner determines appropriate.

15 (d) CLARIFICATION OF TREATMENT OF AFFORD-
16 ABILITY CREDITS.—Affordability credits under this sub-
17 title shall not be treated, for purposes of title IV of the
18 Personal Responsibility and Work Opportunity Reconcili-
19 ation Act of 1996, to be a benefit provided under section
20 403 of such title.

21 **SEC. 243. AFFORDABLE PREMIUM CREDIT.**

22 (a) IN GENERAL.—The affordability premium credit
23 under this section for an affordable credit eligible indi-
24 vidual enrolled in an Exchange-participating health bene-
25 fits plan is in an amount equal to the amount (if any)

1 by which the premium for the plan (or, if less, the ref-
2 erence premium amount specified in subsection (c)), ex-
3 ceeds the affordable premium amount specified in sub-
4 section (b) for the individual.

5 (b) AFFORDABLE PREMIUM AMOUNT.—

6 (1) IN GENERAL.—The affordable premium
7 amount specified in this subsection for an individual
8 for monthly premium in a plan year shall be equal
9 to $\frac{1}{12}$ of the product of—

10 (A) the premium percentage limit specified
11 in paragraph (2) for the individual based upon
12 such income for the plan year; and

13 (B) the income of the individual for such
14 plan year.

15 (2) PREMIUM PERCENTAGE LIMITS.—The Com-
16 missioner shall establish premium percentage limits,
17 on a sliding scale in a linear manner, for affordable
18 credit eligible individuals in manner so that, for indi-
19 viduals with income at or below 133 percent of FPL
20 the premium percentage limit is 1 percent and for
21 individuals with income at 400 percent of FPL the
22 premium percentage limit is 10 percent.

23 (c) REFERENCE PREMIUM AMOUNT.—The reference
24 premium amount specified in this subsection for a plan
25 year for an individual in a premium rating area is equal

1 to the average premium for the 3 basic plans in the area
2 for the plan year with the lowest premium levels. The
3 Commissioner may increase the reference premium
4 amount for an area in order to assure that affordable cred-
5 it eligible individuals have multiple plan options from
6 which to choose and to reduce frequent change in enroll-
7 ment among Exchange-participating health benefits plans.

8 **SEC. 244. AFFORDABILITY COST-SHARING CREDIT.**

9 (a) IN GENERAL.—The affordability cost-sharing
10 credit under this section for an affordable credit eligible
11 individual enrolled in an Exchange-participating health
12 benefits plan is in the form of the cost-sharing reduction
13 described in subsection (c) provided under this section for
14 the income tier in which the individual is classified based
15 on the individual's family income.

16 (b) ESTABLISHMENT OF INCOME TIERS.—For pur-
17 poses of this section, the Commissioner shall establish 6
18 income tiers, equally spaced in progressive manner as
19 specified by the Commissioner, for affordable credit eligi-
20 ble individuals with family income starting at or below 133
21 percent of FPL and ending at 400 percent of FPL.

22 (c) COST-SHARING REDUCTIONS.—The Commis-
23 sioner shall specify a reduction of cost-sharing under a
24 basic plan for each income tier established under sub-

1 section (b), with respect to a year, consistent with the fol-
2 lowing:

3 (1) REDUCTION IN ANNUAL COST-SHARING
4 LIMIT.—

5 (A) IN GENERAL.—A reduction, on a slid-
6 ing scale, in the annual limitation on cost-shar-
7 ing specified in section 122(c)(2)(B) in manner
8 so that—

9 (i) for individuals with family income
10 at or below 133 percent of FPL the annual
11 limitation shall be the applicable level spec-
12 ified in subparagraph (B); and

13 (ii) for individuals with family income
14 at 400 percent of FPL the annual limita-
15 tion is the annual limitation specified in
16 such section.

17 (B) APPLICABLE LEVEL.—The applicable
18 level specified in this subparagraph for Y1 is
19 \$250 for an individual and \$500 for a family.
20 Such levels shall be increased (rounded to the
21 nearest \$1) for each subsequent year by the an-
22 nual percentage increase in the Consumer Price
23 Index for All Urban Consumers (United States
24 city average) applicable to such year.

1 (C) USE OF COPAYMENTS.—To the extent
2 possible the Commissioner shall use copay-
3 ments, rather than coinsurance, in establishing
4 the reduced levels of cost-sharing under this
5 paragraph.

6 (2) REDUCTION IN COST-SHARING AMOUNTS.—
7 A reduction, on a sliding scale, in cost-sharing
8 amounts to such lower amounts in a manner so that,
9 as estimated by the Commissioner—

10 (A) for individuals with family income at
11 or below 133 percent of FPL the actuarial
12 value of the coverage with such reduced cost-
13 sharing amounts (and the reduced annual cost-
14 sharing limit under paragraph (1)) is equal to
15 98 percent of the full actuarial value if there
16 were no cost-sharing imposed under the plan;
17 and

18 (B) for individuals with family income at
19 400 percent of FPL the actuarial value of the
20 coverage with such reduced cost-sharing
21 amounts (and the reduced annual cost-sharing
22 limit under paragraph (1)) is equal to 70 per-
23 cent of the full actuarial value if there were no
24 cost-sharing imposed under the plan.

1 (d) DETERMINATION AND PAYMENT OF COST-SHAR-
2 ING AFFORDABILITY CREDIT.—In the case of an afford-
3 able credit eligible individual in a tier enrolled in an Ex-
4 change-participating health benefits plan offered by a
5 QHBP offering entity, the Commissioner shall provide for
6 payment to the offering entity of an amount equivalent
7 to the increased actuarial value of the benefits under the
8 plan resulting from the reduction in cost-sharing described
9 in subsection (c).

10 **SEC. 245. INCOME DETERMINATIONS.**

11 (a) IN GENERAL.—In applying this subtitle for an
12 affordability credit for an individual for a plan year, the
13 individual's income shall be the income (as defined in sec-
14 tion 242(b)) for the individual for the most recent taxable
15 year (as determined in accordance with rules of the Com-
16 missioner).

17 (b) PROGRAM INTEGRITY; INCOME VERIFICATION
18 PROCEDURES.—

19 (1) PROGRAM INTEGRITY.—The Commissioner
20 shall take such steps as may be appropriate to en-
21 sure the accuracy of determinations under this sub-
22 title.

23 (2) INCOME VERIFICATION.—

24 (A) IN GENERAL.—Upon an initial applica-
25 tion of an individual for an affordability credit

1 under this subtitle or upon an application for a
2 change in the affordability credit based upon a
3 significant change in family income described in
4 subparagraph (A)—

5 (i) the Commissioner shall request
6 from the Secretary of the Treasury the dis-
7 closure to the Commissioner of such infor-
8 mation as may be permitted to verify the
9 information contained in such application;
10 and

11 (ii) the Commissioner shall use the in-
12 formation so disclosed to verify such infor-
13 mation.

14 (B) ALTERNATIVE PROCEDURES.—The
15 Commissioner shall establish procedures for the
16 verification of income for purposes of this sub-
17 title if no income tax return is available for the
18 most recent completed tax year.

19 (c) SPECIAL RULES.—

20 (1) CHANGES IN INCOME AS A PERCENT OF
21 FPL.—In the case that an individual's income (ex-
22 pressed as a percentage of the Federal poverty level
23 for a family of the size involved) for a plan year is
24 expected (in a manner specified by the Commis-
25 sioner) to be significantly different from the income

1 (as so expressed) used under subsection (a), the
2 Commissioner shall establish rules for the substi-
3 tution of such income for the income otherwise ap-
4 plicable.

5 (2) REPORTING OF SIGNIFICANT CHANGES IN
6 INCOME.—The Commissioner shall establish a mech-
7 anism whereby an individual determined to be an af-
8 fordable credit eligible individual would be required
9 to inform the Commissioner when there is a signifi-
10 cant change in the family income of the individual
11 (expressed as a percentage of the FPL for a family
12 of the size involved). If the Commissioner receives
13 new information from an individual regarding the
14 family income of the individual, the Commissioner
15 shall provide for a redetermination of the individ-
16 ual's eligibility to be an affordable credit eligible in-
17 dividual.

18 (3) TRANSITION FOR CHIP.—In the case of a
19 child described in section **205**(d)(3)(B), during Y1
20 the Commissioner shall establish rules under which
21 the family income of the child is deemed to be no
22 greater than the family income of the child as most
23 recently determined before Y1 by the State under
24 title XXI of the Social Security Act.

1 (4) STUDY OF GEOGRAPHIC VARIATION IN AP-
2 PLICATION OF FPL.—The Commissioner shall exam-
3 ine the feasibility and implication of adjusting the
4 application of the Federal poverty level under this
5 subtitle for different geographic areas so as to re-
6 flect the variations in cost-of-living among different
7 areas within the United States. If the Commissioner
8 determines that an adjustment is feasible, the study
9 should include a methodology to make such an ad-
10 justment. Not later than the first day of Y2, the
11 Commissioner shall submit to Congress a report on
12 such study and shall include such recommendations
13 as the Commissioner determines appropriate.

14 (d) PENALTIES FOR MISREPRESENTATION.—In the
15 case of an individual intentionally misrepresents family in-
16 come or the individual fails (without regard to intent) to
17 disclose to the Commissioner a significant change in fam-
18 ily income under subsection (c)(2) in a manner that re-
19 sults in the individual becoming an affordable credit eligi-
20 ble individual when the individual is not or in the amount
21 of the affordability credit exceeding the correct amount—

22 (1) the individual is liable for repayment of the
23 amount of the improper affordability credit; ;and

24 (2) in the case of such an intentional misrepre-
25 sentation or other egregious circumstances specified

1 by the Commissioner, the Commissioner may impose
2 an additional penalty.

3 **SEC. 246. NO FEDERAL PAYMENT FOR UNDOCUMENTED**
4 **ALIENS.**

5 Nothing in this subtitle shall allow Federal payments
6 for affordability credits on behalf of individuals who are
7 not lawfully present in the United States.

8 **TITLE III—SHARED**
9 **RESPONSIBILITY**
10 **Subtitle A—Individual**
11 **Responsibility**

12 **SEC. 301. INDIVIDUAL RESPONSIBILITY.**

13 For an individual's responsibility to obtain acceptable
14 coverage, see section 59B of the Internal Revenue Code
15 of 1986 (as added by section 401 of this Act).

16 **Subtitle B—Employer**
17 **Responsibility**

18 **PART 1—HEALTH COVERAGE PARTICIPATION**
19 **REQUIREMENTS**

20 **SEC. 311. HEALTH COVERAGE PARTICIPATION REQUIRE-**
21 **MENTS.**

22 An employer meets the requirements of this section
23 if such employer does all of the following:

24 (1) OFFER OF COVERAGE.—The employer of-
25 fers each employee individual and family coverage

1 under a qualified health benefits plan (or under a
2 current group health plan (within the meaning of
3 section 102(b))) in accordance with section 312.

4 (2) CONTRIBUTION TOWARDS COVERAGE.—If
5 an employee accepts such offer of coverage, the em-
6 ployer makes timely contributions towards such cov-
7 erage in accordance with section 312.

8 (3) CONTRIBUTION IN LIEU OF COVERAGE.—
9 Beginning with Y5, if an employee declines such
10 offer but otherwise obtains coverage in an Exchange-
11 participating health benefits plan, the employer shall
12 make a timely contribution to the Health Insurance
13 Exchange in accordance with section 313.

14 **SEC. 312. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TO-**
15 **WARDS EMPLOYEE AND DEPENDENT COV-**
16 **ERAGE.**

17 (a) IN GENERAL.—An employer meets the require-
18 ments of this section with respect to an employee if the
19 following requirements are met:

20 (1) OFFERING OF COVERAGE.—The employer
21 offers the coverage described in section 311(1) either
22 through an Exchange-participating health benefits
23 plan or other than through such a plan.

24 (2) EMPLOYER REQUIRED CONTRIBUTION.—
25 The employer timely pays to the issuer of such cov-

1 erage an amount not less than the employer required
2 contribution specified in subsection (b) for such cov-
3 erage.

4 (3) PROVISION OF INFORMATION.—The em-
5 ployer provides the Health Choices Commissioner,
6 the Secretary of Labor, the Secretary of Health and
7 Human Services, and the Secretary of the Treasury,
8 as applicable, with such information as the Commis-
9 sioner may require to ascertain compliance with the
10 requirements of this section.

11 (b) REDUCTION OF EMPLOYEE PREMIUMS THROUGH
12 MINIMUM EMPLOYER CONTRIBUTION.—

13 (1) FULL-TIME EMPLOYEES.—The minimum
14 employer contribution described in this subsection
15 for coverage of a full-time employee (and, if any, the
16 employee's spouse and qualifying children (as de-
17 fined in section 152(c) of the Internal Revenue Code
18 of 1986) under a qualified health benefits plan (or
19 current group health plan) is equal to—

20 (A) in case of individual coverage, not less
21 than 72.5 percent of the lowest cost plan that
22 meets the essential benefits package; and

23 (B) in the case of family coverage which
24 includes coverage of such spouse and children,

1 not less 65 percent of the lowest cost plan that
2 meets the essential benefits package.

3 (2) APPLICABLE PREMIUM FOR EXCHANGE COV-
4 ERAGE.—In this subtitle, the amount of the applica-
5 ble premium with respect to coverage of an employee
6 under an Exchange-participating health benefits
7 plan is the reference premium amount under section
8 243(b) for individual coverage or, if elected, family
9 coverage.

10 (3) MINIMUM EMPLOYER CONTRIBUTION FOR
11 EMPLOYEES OTHER THAN FULL-TIME EMPLOY-
12 EES.—In the case of coverage for an employee who
13 is not a full-time employee, the amount of the min-
14 imum employer contribution under this subsection
15 shall be a proportion (as determined in accordance
16 with rules of the Health Choices Commissioner, the
17 Secretary of Labor, the Secretary of Health and
18 Human Services, and the Secretary of the Treasury,
19 as applicable) of the minimum employer contribution
20 under this subsection with respect to a full-time em-
21 ployee that reflects the proportion of—

22 (A) the average weekly hours of employ-
23 ment of the employee by the employer, to

1 (B) the minimum weekly hours specified
2 by the Commissioner for an employee to be a
3 full-time employee.

4 **SEC. 313. EMPLOYER CONTRIBUTIONS IN LIEU OF COV-**
5 **ERAGE.**

6 A contribution is made in accordance with this sec-
7 tion if such contribution is equal to an amount equal to
8 8 percent of the wages paid by the employer to such em-
9 ployee during the period of enrollment. Any such contribu-
10 tion—

11 (1) shall be paid to the Health Choices Com-
12 missioner for deposit into the Health Insurance Ex-
13 change Trust Fund, and

14 (2) shall not be applied against the premium of
15 the employee under the Exchange-participating
16 health benefits plan in which the employee is en-
17 rolled.

18 **SEC. 314. AUTHORITY RELATED TO IMPROPER STEERING.**

19 The Health Choices Commissioner (in coordination
20 with the Secretary of Labor, the Secretary of Health and
21 Human Services, and the Secretary of the Treasury) shall
22 have authority to set standards for determining whether
23 employers are undertaking any actions to affect the risk
24 pool within the Health Insurance Exchange by inducing
25 individuals to decline coverage under a qualified health

1 benefits plan (or current group health plan (within the
2 meaning of section 102(b)) offered by the employer and
3 instead to enroll in an Exchange-participating health ben-
4 efits plan. An employer violating such standards shall be
5 treated as not meeting the requirements of this section.

6 **PART 2—SATISFACTION OF HEALTH COVERAGE**

7 **PARTICIPATION REQUIREMENTS**

8 **SEC. 321. SATISFACTION OF HEALTH COVERAGE PARTICI-**
9 **PATION REQUIREMENTS UNDER THE EM-**
10 **PLOYEE RETIREMENT INCOME SECURITY**
11 **ACT OF 1974.**

12 (a) IN GENERAL.—Part 6 of subtitle B of title I of
13 the Employee Retirement Income Security Act of 1974 is
14 amended—

15 (1) by inserting after the heading for part 6 the
16 following:

17 **“Subpart A—Continuation Coverage and Other**
18 **Requirements”;** and

19 (2) by adding at the end the following new sub-
20 part:

1 **“Subpart B—National Health Coverage Participation**
2 **Requirements**

3 **“SEC. 611. GROUP HEALTH PLAN COVERAGE TO MEET NA-**
4 **TIONAL HEALTH COVERAGE PARTICIPATION**
5 **REQUIREMENTS.**

6 “(a) ELECTION OF EMPLOYER RESPONSIBILITY TO
7 PROVIDE HEALTH COVERAGE.—An employer may make
8 an election with the Secretary to be subject to the health
9 coverage participation requirements.

10 “(b) TIME AND MANNER.—An election under sub-
11 section (a) may be made at such time and in such form
12 and manner as the Secretary may prescribe.

13 **“SEC. 612. GROUP HEALTH PLAN COVERAGE RESULTING**
14 **FROM ELECTION.**

15 “(a) IN GENERAL.—If an employer makes an election
16 to the Secretary under section 611—

17 “(1) such election shall be treated as the estab-
18 lishment and maintenance of a group health plan (as
19 defined in section 733(a)) for purposes of this title,
20 and

21 “(2) the health coverage participation require-
22 ments shall be deemed to be included as terms and
23 conditions of such plan and, for purposes of part 5
24 of this subtitle, shall be deemed to be included in the
25 provisions of this title.

1 “(b) PERIODIC INVESTIGATIONS TO DISCOVER NON-
2 COMPLIANCE.—The Secretary shall regularly audit a rep-
3 resentative sampling of employers and group health plans
4 and conduct investigations and other activities under sec-
5 tion 504 with respect to such sampling of plans so as to
6 discover noncompliance with the health coverage participa-
7 tion requirements in connection with such plans. The Sec-
8 retary shall communicate findings of noncompliance made
9 by the Secretary under this subsection to the Secretary
10 of the Treasury and the Health Choices Commissioner.
11 The Secretary shall take such timely enforcement action
12 as appropriate to achieve compliance.

13 **“SEC. 613. HEALTH COVERAGE PARTICIPATION REQUIRE-**
14 **MENTS.**

15 “For purposes of this part, the term ‘health coverage
16 participation requirements’ means the requirements of
17 part 1 of subtitle B of title III of the [_____ Act of
18 2009] (as in effect on the date of the enactment of this
19 part).

20 **“SEC. 614. RULES FOR APPLYING REQUIREMENTS.**

21 “(a) AFFILIATED GROUPS.—In the case of any em-
22 ployer which is part of a group of employers who are treat-
23 ed as a single employer under subsection (b), (c), (m), or
24 (o) of section 414 of the Internal Revenue Code of 1986,
25 the election under section 801 shall be made by such em-

1 ployer as the Secretary may provide. Any such election,
2 once made, shall apply to all members of such group.

3 “(b) SEPARATE ELECTIONS.—Under regulations pre-
4 scribed by the Secretary, separate elections may be made
5 under section 611 with respect to—

6 “(1) separate lines of business, and

7 “(2) full-time employees and employees who are
8 not full-time employees.

9 **“SEC. 615. TERMINATION OF ELECTION IN CASES OF SUB-**
10 **STANTIAL NONCOMPLIANCE.**

11 “The Secretary may terminate the election of any em-
12 ployer under section 611 if the Secretary (in coordination
13 with the Health Choices Commissioner) determines that
14 such employer is in substantial noncompliance with the
15 health coverage participation requirements and shall refer
16 any such determination to the Secretary of the Treasury
17 as appropriate.

18 **“SEC. 616. EFFECT ON OTHER PROVISIONS.**

19 “(a) CONTINUATION OF CERTAIN GROUP HEALTH
20 PLAN REQUIREMENTS.—Nothing in this subpart shall be
21 construed to limit or affect the requirements of subpart
22 A of this part and of part 7 which are otherwise applicable
23 to a group health plan, except to the extent such require-
24 ments are inconsistent with the health coverage participa-
25 tion requirements.

1 “(b) PREEMPTION PROVISIONS.—Nothing in this
2 subpart shall be construed to limit or affect the provisions
3 of section 514.

4 **“SEC. 617. REGULATIONS.**

5 “The Secretary may promulgate such regulations as
6 may be necessary or appropriate to carry out the provi-
7 sions of this subpart, in accordance with section 324(a)
8 of the [_____ Act of 2009]. The Secretary may promul-
9 gate any interim final rules as the Secretary determines
10 are appropriate to carry out this subpart.”.

11 (b) ENFORCEMENT OF HEALTH COVERAGE PARTICI-
12 PATION REQUIREMENTS.—Section 502 of such Act (29
13 U.S.C. 1132) is amended—

14 (1) in subsection (a)(6), by striking “para-
15 graph” and all that follows through “subsection (c)”
16 and inserting “paragraph (2), (4), (5), (6), (7), (8),
17 (9), (10), or (11) of subsection (c)”; and

18 (2) in subsection (c), by redesignating the sec-
19 ond paragraph (10) as paragraph (12) and by in-
20 sserting after the first paragraph (10) the following
21 new paragraph:

22 “(11) HEALTH COVERAGE PARTICIPATION RE-
23 QUIREMENTS.—

24 “(A) CIVIL PENALTIES.—In the case of
25 any employer who fails (during any period with

1 respect to which the election under subsection
2 (a) is in effect) to satisfy the health coverage
3 participation requirements with respect to any
4 participant, the Secretary may assess a civil
5 penalty against the employer of \$100 for each
6 day in the period beginning on the date such
7 failure first occurs and ending on the date such
8 failure is corrected.

9 “(B) HEALTH COVERAGE PARTICIPATION
10 REQUIREMENTS.—For purposes of this para-
11 graph, the term ‘health coverage participation
12 requirements’ has the meaning provided in sec-
13 tion 613.

14 “(C) LIMITATIONS ON AMOUNT OF PEN-
15 ALTY.—

16 “(i) PENALTY NOT TO APPLY WHERE
17 FAILURE NOT DISCOVERED EXERCISING
18 REASONABLE DILIGENCE.—No penalty
19 shall be assessed under subparagraph (A)
20 with respect to any failure during any pe-
21 riod for which it is established to the satis-
22 faction of the Secretary that the employer
23 did not know, or exercising reasonable dili-
24 gence would have known, that such failure
25 existed.

1 “(ii) PENALTY NOT TO APPLY TO
2 FAILURES CORRECTED WITHIN 30 DAYS.—
3 No penalty shall be assessed under sub-
4 paragraph (A) with respect to any failure
5 if—

6 “(I) such failure was due to rea-
7 sonable cause and not to willful ne-
8 glect, and

9 “(II) such failure is corrected
10 during the 30-day period beginning on
11 the 1st date that the employer knew,
12 or exercising reasonable diligence
13 would have known, that such failure
14 existed.

15 “(iii) OVERALL LIMITATION FOR UN-
16 INTENTIONAL FAILURES.—In the case of
17 failures which are due to reasonable cause
18 and not to willful neglect, the penalty as-
19 sessed under subparagraph (A) for failures
20 during any 1-year period shall not exceed
21 the amount equal to the lesser of—

22 “(I) 10 percent of the aggregate
23 amount paid or incurred by the em-
24 ployer (or predecessor employer) dur-

1 ing the preceding 1-year period for
2 group health plans, or

3 “(II) \$500,000.

4 “(D) ADVANCE NOTIFICATION OF FAILURE
5 PRIOR TO ASSESSMENT.—Before a reasonable
6 time prior to the assessment of any penalty
7 under this paragraph with respect to any failure
8 by an employer, the Secretary shall inform the
9 employer in writing of such failure and shall
10 provide the employer information regarding ef-
11 forts and procedures which may be undertaken
12 by the employer to correct such failure.

13 “(E) COORDINATION WITH EXCISE TAX.—
14 Under regulations prescribed in accordance
15 with section 324 of the [_____ Act of
16 2009], the Secretary and the Secretary of the
17 Treasury shall coordinate the assessment of
18 penalties under this section in connection with
19 failures to satisfy health coverage participation
20 requirements with the imposition of excise taxes
21 on such failures under section 4980H(b) of the
22 Internal Revenue Code of 1986 so as to avoid
23 duplication of penalties with respect to such
24 failures.

1 “(F) DEPOSIT OF PENALTY COLLECTED.—
2 Any amount of penalty collected under this
3 paragraph shall be deposited as miscellaneous
4 receipts in the Treasury of the United States.”.

5 (c) CLERICAL AMENDMENTS.—The table of contents
6 in section 1 of such Act is amended—

7 (1) by inserting after the item relating to the
8 heading for part 6 the following new item:

 “Subpart A—Continuation Coverage and Other Requirements”; and

9 (2) by inserting after the item relating to sec-
10 tion 609 the following new items:

 “SUBPART B—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS

 “Sec. 611. Group health plan coverage to meet national health coverage partici-
 pation requirements.

 “Sec. 612. Group health plan coverage resulting from election.

 “Sec. 613. Health coverage participation requirements.

 “Sec. 614. Rules for applying requirements.

 “Sec. 615. Termination of election in cases of substantial noncompliance.

 “Sec. 616. Effect on other provisions.

 “Sec. 617. Regulations.”.

11 (d) EFFECTIVE DATE.—The amendments made by
12 this subsection shall apply to periods beginning after De-
13 cember 31, 2012.

14 **SEC. 322. SATISFACTION OF HEALTH COVERAGE PARTICI-**
15 **PATION REQUIREMENTS UNDER THE INTER-**
16 **NAL REVENUE CODE OF 1986.**

17 (a) FAILURE TO ELECT, OR SUBSTANTIALLY COM-
18 PLY WITH, HEALTH COVERAGE PARTICIPATION RE-
19 QUIREMENTS.—For employment tax on employers who fail
20 to elect, or substantially comply with, the health coverage

1 participation requirements described in part 1, see section
2 3111(c) of the Internal Revenue Code of 1986 (as added
3 by section 412 of this Act).

4 (b) OTHER FAILURES.—For excise tax on other fail-
5 ures of electing employers to comply with such require-
6 ments, see section 4980H of the Internal Revenue Code
7 of 1986 (as added by section 411 of this Act).

8 **SEC. 323. SATISFACTION OF HEALTH COVERAGE PARTICI-
9 PATION REQUIREMENTS UNDER THE PUBLIC
10 HEALTH SERVICE ACT.**

11 (a) IN GENERAL.—Part C of title XXVII of the Pub-
12 lic Health Service Act is amended by adding at the end
13 the following new section:

14 **“SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION
15 REQUIREMENTS.**

16 “(a) GROUP HEALTH PLAN COVERAGE TO MEET
17 NATIONAL HEALTH COVERAGE PARTICIPATION REQUIRE-
18 MENTS.—

19 “(1) ELECTION OF EMPLOYER RESPONSIBILITY
20 TO PROVIDE HEALTH COVERAGE.—An employer may
21 make an election with the Secretary to be subject to
22 the health coverage participation requirements.

23 “(2) TIME AND MANNER.—An election under
24 paragraph (1) may be made at such time and in

1 such form and manner as the Secretary may pre-
2 scribe.

3 “(b) GROUP HEALTH PLAN COVERAGE RESULTING
4 FROM ELECTION.—

5 “(1) IN GENERAL.—If an employer makes an
6 election to the Secretary under subsection (a)—

7 “(A) such election shall be treated as the
8 establishment and maintenance of a group
9 health plan for purposes of this title, and

10 “(B) the health coverage participation re-
11 quirements shall be deemed to be included as
12 terms and conditions of such plan and, for pur-
13 poses of subsection (g), shall be deemed to be
14 included in the provisions of this section.

15 “(2) PERIODIC INVESTIGATIONS TO DETERMINE
16 COMPLIANCE.—The Secretary shall regularly audit a
17 representative sampling of employers and group
18 health plans and conduct investigations and other
19 activities with respect to such sampling of plans so
20 as to discover noncompliance with the health cov-
21 erage participation requirements in connection with
22 such plans. The Secretary shall communicate find-
23 ings of noncompliance made by the Secretary under
24 this subsection to the Secretary of the Treasury and
25 the Health Choices Commissioner. The Secretary

1 shall take such timely enforcement action as appro-
2 priate to achieve compliance.

3 “(c) HEALTH COVERAGE PARTICIPATION REQUIRE-
4 MENTS.—For purposes of this section, the term ‘health
5 coverage participation requirements’ means the require-
6 ments of part 1 of subtitle B of title III of the [_____
7 Act of 2009] (as in effect on the date of the enactment
8 of this section).

9 “(d) SEPARATE ELECTIONS.—Under regulations pre-
10 scribed by the Secretary, separate elections may be made
11 under subsection (a) with respect to full-time employees
12 and employees who are not full-time employees.

13 “(e) TERMINATION OF ELECTION IN CASES OF SUB-
14 STANTIAL NONCOMPLIANCE.—The Secretary may termi-
15 nate the election of any employer under subsection (a) if
16 the Secretary (in coordination with the Health Choices
17 Commissioner) determines that such employer is in sub-
18 stantial noncompliance with the health coverage participa-
19 tion requirements and shall refer any such determination
20 to the Secretary of the Treasury as appropriate.

21 “(f) EFFECT ON OTHER PROVISIONS.—Nothing in
22 this section shall be construed to limit or affect the re-
23 quirements of subparts 1 and 2 of part A of this title and
24 title XXII otherwise applicable to a group health plan, ex-

1 cept to the extent such requirements are inconsistent with
2 the health coverage participation requirements.

3 “(g) ENFORCEMENT OF HEALTH COVERAGE PAR-
4 TICIPATION REQUIREMENTS.—

5 “(1) CIVIL PENALTIES.—In the case of any em-
6 ployer who fails (during any period with respect to
7 which the election under subsection (a) is in effect)
8 to satisfy the health coverage participation require-
9 ments with respect to any participant, the Secretary
10 may assess a civil penalty against the employer of
11 \$100 for each day in the period beginning on the
12 date such failure first occurs and ending on the date
13 such failure is corrected.

14 “(2) LIMITATIONS ON AMOUNT OF PENALTY.—

15 “(A) PENALTY NOT TO APPLY WHERE
16 FAILURE NOT DISCOVERED EXERCISING REA-
17 SONABLE DILIGENCE.—No penalty shall be as-
18 sessed under paragraph (1) with respect to any
19 failure during any period for which it is estab-
20 lished to the satisfaction of the Secretary that
21 the employer did not know, or exercising rea-
22 sonable diligence would have known, that such
23 failure existed.

24 “(B) PENALTY NOT TO APPLY TO FAIL-
25 URES CORRECTED WITHIN 30 DAYS.—No pen-

1 alty shall be assessed under paragraph (1) with
2 respect to any failure if—

3 “(i) such failure was due to reason-
4 able cause and not to willful neglect, and

5 “(ii) such failure is corrected during
6 the 30-day period beginning on the 1st
7 date that the employer knew, or exercising
8 reasonable diligence would have known,
9 that such failure existed.

10 “(C) OVERALL LIMITATION FOR UNINTEN-
11 TIONAL FAILURES.—In the case of failures
12 which are due to reasonable cause and not to
13 willful neglect, the penalty assessed under para-
14 graph (1) for failures during any 1-year period
15 shall not exceed the amount equal to the lesser
16 of—

17 “(i) 10 percent of the aggregate
18 amount paid or incurred by the employer
19 (or predecessor employer) during the pre-
20 ceding taxable year for group health plans,
21 or

22 “(ii) \$500,000.

23 “(3) ADVANCE NOTIFICATION OF FAILURE
24 PRIOR TO ASSESSMENT.—Before a reasonable time
25 prior to the assessment of any penalty under this

1 paragraph with respect to any failure by an em-
2 ployer, the Secretary shall inform the employer in
3 writing of such failure and shall provide the em-
4 ployer information regarding efforts and procedures
5 which may be undertaken by the employer to correct
6 such failure.

7 “(4) ACTIONS TO ENFORCE ASSESSMENTS.—
8 The Secretary may bring a civil action in any Dis-
9 trict Court of the United States to collect any civil
10 penalty under this subsection (a).

11 “(5) COORDINATION WITH EXCISE TAX.—
12 Under regulations prescribed in accordance with sec-
13 tion 324 of the [_____ Act of 2009], the Sec-
14 retary and the Secretary of the Treasury shall co-
15 ordinate the assessment of penalties under this sec-
16 tion in connection with failures to satisfy health cov-
17 erage participation requirements with the imposition
18 of excise taxes on such failures under section
19 4980H(b) of the Internal Revenue Code of 1986 so
20 as to avoid duplication of penalties with respect to
21 such failures.

22 “(6) DEPOSIT OF PENALTY COLLECTED.—Any
23 amount of penalty collected under this subsection
24 shall be deposited as miscellaneous receipts in the
25 Treasury of the United States.

1 “(h) REGULATIONS.—The Secretary may promulgate
2 such regulations as may be necessary or appropriate to
3 carry out the provisions of this section, in accordance with
4 section 324(a) of the [_____ Act of 2009]. The
5 Secretary may promulgate any interim final rules as the
6 Secretary determines are appropriate to carry out this sec-
7 tion.”.

8 (b) EFFECTIVE DATE.—The amendments made by
9 subsection (a) shall apply to periods beginning after De-
10 cember 31, 2012.

11 **SEC. 324. ADDITIONAL RULES RELATING TO HEALTH COV-
12 ERAGE PARTICIPATION REQUIREMENTS.**

13 (a) ASSURING COORDINATION.—The officers con-
14 sisting of the Secretary of Labor, the Secretary of the
15 Treasury, the Secretary of Health and Human Services,
16 and the Health Choices Commissioner shall ensure,
17 through the execution of an interagency memorandum of
18 understanding among such officers, that—

19 (1) regulations, rulings, and interpretations
20 issued by such officers relating to the same matter
21 over which two or more of such officers have respon-
22 sibility under subpart B of part 6 of subtitle B of
23 title I of the Employee Retirement Income Security
24 Act of 1974, section 4980H of the Internal Revenue
25 Code of 1986, and section 2793 of the Public Health

1 Service Act are administered so as to have the same
2 effect at all times; and

3 (2) coordination of policies relating to enforcing
4 the same requirements through such officers in
5 order to have a coordinated enforcement strategy
6 that avoids duplication of enforcement efforts and
7 assigns priorities in enforcement.

8 (b) **MULTIEMPLOYER PLANS.**—In the case of a group
9 health plan that is a multiemployer plan (as defined in
10 section 3(37) of the Employee Retirement Income Secu-
11 rity Act of 1974), the regulations prescribed in accordance
12 with subsection (a) by the officers referred to in subsection
13 (a) shall provide for the application of the health coverage
14 participation requirements to the plan sponsor and con-
15 tributing sponsors of such plan.

16 **TITLE IV—AMENDMENTS TO IN-**
17 **TERNAL REVENUE CODE OF**
18 **1986**

19 **Subtitle A—Shared Responsibility**

20 **PART 1—INDIVIDUAL RESPONSIBILITY**

21 **SEC. 401. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE**
22 **HEALTH CARE COVERAGE.**

23 (a) **IN GENERAL.**—Subchapter A of chapter 1 of the
24 Internal Revenue Code of 1986 is amended by adding at
25 the end the following new part:

1 **“PART VIII—TAX ON INDIVIDUALS WITHOUT**
2 **ACCEPTABLE HEALTH CARE COVERAGE**

“Sec. 59B. Tax on individuals without acceptable health care coverage.

3 **“SEC. 59B. TAX ON INDIVIDUALS WITHOUT ACCEPTABLE**
4 **HEALTH CARE COVERAGE.**

5 “(a) TAX IMPOSED.—In the case of any individual
6 who does not meet the requirements of subsection (e) at
7 any time during the taxable year, there is hereby imposed
8 a tax equal to 2 percent of the excess of—

9 “(1) the taxpayer’s adjusted gross income for
10 the taxable year, over

11 “(2) the threshold amount.

12 “(b) THRESHOLD AMOUNT.—For purposes of sub-
13 section (a), the term ‘threshold amount’ means the
14 amount applicable to the taxpayer under section
15 6012(a)(1).

16 “(c) LIMITATIONS.—

17 “(1) TAX LIMITED TO AVERAGE PREMIUM.—

18 “(A) IN GENERAL.—The tax imposed
19 under subsection (a) with respect to any tax-
20 payer for any taxable year shall not exceed the
21 applicable national average premium.

22 “(B) APPLICABLE NATIONAL AVERAGE
23 PREMIUM.—

24 “(i) IN GENERAL.—For purposes of
25 subparagraph (A), the ‘applicable national

1 average premium’ means the average pre-
2 mium (as determined by the Secretary, in
3 coordination with the Health Choices Com-
4 missioner) for self-only coverage under a
5 basic plan which is offered in a Health In-
6 surance Exchange.

7 “(ii) FAILURE TO PROVIDE COVERAGE
8 FOR MORE THAN ONE INDIVIDUAL.—In the
9 case of any taxpayer who fails to meet the
10 requirements of subsection (e) with respect
11 to more than one individual during the tax-
12 able year, clause (i) shall be applied by
13 substituting ‘family coverage’ for ‘self-only
14 coverage’.

15 “(2) PRORATION FOR PART YEAR FAILURES.—
16 The tax imposed under subsection (a) with respect
17 to any taxpayer for any taxable year shall not exceed
18 the amount which bears the same ratio to the
19 amount of tax so imposed (determined without re-
20 gard to this paragraph and after application of para-
21 graph (1)) as—

22 “(A) the aggregate periods during such
23 taxable year for which such individual failed to
24 meet the requirements of subsection (e), bears
25 to

1 “(B) the entire taxable year.

2 “(d) EXCEPTIONS.—

3 “(1) DEPENDENTS.—Subsection (a) shall not
4 apply to any individual for any taxable year if a de-
5 duction is allowable under section 151 with respect
6 to such individual to another taxpayer for any tax-
7 able year beginning in the same calendar year as
8 such taxable year.

9 “(2) NONRESIDENT ALIENS.—Subsection (a)
10 shall not apply to any individual who is a non-
11 resident alien.

12 “(3) INDIVIDUALS RESIDING OUTSIDE UNITED
13 STATES.—Any qualified individual (as defined in
14 section 911(d)) (and any qualifying child residing
15 with such individual) shall be treated for purposes of
16 this section as covered by acceptable coverage during
17 the period described in subparagraph (A) or (B) of
18 section 911(d)(1), whichever is applicable.

19 “(4) RELIGIOUS CONSCIENCE EXEMPTION.—

20 “(A) IN GENERAL.—Subsection (a) shall
21 not apply to any individual (and any qualifying
22 child residing with such individual) for any pe-
23 riod if such individual has in effect an exemp-
24 tion which certifies that such individual is a
25 member of a recognized religious sect or divi-

1 sion thereof described in section 1402(g)(1) and
2 an adherent of established tenets or teachings
3 of such sect or division as described in such sec-
4 tion.

5 “(B) EXEMPTION.—An application for the
6 exemption described in subparagraph (A) shall
7 be filed with the Secretary at such time and in
8 such form and manner as the Secretary may
9 prescribe. Any such exemption granted by the
10 Secretary shall be effective for such period as
11 the Secretary determines appropriate.

12 “(e) ACCEPTABLE COVERAGE REQUIREMENT.—

13 “(1) IN GENERAL.—The requirements of this
14 subsection are met with respect to any individual for
15 any period if such individual (and each qualifying
16 child of such individual) is covered by acceptable
17 coverage at all times during such period.

18 “(2) ACCEPTABLE COVERAGE.—For purposes
19 of this section, the term ‘acceptable coverage’ means
20 any of the following:

21 “(A) QUALIFIED HEALTH BENEFITS PLAN
22 COVERAGE.—Coverage under a qualified health
23 benefits plan (as defined in section 100(c) of
24 the [____ Act of 2009]).

1 “(B) GRANDFATHERED HEALTH INSUR-
2 ANCE COVERAGE; COVERAGE UNDER GRAND-
3 FATHERED GROUP HEALTH PLAN.—Coverage
4 under a grandfathered health insurance cov-
5 erage (as defined in subsection (a) of section
6 102 of the [____ Act of 2009]) or under a cur-
7 rent group health plan (as defined in subsection
8 (b) of such section).

9 “(C) MEDICARE.—Coverage under part A
10 of title XVIII of the Social Security Act.

11 “(D) MEDICAID.—Coverage for medical as-
12 sistance under title XIX of the Social Security
13 Act.

14 “(E) MEMBERS OF THE ARMED FORCES
15 AND DEPENDENTS (INCLUDING TRICARE).—
16 Coverage under chapter 55 of title 10, United
17 States Code, including similar coverage fur-
18 nished under section 1781 of title 38 of such
19 Code.

20 “(F) VA.—Coverage under the veteran’s
21 health care program under chapter 17 of title
22 38, United States Code, as specified by the Sec-
23 retary in coordination with the Health Choices
24 Commissioner.

1 “(G) OTHER COVERAGE.—Such other
2 health benefits coverage as the Secretary, in co-
3 ordination with the Health Choices Commis-
4 sioner, recognizes for purposes of this sub-
5 section.

6 “(f) OTHER DEFINITIONS AND SPECIAL RULES.—

7 “(1) QUALIFYING CHILD.—For purposes of this
8 section, the term ‘qualifying child’ has the meaning
9 given such term by section 152(c).

10 “(2) BASIC PLAN.—For purposes of this sec-
11 tion, the term ‘basic plan’ has the meaning given
12 such term under section 100(c) of the [____ Act of
13 2009].

14 “(3) HEALTH INSURANCE EXCHANGE.—For
15 purposes of this section, the term ‘Health Insurance
16 Exchange’ has the meaning given such term under
17 section 100(c) of the [____ Act of 2009], including
18 any State-based health insurance exchange approved
19 for operation under section 208 of such Act.

20 “(4) FAMILY COVERAGE.—For purposes of this
21 section, the term ‘family coverage’ means any cov-
22 erage other than self-only coverage.

23 “(5) NOT TREATED AS TAX IMPOSED BY THIS
24 CHAPTER FOR CERTAIN PURPOSES.—The tax im-
25 posed under this part shall not be treated as tax im-

1 posed by this chapter for purposes of determining
2 the amount of any credit under this chapter or for
3 purposes of section 55.

4 “(g) REGULATIONS.—The Secretary shall prescribe
5 such regulations or other guidance as may be necessary
6 or appropriate to carry out the purposes of this section,
7 including regulations or other guidance (developed in co-
8 ordination with the Health Choices Commissioner) which
9 provide—

10 “(1) exemption from the tax imposed under
11 subsection (a) in cases of de minimis lapses of ac-
12 ceptable coverage, and

13 “(2) a process for applying for a waiver of the
14 application of subsection (a) in cases of hardship.”.

15 (b) INFORMATION REPORTING.—

16 (1) IN GENERAL.—Subpart B of part III of
17 subchapter A of chapter 61 of such Code is amended
18 by inserting after section 6050W the following new
19 section:

20 **“SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE**
21 **COVERAGE.**

22 “(a) REQUIREMENT OF REPORTING.—Every person
23 who provides acceptable coverage (as defined in section
24 59B(e)) to any individual during any calendar year shall,
25 at such time as the Secretary may prescribe, make the

1 return described in subsection (b) with respect to such in-
2 dividual.

3 “(b) FORM AND MANNER OF RETURNS.—A return
4 is described in this subsection if such return—

5 “(1) is in such form as the Secretary may pre-
6 scribe, and

7 “(2) contains—

8 “(A) the name, address, and TIN of the
9 primary insured and the name of each other in-
10 dividual obtaining coverage under the policy,

11 “(B) the period for which each such indi-
12 vidual was provided with the coverage referred
13 to in subsection (a), and

14 “(C) such other information as the Sec-
15 retary may require.

16 “(c) STATEMENTS TO BE FURNISHED TO INDIVID-
17 UALS WITH RESPECT TO WHOM INFORMATION IS RE-
18 QUIRED.—Every person required to make a return under
19 subsection (a) shall furnish to each primary insured whose
20 name is required to be set forth in such return a written
21 statement showing—

22 “(1) the name and address of the person re-
23 quired to make such return and the phone number
24 of the information contact for such person, and

1 “(2) the information required to be shown on
2 the return with respect to such individual.

3 The written statement required under the preceding sen-
4 tence shall be furnished on or before January 31 of the
5 year following the calendar year for which the return
6 under subsection (a) is required to be made.

7 “(d) COVERAGE PROVIDED BY GOVERNMENTAL
8 UNITS.—In the case of coverage provided by any govern-
9 mental unit or any agency or instrumentality thereof, the
10 officer or employee who enters into the agreement to pro-
11 vide such coverage (or the person appropriately designated
12 for purposes of this section) shall make the returns and
13 statements required by this section.”.

14 (2) PENALTY FOR FAILURE TO FILE.—

15 (A) RETURN.—Subparagraph (B) of sec-
16 tion 6724(d)(1) of such Code is amended by
17 striking “or” at the end of clause (xxii), by
18 striking “and” at the end of clause (xxiii) and
19 inserting “or”, and by adding at the end the
20 following new clause:

21 “(xxiv) section 6050X (relating to re-
22 turns relating to health insurance cov-
23 erage), and”.

24 (B) STATEMENT.—Paragraph (2) of sec-
25 tion 6724(d) of such Code is amended by strik-

1 ing “or” at the end of subparagraph (EE), by
2 striking the period at the end of subparagraph
3 (FF) and inserting “, or”, and by inserting
4 after subparagraph (FF) the following new sub-
5 paragraph:

6 “(GG) section 6050X (relating to returns
7 relating to health insurance coverage).”.

8 (c) RETURN REQUIREMENT.—Subsection (a) of sec-
9 tion 6012 of such Code is amended by inserting after
10 paragraph (9) the following new paragraph:

11 “(10) Every individual to whom section 59B(a)
12 applies and who fails to meet the requirements of
13 section 59B(e) with respect to such individual or any
14 qualifying child (as defined in section 152(c)) of
15 such individual.”.

16 (d) CLERICAL AMENDMENTS.—

17 (1) The table of parts for subchapter A of chap-
18 ter 1 of the Internal Revenue Code of 1986 is
19 amended by adding at the end the following new
20 item:

“PART VIII. REQUIREMENT OF HEALTH INSURANCE COVERAGE FOR
INDIVIDUALS.”.

21 (2) The table of sections for subpart B of part
22 III of subchapter A of chapter 61 is amended by
23 adding at the end the following new item:

“Sec. 6050X. Returns relating to health insurance coverage.”.

1 (e) TAX NOT APPLICABLE TO POSSESSIONS.—In the
2 case of a possession of the United States with a mirror
3 code tax system, such system shall be administered with-
4 out regard to the amendments made by this section. For
5 purposes of the preceding sentence, the term “mirror code
6 tax system” means, with respect to any possession of the
7 United States, the income tax system of such possession
8 if the income tax liability of the residents of such posses-
9 sion under such system is determined by reference to the
10 income tax laws of the United States as if such possession
11 were the United States.

12 (f) SECTION 15 NOT TO APPLY.—The amendment
13 made by subsection (a) shall not be treated as a change
14 in a rate of tax for purposes of section 15 of the Internal
15 Revenue Code of 1986.

16 (g) EFFECTIVE DATE.—

17 (1) IN GENERAL.—The amendments made by
18 this section shall apply to taxable years beginning
19 after December 31, 2012.

20 (2) RETURNS.—The amendments made by sub-
21 section (b) shall apply to calendar years beginning
22 after December 31, 2012.

1 **PART 2—EMPLOYER RESPONSIBILITY**

2 **SEC. 411. ELECTION TO SATISFY HEALTH COVERAGE PAR-**
3 **TICIPATION REQUIREMENTS.**

4 (a) IN GENERAL.—Chapter 43 of the Internal Rev-
5 enue Code of 1986 is amended by adding at the end the
6 following new section:

7 **“SEC. 4980H. ELECTION WITH RESPECT TO HEALTH COV-**
8 **ERAGE PARTICIPATION REQUIREMENTS.**

9 “(a) ELECTION OF EMPLOYER RESPONSIBILITY TO
10 PROVIDE HEALTH COVERAGE.—

11 “(1) IN GENERAL.—Subsection (b) shall apply
12 to any employer with respect to whom an election
13 under paragraph (2) is in effect.

14 “(2) TIME AND MANNER.—An employer may
15 make an election under this paragraph at such time
16 and in such form and manner as the Secretary may
17 prescribe.

18 “(3) AFFILIATED GROUPS.—In the case of any
19 employer which is part of a group of employers who
20 are treated as a single employer under subsection
21 (b), (c), (m), or (o) of section 414, the election
22 under paragraph (2) shall be made by such person
23 as the Secretary may provide. Any such election,
24 once made, shall apply to all members of such
25 group.

1 “(4) SEPARATE ELECTIONS.—Under regula-
2 tions prescribed by the Secretary, separate elections
3 may be made under paragraph (2) with respect to—

4 “(A) separate lines of business, and

5 “(B) full-time employees and employees
6 who are not full-time employees.

7 “(5) TERMINATION OF ELECTION IN CASES OF
8 SUBSTANTIAL NONCOMPLIANCE.—The Secretary
9 may terminate the election of any employer under
10 paragraph (2) if the Secretary (in coordination with
11 the Health Choices Commissioner) determines that
12 such employer is in substantial noncompliance with
13 the health coverage participation requirements.

14 “(b) EXCISE TAX WITH RESPECT TO FAILURE TO
15 MEET HEALTH COVERAGE PARTICIPATION REQUIRE-
16 MENTS.—

17 “(1) IN GENERAL.—In the case of any employer
18 who fails (during any period with respect to which
19 the election under subsection (a) is in effect) to sat-
20 isfy the health coverage participation requirements
21 with respect to any employee to whom such election
22 applies, there is hereby imposed on each such failure
23 with respect to each such employee a tax of \$100 for
24 each day in the period beginning on the date such

1 failure first occurs and ending on the date such fail-
2 ure is corrected.

3 “(2) LIMITATIONS ON AMOUNT OF TAX.—

4 “(A) TAX NOT TO APPLY WHERE FAILURE
5 NOT DISCOVERED EXERCISING REASONABLE
6 DILIGENCE.—No tax shall be imposed by para-
7 graph (1) on any failure during any period for
8 which it is established to the satisfaction of the
9 Secretary that the employer did not know, or
10 exercising reasonable diligence would have
11 known, that such failure existed.

12 “(B) TAX NOT TO APPLY TO FAILURES
13 CORRECTED WITHIN 30 DAYS.—No tax shall be
14 imposed by paragraph (1) on any failure if—

15 “(i) such failure was due to reason-
16 able cause and not to willful neglect, and

17 “(ii) such failure is corrected during
18 the 30-day period beginning on the 1st
19 date that the employer knew, or exercising
20 reasonable diligence would have known,
21 that such failure existed.

22 “(C) OVERALL LIMITATION FOR UNINTEN-
23 TIONAL FAILURES.—In the case of failures
24 which are due to reasonable cause and not to
25 willful neglect, the tax imposed by subsection

1 (a) for failures during the taxable year of the
2 employer shall not exceed the amount equal to
3 the lesser of—

4 “(i) 10 percent of the aggregate
5 amount paid or incurred by the employer
6 (or predecessor employer) during the pre-
7 ceding taxable year for group health plans,
8 or

9 “(ii) \$500,000.

10 “(c) HEALTH COVERAGE PARTICIPATION REQUIRE-
11 MENTS.—For purposes of this section, the term ‘health
12 coverage participation requirements’ means the require-
13 ments of part I of subtitle B of title III of the [____ Act
14 of 2009] (as in effect on the date of the enactment of
15 this section).”.

16 (b) CLERICAL AMENDMENT.—The table of sections
17 for chapter 43 of such Code is amended by adding at the
18 end the following new item:

“Sec. 4980H. Election to satisfy health coverage participation requirements.”.

19 (c) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to periods beginning after Decem-
21 ber 31, 2012.

22 **SEC. 412. RESPONSIBILITIES OF NONELECTING EMPLOY-**
23 **ERS.**

24 (a) IN GENERAL.—Section 3111 of the Internal Rev-
25 enue Code of 1986 is amended by redesignating subsection

1 (c) as subsection (d) and by inserting after subsection (b)
2 the following new subsection:

3 “(c) EMPLOYERS ELECTING TO NOT PROVIDE
4 HEALTH BENEFITS.—

5 “(1) IN GENERAL.—In addition to other taxes,
6 there is hereby imposed on every nonelecting em-
7 ployer an excise tax, with respect to having individ-
8 uals in his employ, equal to 8 percent of the wages
9 (as defined in section 3121(a)) paid by him with re-
10 spect to employment (as defined in section 3121(b)).

11 “(2) NONELECTING EMPLOYER.—For purposes
12 of paragraph (1), the term ‘nonelecting employer’
13 means any employer for any period with respect to
14 which such employer does not have an election under
15 section 4980H(a) in effect.

16 “(3) SPECIAL RULE FOR SEPARATE ELEC-
17 TIONS.—In the case of an employer who makes a
18 separate election described in section 4980H(a)(4)
19 for any period, subsection (a) shall be applied for
20 such period by taking into account only the wages
21 paid to employees who are not subject to such elec-
22 tion.

23 “(4) EXCEPTION FOR SMALL EMPLOYERS.—
24 *【There will be an exemption for certain small busi-*
25 *nesses】*”.

1 (b) DEFINITIONS.—Section 3121 of such Code is
2 amended by adding at the end the following new sub-
3 section:

4 “(aa) SPECIAL RULES FOR TAX ON EMPLOYERS
5 ELECTING NOT TO PROVIDE HEALTH BENEFITS.—For
6 purposes of section 3111(c)—

7 “(1) Paragraph (1) of subsection (a) shall not
8 apply.

9 “(2) Paragraphs (1), (5), (9), and (19) of sub-
10 section (b) shall not apply.

11 “(3) Paragraph (7) of subsection (b) shall apply
12 by treating all services as not covered by the retire-
13 ment systems referred to in subparagraphs (C) and
14 (F) thereof.

15 “(4) Subsection (e) shall not apply and the
16 term ‘State’ shall include the District of Columbia.”.

17 (c) CONFORMING AMENDMENT.—Subsection (d) of
18 section 3111 of such Code, as redesignated by this section,
19 is amended by striking “this section” and inserting “sub-
20 sections (a) and (b)”.

21 (d) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to periods beginning after Decem-
23 ber 31, 2012.

1 **Subtitle B—Credit for Small Busi-**
2 **ness Employee Health Coverage**
3 **Expenses**

4 **SEC. 421. CREDIT FOR SMALL BUSINESS EMPLOYEE**
5 **HEALTH COVERAGE EXPENSES.**

6 (a) IN GENERAL.—Subpart D of part IV of sub-
7 chapter A of chapter 1 of the Internal Revenue Code of
8 1986 (relating to business-related credits) is amended by
9 adding at the end the following new section:

10 **“SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COV-**
11 **ERAGE CREDIT.**

12 “(a) IN GENERAL.—For purposes of section 38, in
13 the case of a qualified small employer, the small business
14 employee health coverage credit determined under this sec-
15 tion for the taxable year is an amount equal to the applica-
16 ble percentage of the qualified employee health coverage
17 expenses of such employer for such taxable year.

18 “(b) APPLICABLE PERCENTAGE.—

19 “(1) IN GENERAL.—For purposes of this sec-
20 tion, the applicable percentage is 50 percent.

21 “(2) PHASEOUT BASED ON AVERAGE COM-
22 PENSATION OF EMPLOYEES.—In the case of an em-
23 ployer whose average annual employee compensation
24 for the taxable year exceeds \$20,000, the percentage
25 specified in paragraph (1) shall be reduced by a

1 number of percentage points which bears the same
2 ratio to 50 as such excess bears to \$20,000.

3 “(c) LIMITATIONS.—

4 “(1) PHASEOUT BASED ON EMPLOYER SIZE.—

5 In the case of an employer who employs more than
6 10 qualified employees during the taxable year, the
7 credit determined under subsection (a) shall be re-
8 duced by an amount which bears the same ratio to
9 the amount of such credit (determined without re-
10 gard to this paragraph and after the application of
11 the other provisions of this section) as—

12 “(A) the excess of—

13 “(i) the number of qualified employees
14 employed by the employer during the tax-
15 able year, over

16 “(ii) 10, bears to

17 “(B) 15.

18 “(2) CREDIT NOT ALLOWED WITH RESPECT TO
19 CERTAIN HIGHLY COMPENSATED EMPLOYEES.—No
20 credit shall be allowed under subsection (a) with re-
21 spect to qualified employee health coverage expenses
22 paid or incurred with respect to any employee for
23 any taxable year if the aggregate compensation paid
24 by the employer to such employee during such tax-
25 able year exceeds \$125,000.

1 “(d) QUALIFIED EMPLOYEE HEALTH COVERAGE EX-
2 PENSES.—For purposes of this section—

3 “(1) IN GENERAL.—The term ‘qualified em-
4 ployee health coverage expenses’ means, with respect
5 to any employer for any taxable year, the aggregate
6 amount paid or incurred by such employer during
7 such taxable year for coverage of any qualified em-
8 ployee of the employer (including any family cov-
9 erage which covers such employee) under qualified
10 health coverage.

11 “(2) QUALIFIED HEALTH COVERAGE.—The
12 term ‘qualified health coverage’ means acceptable
13 coverage (as defined in section 59B(e)) which—

14 “(A) is provided pursuant to an election
15 under section 4980H(a), and

16 “(B) satisfies the requirements referred to
17 in section 4980H(c).

18 “(e) OTHER DEFINITIONS.—For purposes of this
19 section—

20 “(1) QUALIFIED SMALL EMPLOYER.—For pur-
21 poses of this section, the term ‘qualified small em-
22 ployer’ means any employer for any taxable year
23 if—

1 “(A) the number of qualified employees
2 employed by such employer during the taxable
3 year does not exceed 25, and

4 “(B) the average annual employee com-
5 pensation of such employer for such taxable
6 year does not exceed the sum of the dollar
7 amounts in effect under subsection (b)(2).

8 “(2) QUALIFIED EMPLOYEE.—The term ‘quali-
9 fied employee’ means any employee of an employer
10 for any taxable year of the employer if such em-
11 ployee received at least \$5,000 of compensation from
12 such employer during such taxable year.

13 “(3) AVERAGE ANNUAL EMPLOYEE COMPENSA-
14 TION.—The term ‘average annual employee com-
15 pensation’ means, with respect to any employer for
16 any taxable year, the average amount of compensa-
17 tion paid by such employer to qualified employees of
18 such employer during such taxable year.

19 “(4) COMPENSATION.—The term ‘compensa-
20 tion’ has the meaning given such term in section
21 408(p)(6)(A).

22 “(5) FAMILY COVERAGE.—The term ‘family
23 coverage’ means any coverage other than self-only
24 coverage.

1 “(f) SPECIAL RULES.—For purposes of this sec-
2 tion—

3 “(1) SPECIAL RULE FOR PARTNERSHIPS AND
4 SELF-EMPLOYED.—In the case of a partnership (or
5 a trade or business carried on by an individual)
6 which has one or more qualified employees (deter-
7 mined without regard to this paragraph) with re-
8 spect to whom the election under 4980H(a) applies,
9 each partner (or, in the case of a trade or business
10 carried on by an individual, such individual) shall be
11 treated as an employee.

12 “(2) AGGREGATION RULE.—All persons treated
13 as a single employer under subsection (b), (c), (m),
14 or (o) of section 414 shall be treated as 1 employer.

15 “(3) DENIAL OF DOUBLE BENEFIT.—Any de-
16 duction otherwise allowable with respect to amounts
17 paid or incurred for health insurance coverage to
18 which subsection (a) applies shall be reduced by the
19 amount of the credit determined under this section.

20 “(4) INFLATION ADJUSTMENT.—In the case of
21 any taxable year beginning after 2013, each of the
22 dollar amounts in subsections (b)(2), (c)(2), and
23 (e)(2) shall be increased by an amount equal to—

24 “(A) such dollar amount, multiplied by

1 “(B) the cost of living adjustment deter-
2 mined under section 1(f)(3) for the calendar
3 year in which the taxable year begins deter-
4 mined by substituting ‘calendar year 2012’ for
5 ‘calendar year 1992’ in subparagraph (B)
6 thereof.

7 If any increase determined under this paragraph is
8 not a multiple of \$50, such increase shall be rounded
9 to the next lowest multiple of \$50.”.

10 (b) CREDIT TO BE PART OF GENERAL BUSINESS
11 CREDIT.—Subsection (b) of section 38 of such Code (re-
12 lating to general business credit) is amended by striking
13 “plus” at the end of paragraph (34), by striking the period
14 at the end of paragraph (35) and inserting “, plus” , and
15 by adding at the end the following new paragraph:

16 “(36) in the case of a qualified small employer
17 (as defined in section 45R(e)), the small business
18 employee health coverage credit determined under
19 section 45R(a).”.

20 (c) CLERICAL AMENDMENT.—The table of sections
21 for subpart D of part IV of subchapter A of chapter 1
22 of such Code is amended by inserting after the item relat-
23 ing to section 45Q the following new item:

“Sec. 45R. Small business employee health coverage credit.”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 2012.

4 **Subtitle C—Disclosures to Carry-**
5 **out Health Insurance Exchange**
6 **Subsidies**

7 **SEC. 431. DISCLOSURES TO CARRYOUT HEALTH INSUR-**
8 **ANCE EXCHANGE SUBSIDIES.**

9 (a) IN GENERAL.—Subsection (l) of section 6103 of
10 the Internal Revenue Code of 1986 is amended by adding
11 at the end the following new paragraph:

12 “(21) DISCLOSURE OF RETURN INFORMATION
13 TO CARRY OUT HEALTH INSURANCE EXCHANGE SUB-
14 SIDIES.—

15 “(A) IN GENERAL.—The Secretary, upon
16 written request from the Health Choices Com-
17 missioner or the head of a State-based health
18 insurance exchange approved for operation
19 under section 208 of the [____ Act of 2009],
20 shall disclose to officers and employees of the
21 Health Choices Administration or such State-
22 based health insurance exchange, as the case
23 may be, return information of any taxpayer
24 whose income is relevant in determining any af-
25 fordability credit described in subtitle C of title

1 I of the [____ Act of 2009]. Such return infor-
2 mation shall be limited to—

3 “(i) taxpayer identity information
4 with respect to such taxpayer,

5 “(ii) the filing status of such tax-
6 payer,

7 “(iii) the adjusted gross income of
8 such taxpayer,

9 “(iv) such other information as is pre-
10 scribed by the Secretary by regulation as
11 might indicate whether the taxpayer is eli-
12 gible for such affordability credits (and the
13 amount thereof), and

14 “(v) the taxable year with respect to
15 which the preceding information relates or,
16 if applicable, the fact that such informa-
17 tion is not available.

18 “(B) RESTRICTION ON USE OF DISCLOSED
19 INFORMATION.—Return information disclosed
20 under subparagraph (A) may be used by offi-
21 cers and employees of the Health Choices Ad-
22 ministration or such State-based health insur-
23 ance exchange, as the case may be, only for the
24 purposes of, and to the extent necessary in, es-
25 tablishing and verifying the appropriate amount

1 of any affordability credit described in subtitle
2 C of title I of the [____ Act of 2009] and pro-
3 viding for the repayment of any such credit
4 which was in excess of such appropriate
5 amount.”.

6 (b) CONFIDENTIALITY AND DISCLOSURE.—Para-
7 graph (3) of section 6103(a) of such Code is amended by
8 striking “or (20)” and inserting “(20), or (21)”.

9 (c) PROCEDURES AND RECORDKEEPING RELATED
10 TO DISCLOSURES.—Paragraph (4) of section 6103(p) of
11 such Code is amended—

12 (1) by inserting “, or any entity described in
13 subsection (l)(21),” after “or (20)” in the matter
14 preceding subparagraph (A),

15 (2) by inserting “or any entity described in sub-
16 section (l)(21),” after “or (o)(1)(A)” in subpara-
17 graph (F)(ii), and

18 (3) by inserting “or any entity described in sub-
19 section (l)(21),” after “or (20)” both places it ap-
20 pears in the matter after subparagraph (F).

21 (d) UNAUTHORIZED DISCLOSURE OR INSPECTION.—
22 Paragraph (2) of section 7213(a) of such Code is amended
23 by striking “or (20)” and inserting “(20), or (21)”.

1 **Subtitle D—Other Revenue**
2 **Provisions**

3 **SEC. 441. [TO BE PROVIDED].**

4 **TITLE V—IMMEDIATE**
5 **INVESTMENTS**

6 **SEC. 501. IMMEDIATE INVESTMENTS.**

7 (a) IN GENERAL.— Before the implementation of
8 comprehensive health insurance reforms under the pre-
9 vious provisions of this division, the Secretary (or, for peri-
10 ods beginning more than one year after the date of the
11 enactment of this Act, the Commissioner) shall provide for
12 the following immediate investments for improving effi-
13 ciency and value in health care:

14 (1) ADMINISTRATIVE SIMPLIFICATION.—Admin-
15 istrative simplification in health insurance adminis-
16 tration, including—

17 (A) establishment of standardized language
18 and forms and standards for claims attach-
19 ments;

20 (B) establishing operating rules and com-
21 panion guides for using and processing health
22 care transactions;

23 (C) increasing consistency of claims edits
24 and code corrections across health plans and
25 products;

1 (D) increasing electronic exchange of ad-
2 ministrative and clinical data; and

3 (E) standardizing quality reporting re-
4 quirements.

5 (2) ENSURING VALUE AND LOWERING PRE-
6 MIUMS.—Implementing a minimum loss ratio of not
7 less than 85 percent, enforceable through a rebate
8 back to consumers, to ensure value in the provision
9 of health insurance coverage and group health plans.

10 (b) ADDITIONAL PROGRAMS.—**[To be specified later]**
11 Subject to appropriation, the Secretary (or Commissioner
12 during the period described in subsection (a)) shall estab-
13 lish programs such as the following:

14 (1) REINSURANCE PROGRAM TO ASSIST IN COV-
15 ERAGE OF EARLY RETIREES.—Establishment of a
16 reinsurance program to lower cost of providing
17 group health coverage for early retirees.

18 (2) INSURANCE SMART CARD.—Promoting the
19 issuance of electronic insurance cards, with privacy
20 protections, to reduce administrative difficulties and
21 confusion for providers and patients.

22 (3) PREVENTIVE CARE VISIT CARD.— Encour-
23 aging the use of preventive services to promote
24 health and wellness.

1 **DIVISION B—MEDICARE AND**
2 **MEDICAID IMPROVEMENTS**

3 **SEC. 1001. TABLE OF CONTENTS.**

4 The table of contents of this division is as follows:

Sec. 1001. Table of contents.

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare Part A

PART 1—MARKET BASKET UPDATES

- Sec. 1101. Skilled nursing facility payment update.
- Sec. 1102. Inpatient rehabilitation facility payment update.
- Sec. 1103. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

PART 2—OTHER MEDICARE PART A PROVISIONS

- Sec. 1111. Payments to skilled nursing facilities.
- Sec. 1112. Medicare DSH report.

Subtitle B—Provisions Related to Part B

PART 1—PHYSICIANS SERVICES

- Sec. 1121. Sustainable growth rate reform.
- Sec. 1122. Misvalued codes under the physician fee schedule.
- Sec. 1123. Payments for efficient areas.
- Sec. 1124. Modifications to the Physician Quality Reporting Initiative (PQRI).
- Sec. 1125. Adjustment to Medicare payment localities.

PART 2—MARKET BASKET UPDATES

- Sec. 1131. Incorporating productivity adjustment into market basket updates that do not already incorporate such adjustment.

PART 3—OTHER PROVISIONS

- Sec. 1141. Rental and purchase of power-driven wheelchairs.
- Sec. 1142. Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals.
- Sec. 1143. Home infusion therapy report to Congress.
- Sec. 1144. Require ambulatory surgical centers (ASCs) to submit cost data and other data.
- Sec. 1145. Treatment of certain cancer hospitals.
- Sec. 1146. Medicare Improvement Fund.
- Sec. 1147. Payment for imaging services.

Subtitle C—Provisions Related to Medicare Parts A and B

- Sec. 1151. Reducing potentially preventable hospital readmissions.
- Sec. 1152. Post acute care services payment reform plan.

- Sec. 1153. Home health payment update for 2010.
- Sec. 1154. Payment adjustments for home health care.
- Sec. 1155. Incorporating productivity adjustment into market basket update for home health services.
- Sec. 1156. Limitation on Medicare exception to the prohibition on certain physician referrals for hospitals.

Subtitle D—Medicare Advantage Reforms

PART 1—PAYMENT AND ADMINISTRATION

- Sec. 1161. Phase-in of payment based on fee-for-service costs.
- Sec. 1162. Quality bonus payments.
- Sec. 1163. Extension of Secretarial coding intensity adjustment authority.
- Sec. 1164. Adding 2 week processing period between open election periods and effective date of enrollments.
- Sec. 1165. Extension of reasonable cost contracts.
- Sec. 1166. Limitation of waiver authority for employer group plans.
- Sec. 1167. Improving risk adjustment for MA payments.
- Sec. 1168. Elimination of MA Regional Plan Stabilization Fund.

PART 2—CONSUMER PROTECTIONS AND ANTI-FRAUD

- Sec. 1171. Limitation on out-of-pocket costs for individual health services.
- Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspension.
- Sec. 1173. Information for beneficiaries on MA plan administrative costs.
- Sec. 1174. Strengthening audit authority .
- Sec. 1175. Authority to deny plan bids.

PART 3—TREATMENT OF SPECIAL NEEDS INDIVIDUALS; MEDICAID INTEGRATION

- Sec. 1176. Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals.
- Sec. 1177. Extension of authority of special needs plans to restrict enrollment.
- Sec. 1178. Fully integrated dual eligible special needs plans.
- Sec. 1179. Improved coordination for dual eligibles.

Subtitle E—Improvements to Medicare Part D

- Sec. 1181. Requiring drug manufacturers to provide drug rebates for certain full premium subsidy eligible individuals.
- Sec. 1182. Phased-in elimination of coverage gap.
- Sec. 1183. Repeal of provision relating to submission of claims by pharmacies located in or contracting with long-term care facilities.
- Sec. 1184. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under part D.
- Sec. 1185. Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee.

Subtitle F—Medicare Rural Access Protections

- Sec. 1191. Telehealth expansion and enhancements.
- Sec. 1192. Extension of outpatient hold harmless provision.
- Sec. 1193. Extension of section 508 hospital reclassifications.

- Sec. 1194. Extension of geographic floor for work.
- Sec. 1195. Extension of payment for technical component of certain physician pathology services.
- Sec. 1196. Extension of ambulance add-ons.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

- Sec. 1201. Improving assets tests for Medicare Savings Program and low-income subsidy program.
- Sec. 1202. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
- Sec. 1203. Eliminating barriers to enrollment.
- Sec. 1204. Enhanced oversight relating to reimbursements for retroactive low income subsidy enrollment.
- Sec. 1205. Intelligent assignment in enrollment.
- Sec. 1206. Automatic enrollment process for certain subsidy eligible individuals.
- Sec. 1207. Application of MA premiums prior to rebate in calculation of low income subsidy benchmark.

Subtitle B—Reducing Health Disparities

- Sec. 1221. Ensuring effective communication in Medicare.
- Sec. 1222. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.
- Sec. 1223. IOM report on impact of language access services.
- Sec. 1224. Definitions.

Subtitle C—Miscellaneous Improvements

- Sec. 1231. Extension of therapy caps exceptions process.
- Sec. 1232. Extended months of coverage of immunosuppressive drugs for kidney transplant patients and other renal dialysis provisions.
- Sec. 1233. Part B premium.
- Sec. 1234. Requiring guaranteed issue for certain individuals under Medigap.
- Sec. 1235. Consultation and information regarding end-of-life planning.
- Sec. 1236. Part B special enrollment period and waiver of limited enrollment penalty for TRICARE beneficiaries.

TITLE III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

- Sec. 1301. Accountable Care Organization pilot program.
- Sec. 1302. Medical home pilot program.
- Sec. 1303. Rate increase for selected primary care services.
- Sec. 1304. Increased reimbursement rate for certified nurse-midwives.
- Sec. 1305. Coverage and waiver of cost-sharing for preventive services.
- Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal .
- Sec. 1307. Excluding clinical social worker services from coverage under the medicare skilled nursing facility prospective payment system and consolidated payment.
- Sec. 1308. Coverage of marriage and family therapist services and mental health counselor services.

- Sec. 1309. Extension of physician fee schedule mental health add-on.
- Sec. 1310. Expanding access to vaccines.
- Sec. 1311. Elimination of 190-day lifetime limit on psychiatric hospital stays.

TITLE IV—QUALITY

Subtitle A—Comparative Effectiveness Research

- Sec. 1401. Comparative effectiveness research.

Subtitle B.—Nursing Home Transparency

PART 1—IMPROVING TRANSPARENCY OF INFORMATION ON SKILLED NURSING FACILITIES AND NURSING FACILITIES

- Sec. 1411. Required disclosure of ownership and additional disclosable parties information.
- Sec. 1412. Accountability requirements.
- Sec. 1413. Nursing home compare medicare website.
- Sec. 1414. Reporting of expenditures.
- Sec. 1415. Standardized complaint form.
- Sec. 1416. Ensuring staffing accountability.

PART 2—TARGETING ENFORCEMENT

- Sec. 1421. Civil money penalties.
- Sec. 1422. National independent monitor pilot program.
- Sec. 1423. Notification of facility closure.

PART 3—IMPROVING STAFF TRAINING

- Sec. 1431. Dementia and abuse prevention training.
- Sec. 1432. Study and report on training required for certified nurse aides and supervisory staff.

Subtitle C—Quality Measurements

- Sec. 1441. Establishment of national priorities and performance measures for quality improvement.

Subtitle D—Physician Payments Sunshine Provisions

- Sec. 1451. Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities.
- Sec. 1452. Limitation on tax deductions for advertising by certain manufacturers of drugs, devices, or medical supplies.

TITLE V—MEDICARE GRADUATE MEDICAL EDUCATION

- Sec. 1501. Distribution of unused residency positions.
- Sec. 1502. Increasing training in non-provider settings.
- Sec. 1503. Rules for counting resident time for didactic and scholarly activities and other activities.
- Sec. 1504. Preservation of resident cap positions from closed hospitals.
- Sec. 1505. Improving accountability for approved medical residency training.

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse

Sec. 1601. Increased funding for HCFAC Fund.

Subtitle B—Enhanced Penalties for Fraud and Abuse

- Sec. 1611. Enhanced penalties for false statements on provider or supplier enrollment applications.
- Sec. 1612. Enhanced penalties for submission of false Medicare, Medicaid, or CHIP claims data.
- Sec. 1613. Enhanced penalties for delaying Inspector General investigations.
- Sec. 1614. Enhanced hospice program safeguards.
- Sec. 1615. Enhanced penalties for individuals excluded from program participation.
- Sec. 1616. Enhanced penalties for provision of false information by Medicare Advantage and part D plans.
- Sec. 1617. Enhanced penalties for Medicare Advantage and part D marketing violations.
- Sec. 1618. Enhanced penalties for obstruction of program audits.

Subtitle C—Enhanced Program and Provider Protections

- Sec. 1631. Enhanced CMS program protection authority.
- Sec. 1632. Enhanced Medicare, Medicaid, and CHIP program disclosure requirements relating to previous affiliations.
- Sec. 1633. Required inclusion of payment modifier for certain evaluation and management services.
- Sec. 1634. Evaluations and reports required under Medicare Integrity Program.
- Sec. 1635. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.
- Sec. 1636. Maximum period for submission of Medicare claims reduced to not more than 12 months.
- Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare participating physicians.
- Sec. 1638. Requirement for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
- Sec. 1639. Face to face encounter with patient required before physicians may certify eligibility for home health services under Medicare.
- Sec. 1640. Extension of testimonial subpoena authority to program exclusion investigations.
- Sec. 1641. Required repayments of Medicare and Medicaid overpayments.
- Sec. 1642. Expanded application of hardship waivers for OIG exclusions to beneficiaries of any Federal health care program.
- Sec. 1643. OIG access to certain information on renal dialysis facilities.

Subtitle D—Access to Information Needed to Prevent Fraud and Abuse

- Sec. 1651. Access to Information Necessary to Identify Waste and Abuse.
- Sec. 1652. Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank.
- Sec. 1653. Compliance with HIPAA privacy and security standards.

TITLE VII—MISCELLANEOUS PROVISIONS

- Sec. 1701. Repeal of trigger provision.
- Sec. 1702. Repeal of comparative cost adjustment (CCA) program.
- Sec. 1703. Extension of gainsharing demonstration.
- Sec. 1704. Grants to States for quality home visitation programs for families with young children and families expecting children.

TITLE VIII—MEDICAID AND CHIP

PART 1—MEDICAID AND HEALTH REFORM

- Sec. 1801. Eligibility for individuals with income below 133-1/3 percent of the Federal poverty level.
- Sec. 1802. Requirements and special rules for certain Medicaid enrollees and for Medicaid eligible individuals enrolled in a non-Medicaid Exchange-participating health benefits plan.
- Sec. 1803. CHIP Maintenance of effort.
- Sec. 1804. Medicaid DSH report.

PART 2—PREVENTION

- Sec. 1811. Required coverage of preventive services.
- Sec. 1812. Tobacco cessation.
- Sec. 1813. Optional coverage of nurse home visitation services.
- Sec. 1814. State eligibility option for family planning services.
- Sec. 1815. Payment for items and services furnished by certain school-based health clinics.

PART 3—ACCESS

- Sec. 1821. Payments to primary care practitioners.
- Sec. 1822. Medical home pilot program.
- Sec. 1823. Translation services.
- Sec. 1824. Optional coverage for freestanding birth center services.
- Sec. 1825. Inclusion of public health clinics under the vaccines for children program.

PART 4—COVERAGE

- Sec. 1831. Optional medicaid coverage of low-income HIV-infected individuals.
- Sec. 1832. Extending transitional Medicaid Assistance (TMA).
- Sec. 1833. Upgrading electronic eligibility systems.
- Sec. 1834. Expanded outstationing.

PART 5—FINANCING

- Sec. 1841. Payments to pharmacists.
- Sec. 1842. Prescription drug rebates.
- Sec. 1843. Extension of prescription drug discounts to enrollees of medicaid managed care organizations.
- Sec. 1844. Payments for graduate medical education.

PART 6—WASTE, FRAUD, AND ABUSE

- Sec. 1851. Health-care acquired conditions.
- Sec. 1852. Evaluations and reports required under Medicaid Integrity Program.
- Sec. 1853. Require providers and suppliers to adopt programs to reduce waste, fraud, and abuse.
- Sec. 1854. Overpayments.

Sec. 1855. Minimum medical loss ratio for Medicaid Managed Care Organizations.

PART 7—PUERTO RICO AND THE TERRITORIES

Sec. 1861. Puerto Rico and territories.

PART 8—MISCELLANEOUS

Sec. 1871. Technical corrections.

Sec. 1872. Making QI program permanent.

1 **TITLE I—IMPROVING HEALTH**
2 **CARE VALUE**
3 **Subtitle A—Provisions Related to**
4 **Medicare Part A**

5 **PART 1—MARKET BASKET UPDATES**

6 **SEC. 1101. SKILLED NURSING FACILITY PAYMENT UPDATE.**

7 (a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the
8 Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is
9 amended—

10 (1) in subclause (III), by striking “and” at the
11 end;

12 (2) by redesignating subclause (IV) as sub-
13 clause (VI); and

14 (3) by inserting after subclause (III) the fol-
15 lowing new subclauses:

16 “(IV) for each of fiscal years
17 2004 through 2009, the rate com-
18 puted for the previous fiscal year in-
19 creased by the skilled nursing facility

1 market basket percentage change for
2 the fiscal year involved;

3 “(V) for fiscal year 2010, the
4 rate computed for the previous fiscal
5 year; and”.

6 (b) DELAYED EFFECTIVE DATE.—Section
7 1888(e)(4)(E)(ii)(V) of the Social Security Act, as in-
8 serted by subsection (a)(3), shall not apply to payment
9 for days before January 1, 2010.

10 **SEC. 1102. INPATIENT REHABILITATION FACILITY PAY-**
11 **MENT UPDATE.**

12 (a) IN GENERAL.—Section 1886(j)(3)(C) of the So-
13 cial Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended
14 by striking “and 2009” and inserting “through 2010”.

15 (b) DELAYED EFFECTIVE DATE.—The amendment
16 made by subsection (a) shall not apply to payment units
17 occurring before January 1, 2010.

18 **SEC. 1103. INCORPORATING PRODUCTIVITY IMPROVE-**
19 **MENTS INTO MARKET BASKET UPDATES**
20 **THAT DO NOT ALREADY INCORPORATE SUCH**
21 **IMPROVEMENTS.**

22 (a) INPATIENT ACUTE HOSPITALS.—Section
23 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
24 1395ww(b)(3)(B)) is amended—

25 (1) in clause (iii)—

1 (A) by striking “(iii) For purposes of this
2 subparagraph,” and inserting “(iii)(I) For pur-
3 poses of this subparagraph, subject to the pro-
4 ductivity adjustment described in subclause
5 (II),”; and

6 (B) by adding at the end the following new
7 subclause:

8 “(II) The productivity adjustment described in this
9 subclause, with respect to an increase or change for a fis-
10 cal year or year or cost reporting period, or other annual
11 period, is a productivity offset equal to the 10-year moving
12 average of changes in annual economy-wide private non-
13 farm business multi-factor productivity (as recently pub-
14 lished before the promulgation of such increase for the
15 year or period involved Except as otherwise provided, any
16 reference to the increase described in this clause shall be
17 a reference to such increase as adjusted under this sub-
18 clause.”;

19 (2) in the first sentence of clause (viii)(I)—

20 (A) by inserting “(but not below zero)”
21 after “shall be reduced”; and

22 (B) by striking “one-quarter” and insert-
23 ing “a fraction equal to 1 minus the maximum
24 percentage point deduction permitted in the
25 year under clause (ix)(I)”; and

1 (3) in the first sentence of clause (ix)(I)—

2 (A) by inserting “(determined without re-
3 gard to clause (iii)(II)” after “clause (i)” the
4 second time it appears; and

5 (B) by inserting “(but not below zero)”
6 after “reduced”.

7 (b) SKILLED NURSING FACILITIES.—Section
8 1888(e)(5)(B) of such Act (42 U.S.C. 1395yy(e)(5))(B)
9 is amended by inserting “subject to the productivity ad-
10 justment described in section 1886(b)(3)(B)(iii)(II)” after
11 “as calculated by the Secretary” the second place it ap-
12 pears.

13 (c) LONG TERM CARE HOSPITALS.—Section
14 1886(m) of the Social Security Act (42 U.S.C.
15 1395ww(m)) is amended by adding at the end the fol-
16 lowing new paragraph:

17 “(3) PRODUCTIVITY ADJUSTMENT.—In imple-
18 menting the system described in paragraph (1) for
19 discharges occurring during the rate year ending in
20 2010 or any subsequent rate year for a hospital, to
21 the extent that an annual percentage increase factor
22 applies to a base rate for such discharges for the
23 hospital, such factor shall be subject to the produc-
24 tivity adjustment described in section
25 1886(b)(3)(B)(iii)(II).”.

1 (d) INPATIENT REHABILITATION FACILITIES.—Sec-
2 tion 1886(j)(3)(C) of the Social Security Act (42 U.S.C.
3 1395ww(j)(3)(C)) is amended by inserting “(subject to the
4 productivity adjustment described in section
5 1886(b)(3)(B)(iii)(II))” after “appropriate percentage in-
6 crease”.

7 (e) PSYCHIATRIC HOSPITALS.—Section 1886(o) of
8 the Social Security Act, as added by section 1105, is
9 amended by adding at the end the following new para-
10 graph:

11 “(3) PRODUCTIVITY ADJUSTMENT.—In imple-
12 menting the system described in paragraph (1) for
13 discharges occurring during the rate year ending in
14 2011 or any subsequent rate year for a psychiatric
15 hospital or unit described in such paragraph, to the
16 extent that an annual percentage increase factor ap-
17 plies to a base rate for such discharges for the hos-
18 pital or unit, respectively, such factor shall be sub-
19 ject to the productivity adjustment described in sec-
20 tion 1886(b)(3)(B)(iii)(II).”.

21 (f) HOSPICE CARE.—Subclause (IX) of section
22 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C.
23 1395f(i)(1)(C)(ii)) is amended by inserting after “the
24 market basket percentage increase” the following: “(which

1 is subject to the productivity adjustment described in sec-
2 tion 1886(b)(3)(B)(iii)(II))”.

3 (g) EFFECTIVE DATE.—The amendments made by
4 subsections (a), (b), (d), and (f) shall apply to annual in-
5 creases effected for fiscal years beginning with fiscal year
6 2010.

7 **PART 2—OTHER MEDICARE PART A PROVISIONS**

8 **SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.**

9 (a) CHANGE IN RECALIBRATION FACTOR.—

10 (1) ANALYSIS.—The Secretary of Health and
11 Human Services shall conduct, using the fiscal year
12 2006 claims data, an initial analysis comparing total
13 payments under title XVIII of the Social Security
14 Act for skilled nursing facility services under the
15 RUG-53 and under the RUG-44 classification sys-
16 tems. The Secretary may conduct subsequent anal-
17 yses comparing such total payments under the most
18 recent RUG classification system and the previous
19 RUG classification system for which such an anal-
20 ysis was conducted.

21 (2) ADJUSTMENT IN RECALIBRATION FAC-
22 TOR.—Based on the initial analysis under paragraph
23 (1), the Secretary shall adjust the case mix indexes
24 under section 1888(e)(4)(G)(i) of the Social Security
25 Act (42 U.S.C. 1395yy(e)(4)(G)(i)) for fiscal year

1 2010 by the appropriate recalibration factor to en-
2 sure parity of aggregate payment under such section
3 under the RUG-53 and RUG-44 classification sys-
4 tems.

5 (b) CHANGE IN PAYMENT FOR NONTHERAPY ANCIL-
6 LARY (NTA) SERVICES AND THERAPY SERVICES.—

7 (1) IN GENERAL.—Section 1888(e) of the So-
8 cial Security Act (42 U.S.C. 1395yy(e)) is amend-
9 ed—

10 (A) in paragraph (1), by striking “and
11 (12)” and inserting “(12), and (13)”; and

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

14 “(13) REVISION IN PAYMENT FOR NONTHERAPY
15 ANCILLARY (NTA) SERVICES AND THERAPY SERV-
16 ICES.—

17 “(A) IN GENERAL.—The Secretary shall
18 revise the payment system under this subsection
19 for costs of covered skilled nursing facility serv-
20 ices that are nontherapy ancillary services or
21 are therapy services consistent with this para-
22 graph. Such revision shall apply to payment for
23 services furnished on or after October 1, 2010.
24 Except as otherwise provided in this paragraph,
25 the revision for therapy services shall be ef-

1 fected in the same manner as the revision for
2 nontherapy ancillary services.

3 “(B) SEPARATE PAYMENT COMPONENTS
4 FOR NTA SERVICES AND FOR THERAPY SERV-
5 ICES.—

6 “(i) IN GENERAL.—The Secretary
7 shall create a separate payment component
8 related to use of NTA services and shall
9 modify the payment component related to
10 use of therapy services.

11 “(ii) USE OF INDICATORS.—Each
12 such separate payment component shall be
13 prospectively calculated using appropriate
14 indicators, including age, skilled nursing
15 care, physical and mental status, ability to
16 perform activities of daily living, prior
17 nursing home stay, broad RUG category,
18 and a proxy for length-of-stay (such as the
19 number of assessments conducted on a pa-
20 tient).

21 “(iii) USE OF HOSPITAL DIAGNOSES
22 AS INDICATORS.—Such indicators may in-
23 clude hospital diagnoses. If the Secretary
24 does not include hospital diagnoses as such
25 an indicator in calculating the prospective

1 payment for such component, the Sec-
2 retary shall, not later than 3 years after
3 the date of the enactment of this para-
4 graph, submit to Congress a report ex-
5 plaining why hospital diagnoses were not
6 included among the indicators and shall in-
7 clude an estimated time for when hospital
8 diagnoses will be so included.

9 “(iv) BUDGET NEUTRAL.—The pay-
10 ment system under this paragraph shall be
11 designed in a manner to result in—

12 “(I) no net change in the aggre-
13 gate payments made under this sub-
14 section in any fiscal year; and

15 “(II) the amount of payment
16 under this subsection with respect to
17 the NTA services payment component
18 in any fiscal year being equal to the
19 aggregate payment that would have
20 been made under this subsection for
21 items and services included in such
22 payment component (including both
23 the nursing component and the NTA
24 add-on as in effect before the date of
25 the enactment of this paragraph) if

1 this paragraph had not applied but
2 after the application of section
3 1111(a)(2) of the [short title]

4 “(C) OUTLIER POLICY.—

5 “(i) IN GENERAL.—The Secretary
6 shall provide for a payment adjustment
7 that reflects outliers only for ancillary
8 services, including only NTA services and
9 therapy services. Such outlier adjustment
10 shall be based on aggregate costs over a
11 stay in a skilled nursing facility and not
12 upon the number of days in such stay.

13 “(ii) LIMITATION.—The aggregate
14 amount of the adjustment under this sub-
15 paragraph with respect to a fiscal year
16 may not exceed 2 percent of the total pay-
17 ments projected or estimated to be made
18 under this section in the fiscal year, to be
19 determined on a prospective basis.

20 “(D) NTA SERVICES DEFINED.—In this
21 paragraph, the terms ‘nontherapy ancillary
22 services’ and ‘NTA services’ mean nontherapy
23 services, such as intravenous medications, res-
24 piratory therapy, and drugs, that are ancillary

1 to the provision of covered skilled nursing facil-
2 ity services.”.

3 **SEC. 1112. MEDICARE DSH REPORT.**

4 (a) IN GENERAL.—Not later than July 1, 2016, the
5 Secretary of Health and Human Services shall submit to
6 Congress a report on Medicare DSH taking into account
7 the impact of the health care reforms carried out under
8 division A in reducing the number of uninsured individ-
9 uals. The report shall include recommendations relating
10 to the following:

11 (1) The appropriate amount, targeting and dis-
12 tribution of Medicare DSH payments to hospitals
13 given their continued uncompensated care costs, to
14 the extent such costs remain.

15 (2) The appropriate amount, targeting and dis-
16 tribution of Medicare DSH to compensate for higher
17 Medicare costs associated with serving low-income
18 beneficiaries, consistent with the original intent of
19 Medicare DSH.

20 (b) MEDICARE DSH.—In this section, the term
21 “Medicare DSH” means adjustments in payments under
22 section 1886(d)(5)(F) of the Social Security Act (42
23 U.S.C. 1395ww(d)(5)(F)) for inpatient hospital services
24 furnished by disproportionate share hospitals.

1 (c) COORDINATION WITH MEDICAID DSH RE-
2 PORT.—The Secretary shall coordinate the report under
3 this section with the report on Medicaid DSH under sec-
4 tion 1804.

5 **Subtitle B—Provisions Related to** 6 **Part B**

7 **PART 1—PHYSICIANS SERVICES**

8 **SEC. 1121. SUSTAINABLE GROWTH RATE REFORM.**

9 (a) TRANSITIONAL UPDATE FOR 2010.—Section
10 1848(d) of the Social Security Act (42 U.S.C. 1395w-
11 4(d)) is amended by adding at the end the following new
12 paragraph:

13 “(10) UPDATE FOR 2010.—The update to the
14 single conversion factor established in paragraph
15 (1)(C) for 2010 shall be the percentage increase in
16 the MEI (as defined in section 1842(i)(3)) for that
17 year.”.

18 (b) REBASING SGR USING 2009; LIMITATION ON
19 CUMULATIVE ADJUSTMENT PERIOD.—Section 1848(d)(4)
20 of such Act (42 U.S.C. 1395w-4(d)(4)) is amended—

21 (1) in subparagraph (B), by striking “subpara-
22 graph (D)” and inserting “subparagraphs (D) and
23 (G)”; and

24 (2) by adding at the end the following new sub-
25 paragraph:

1 “(G) REBASING USING 2009 FOR FUTURE
2 UPDATE ADJUSTMENTS.—In determining the
3 update adjustment factor under subparagraph
4 (B) for 2011 and subsequent years—

5 “(i) the allowed expenditures for 2009
6 shall be equal to the amount of the actual
7 expenditures for physicians’ services during
8 2009; and

9 “(ii) the reference in subparagraph
10 (B)(ii)(I) to ‘April 1, 1996’ shall be treat-
11 ed as a reference to ‘January 1, 2009 (or,
12 if later, the first day of the fifth year be-
13 fore the year involved)’.”.

14 (c) LIMITATION ON PHYSICIANS’ SERVICES IN-
15 CLUDED IN TARGET GROWTH RATE COMPUTATION TO
16 SERVICES COVERED UNDER PHYSICIAN FEE SCHED-
17 ULE.—Section 1848(f)(4)(A) of such Act is amended by
18 striking “(such as clinical” and all that follows through
19 “in a physician’s office” and insert “for which payment
20 under this part is made under the fee schedule under this
21 section, for services for practitioners described in section
22 1842(b)(18)(C) on a basis related to such fee schedule,
23 or for services described in section 1861(p) (other than
24 such services when furnished in the facility of a provider

1 of services)” inserting “, for years before 2009,” after “in-
2 cludes”.

3 (d) ESTABLISHMENT OF SEPARATE TARGET
4 GROWTH RATES FOR CATEGORIES OF SERVICES.—

5 (1) ESTABLISHMENT OF SERVICE CAT-
6 EGORIES.—Subsection (j) of section 1848 of the So-
7 cial Security Act (42 U.S.C. 1395w-4) is amended
8 by adding at the end the following new paragraph:

9 “(5) SERVICE CATEGORIES.—For services fur-
10 nished on or after January 1, 2009, each of the fol-
11 lowing categories of physicians’ services (as defined
12 in paragraph (3)) shall be treated as a separate
13 ‘service category’:

14 “(A) Evaluation and management services
15 as determined by the Secretary (including new
16 and established patient office services, primary
17 care services, emergency department services,
18 consultations, and home services), and for
19 Medicare covered preventive services (as defined
20 in section 1861(iii)).

21 “(B) All other services not described in
22 subparagraph (A).”.

23 (2) ESTABLISHMENT OF SEPARATE CONVER-
24 SION FACTORS FOR EACH SERVICE CATEGORY.—

1 Subsection (d)(1) of section 1848 of the Social Secu-
2 rity Act (42 U.S.C. 1395w-4) is amended—

3 (A) in subparagraph (A)—

4 (i) by designating the sentence begin-
5 ning “The conversion factor” as clause (i)
6 with the heading “APPLICATION OF SIN-
7 GLE CONVERSION FACTOR.—” and with
8 appropriate indentation;

9 (ii) by striking “The conversion fac-
10 tor” and inserting “Subject to clause (ii),
11 the conversion factor”; and

12 (iii) by adding at the end the fol-
13 lowing new clause:

14 “(ii) APPLICATION OF MULTIPLE CON-
15 VERSION FACTORS BEGINNING WITH
16 2011.—

17 “(I) IN GENERAL.—In applying
18 clause (i) for years beginning with
19 2011, separate conversion factors
20 shall be established for each service
21 category of physicians’ services (as de-
22 fined in subsection (j)(5)) and any
23 reference in this section to a conver-
24 sion factor for such years shall be
25 deemed to be a reference to the con-

1 version factor for each of such cat-
2 egories.

3 “(II) INITIAL CONVERSION FAC-
4 TORS.—Such factors for 2011 shall be
5 based upon the single conversion fac-
6 tor for the previous year multiplied by
7 the update established under para-
8 graph (11) for such category for
9 2011.

10 “(III) UPDATING OF CONVER-
11 SION FACTORS.—Such factor for a
12 service category for a subsequent year
13 shall be based upon the conversion
14 factor for such category for the pre-
15 vious year and adjusted by the update
16 established for such category under
17 paragraph (11) for the year in-
18 volved.”; and

19 (B) in subparagraph (D), by striking
20 “other physicians’ services” and inserting “for
21 physicians’ services described in the service cat-
22 egory described in subsection (j)(5)(B)”.

23 (3) ESTABLISHING UPDATES FOR CONVERSION
24 FACTORS FOR SERVICE CATEGORIES.—Section
25 1848(d) of the Social Security Act (42 U.S.C.

1 1395w-4(d)), as amended by subsection (a), is
2 amended—

3 (A) in paragraph (4)(C)(iii), by striking
4 “The allowed” and inserting “Subject to para-
5 graph (11)(B), the allowed”; and

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

8 “(11) UPDATES FOR SERVICE CATEGORIES BE-
9 GINNING WITH 2011.—

10 “(A) IN GENERAL.—In applying paragraph
11 (4) for a year beginning with 2011, the fol-
12 lowing rules apply:

13 “(i) APPLICATION OF SEPARATE UP-
14 DATE ADJUSTMENTS FOR EACH SERVICE
15 CATEGORY.—Pursuant to paragraph
16 (1)(A)(ii)(I), the update shall be made to
17 the conversion factor for each service cat-
18 egory (as defined in subsection (j)(5))
19 based upon an update adjustment factor
20 for the respective category and year and
21 the update adjustment factor shall be com-
22 puted, for a year, separately for each serv-
23 ice category.

24 “(ii) COMPUTATION OF ALLOWED AND
25 ACTUAL EXPENDITURES BASED ON SERV-

1 ICE CATEGORIES.—In computing the prior
2 year adjustment component and the cumu-
3 lative adjustment component under clauses
4 (i) and (ii) of paragraph (4)(B), the fol-
5 lowing rules apply:

6 “(I) APPLICATION BASED ON
7 SERVICE CATEGORIES.—The allowed
8 expenditures and actual expenditures
9 shall be the allowed and actual ex-
10 penditures for the service category, as
11 determined under subparagraph (B).

12 “(II) APPLICATION OF CATEGORY
13 SPECIFIC TARGET GROWTH RATE.—
14 The growth rate applied under clause
15 (ii)(II) of such paragraph shall be the
16 target growth rate for the service cat-
17 egory involved under subsection (f)(5).

18 “(B) DETERMINATION OF ALLOWED EX-
19 PENDITURES.—In applying paragraph (4) for a
20 year beginning with 2010, notwithstanding sub-
21 paragraph (C)(iii) of such paragraph, the al-
22 lowed expenditures for a service category for a
23 year is an amount computed by the Secretary
24 as follows:

25 “(i) FOR 2010.—For 2010:

1 “(I) TOTAL 2009 ACTUAL EX-
2 PENDITURES FOR ALL SERVICES IN-
3 CLUDED IN SGR COMPUTATION FOR
4 EACH SERVICE CATEGORY.—Compute
5 total actual expenditures for physi-
6 cians’ services (as defined in sub-
7 section (f)(4)(A)) for 2009 for each
8 service category.

9 “(II) INCREASE BY GROWTH
10 RATE TO OBTAIN 2010 ALLOWED EX-
11 PENDITURES FOR SERVICE CAT-
12 EGORY.—Compute allowed expendi-
13 tures for the service category for 2010
14 by increasing the allowed expenditures
15 for the service category for 2009 com-
16 puted under subclause (I) by the tar-
17 get growth rate for such service cat-
18 egory under subsection (f) for 2010.

19 “(ii) FOR SUBSEQUENT YEARS.—For
20 a subsequent year, take the amount of al-
21 lowed expenditures for such category for
22 the preceding year (under clause (i) or this
23 clause) and increase it by the target
24 growth rate determined under subsection
25 (f) for such category and year.”.

1 (4) APPLICATION OF SEPARATE TARGET
2 GROWTH RATES FOR EACH CATEGORY.—

3 (A) IN GENERAL.—Section 1848(f) of the
4 Social Security Act (42 U.S.C. 1395w–4(f)) is
5 amended by adding at the end the following
6 new paragraph:

7 “(5) APPLICATION OF SEPARATE TARGET
8 GROWTH RATES FOR EACH SERVICE CATEGORY BE-
9 GINNING WITH 2010.—The target growth rate for a
10 year beginning with 2010 shall be computed and ap-
11 plied separately under this subsection for each serv-
12 ice category (as defined in subsection (j)(5)) and
13 shall be computed using the same method for com-
14 puting the target growth rate except that the factor
15 described in paragraph (2)(C) for—

16 “(A) the service category described in sub-
17 section (j)(5)(A) shall be increased by 0.02; and

18 “(B) the service category described in sub-
19 section (j)(5)(B) shall be increased by 0.01.”.

20 (B) USE OF TARGET GROWTH RATES.—
21 Section 1848 of such Act is further amended—

22 (i) in subsection (d)—

23 (I) in paragraph (1)(E)(ii), by in-
24 serting “or target” after “sustain-
25 able”; and

1 (II) in paragraph (4)(B)(ii)(II),
2 by inserting “or target” after “sus-
3 tainable”; and

4 (ii) in the heading of subsection (f),
5 by inserting “AND TARGET GROWTH
6 RATE” after “SUSTAINABLE GROWTH
7 RATE”;

8 (iii) in subsection (f)(1)—

9 (I) by striking “and” at the end
10 of subparagraph (A);

11 (II) in subparagraph (B), by in-
12 serting “before 2010” after “each
13 succeeding year” and by striking the
14 period at the end and inserting “;
15 and”;

16 (III) by adding at the end the
17 following new subparagraph:

18 “(C) November 1 of each succeeding year
19 the target growth rate for such succeeding year
20 and each of the 2 preceding years.”; and

21 (iv) in subsection (f)(2), in the matter
22 before subparagraph (A), by inserting after
23 “beginning with 2000” the following: “and
24 ending with 2009”.

1 (e) APPLICATION TO ACCOUNTABLE CARE ORGANI-
2 ZATION PILOT PROGRAM.—In applying the target growth
3 rate under subsections (d) and (f) of section 1848 of the
4 Social Security Act to services furnished by a practitioner
5 to beneficiaries who are attributable to an accountable
6 care organization under the pilot program provided under
7 section 1866D of such Act, the Secretary of Health and
8 Human Services shall develop, not later than January 1,
9 2012, for application beginning with 2012, a method
10 that—

11 (1) allows each such organization to have its
12 own expenditure targets and updates for such practi-
13 tioners, with respect to beneficiaries who are attrib-
14 utable to that organization, that are consistent with
15 the methodologies described in such subsection (f);
16 and

17 (2) provides that the target growth rate appli-
18 cable to other physicians shall not apply to such
19 physicians to the extent that the physicians' services
20 are furnished through the accountable care organiza-
21 tion.

22 In applying paragraph (1), the Secretary of Health and
23 Human Services may apply the difference in the update
24 under such paragraph on a claim-by-claim or lump sum

1 basis and such a payment shall be taken into account
2 under the pilot program.

3 **SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN FEE**
4 **SCHEDULE.**

5 (a) IN GENERAL.—Section 1848(c)(2) of the Social
6 Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by
7 adding at the end the following new subparagraphs:

8 “(K) POTENTIALLY MISVALUED CODES.—

9 “(i) IN GENERAL.—The Secretary
10 shall—

11 “(I) periodically identify services
12 as being potentially misvalued using
13 criteria specified in clause (ii); and

14 “(II) review and make appro-
15 priate adjustments to the relative val-
16 ues established under this paragraph
17 for services identified as being poten-
18 tially misvalued under subclause (I).

19 “(ii) IDENTIFICATION OF POTEN-
20 Tially MISVALUED CODES.—For purposes
21 of identifying potentially misvalued services
22 pursuant to clause (i)(I), the Secretary
23 shall examine (as the Secretary determines
24 to be appropriate) codes (and families of
25 codes as appropriate) for which there has

1 been the fastest growth; codes (and fami-
2 lies of codes as appropriate) that have ex-
3 perienced substantial changes in practice
4 expenses; codes for new technologies or
5 services within an appropriate period (such
6 as three years) after the relative values are
7 initially established for such codes; mul-
8 tiple codes that are frequently billed in
9 conjunction with furnishing a single serv-
10 ice; codes with low relative values, particu-
11 larly those that are often billed multiple
12 times for a single treatment; codes which
13 have not been subject to review since the
14 implementation of the RBRVS (the so-
15 called ‘Harvard-valued codes’); and such
16 other codes determined to be appropriate
17 by the Secretary.

18 “(iii) REVIEW AND ADJUSTMENTS.—

19 “(I) The Secretary may use ex-
20 isting processes to receive rec-
21 ommendations on the review and ap-
22 propriate adjustment of potentially
23 misvalued services described clause
24 (i)(II).

1 “(II) The Secretary may conduct
2 surveys, other data collection activi-
3 ties, studies, or other analyses as the
4 Secretary determines to be appro-
5 priate to facilitate the review and ap-
6 propriate adjustment described in
7 clause (i)(II).

8 “(III) The Secretary may use
9 analytic contractors to identify and
10 analyze services identified under
11 clause (i)(I), conduct surveys or col-
12 lect data, and make recommendations
13 on the review and appropriate adjust-
14 ment of services described in clause
15 (i)(II).

16 “(IV) The Secretary may coordi-
17 nate the review and appropriate ad-
18 justment described in clause (i)(II)
19 with the periodic review described in
20 subparagraph (B).

21 “(V) As part of the review and
22 adjustment described in clause (i)(II),
23 including with respect to codes with
24 low relative values described in clause
25 (ii), the Secretary may make appro-

1 prorate coding revisions (including
2 using existing processes for consider-
3 ation of coding changes) which may
4 include consolidation of individual
5 services into bundled codes for pay-
6 ment under the fee schedule under
7 subsection (b).

8 “(VI) The provisions of subpara-
9 graph (B)(ii)(II) shall apply to adjust-
10 ments to relative value units made
11 pursuant to this subparagraph in the
12 same manner as such provisions apply
13 to adjustments under subparagraph
14 (B)(ii)(II).

15 “(L) VALIDATING RELATIVE VALUE
16 UNITS.—

17 “(i) IN GENERAL.—The Secretary
18 shall establish a process to validate relative
19 value units under the fee schedule under
20 subsection (b).

21 “(ii) COMPONENTS AND ELEMENTS
22 OF WORK.—The process described in
23 clause (i) may include validation of work
24 elements (such as time, mental effort and
25 professional judgment, technical skill and

1 physical effort, and stress due to risk) in-
2 volved with furnishing a service and may
3 include validation of the pre, post, and
4 intra-service components of work.

5 “(iii) SCOPE OF CODES.—The valida-
6 tion of work relative value units shall in-
7 clude a sampling of codes for services that
8 is the same as the codes listed under sub-
9 paragraph (K)(ii)

10 “(iv) METHODS.—The Secretary may
11 conduct the validation under this subpara-
12 graph using methods described in sub-
13 clauses (I) through (V) of subparagraph
14 (K)(iii) as the Secretary determines to be
15 appropriate.

16 “(v) ADJUSTMENTS.—The Secretary
17 shall make appropriate adjustments to the
18 work relative value units under the fee
19 schedule under subsection (b). The provi-
20 sions of subparagraph (B)(ii)(II) shall
21 apply to adjustments to relative value units
22 made pursuant to this subparagraph in the
23 same manner as such provisions apply to
24 adjustments under subparagraph
25 (B)(ii)(II).”.

1 (b) IMPLEMENTATION.—

2 (1) FUNDING.—For purposes of carrying out
3 the provisions of subparagraphs (K) and (L) of
4 1848(c)(2) of the Social Security Act, as added by
5 subsection (a), in addition to funds otherwise avail-
6 able, out of any funds in the Treasury not otherwise
7 appropriated, there are appropriated to the Sec-
8 retary of Health and Human Services for the Center
9 for Medicare & Medicaid Services Program Manage-
10 ment Account \$20,000,000 for fiscal year 2010 and
11 each subsequent fiscal year. Amounts appropriated
12 under this paragraph for a fiscal year shall be avail-
13 able until expended.

14 (2) ADMINISTRATION.—

15 (A) Chapter 35 of title 44, United States
16 Code and the provisions of the Federal Advisory
17 Committee Act (5 U.S.C. App.) shall not apply
18 to this section or the amendment made by this
19 section.

20 (B) Notwithstanding any other provision of
21 law, the Secretary may implement subpara-
22 graphs (K) and (L) of 1848(c)(2) of the Social
23 Security Act, as added by subsection (a), by
24 program instruction or otherwise.

1 (C) Section 4505(d) of the Balanced
2 Budget Act of 1997 is repealed.

3 (D) Except for provisions related to con-
4 fidentiality of information, the provisions of the
5 Federal Acquisition Regulation shall not apply
6 to this section or the amendment made by this
7 section.

8 (3) FOCUSING CMS RESOURCES ON POTEN-
9 Tially OVERVALUED CODES.—Section 1868(a) of
10 the Social Security Act (42 1395ee(a)) is repealed.

11 **SEC. 1123. PAYMENTS FOR EFFICIENT AREAS.**

12 Section 1833 of the Social Security Act (42 U.S.C.
13 1395l) is amended by adding at the end the following new
14 subsection:

15 “(x) INCENTIVE PAYMENTS FOR EFFICIENT
16 AREAS.—

17 “(1) IN GENERAL.—In the case of services fur-
18 nished under the physician fee schedule under sec-
19 tion 1848 on or after January 1, 2011, and before
20 January 1, 2013, by a supplier that is paid under
21 such fee schedule in an efficient area (as identified
22 under paragraph (2)), in addition to the amount of
23 payment that would otherwise be made for such
24 services under this part, there also shall be paid an

1 amount equal to 5 percent of the payment amount
2 for the services under this part.

3 “(2) IDENTIFICATION OF EFFICIENT AREAS.—

4 “(A) IN GENERAL.—Based upon available
5 data, the Secretary shall identify those counties
6 or equivalent areas in the United States in the
7 lowest fifth percentile of utilization based on
8 per capita spending for services provided in the
9 most recent year for which data is available as
10 of the date of the enactment of this subsection,
11 under this part and part A as standardized to
12 eliminate the effect of geographic adjustments
13 in payment rates.

14 “(B) IDENTIFICATION OF COUNTIES
15 WHERE SERVICE IS FURNISHED.—For pur-
16 poses of paying the additional amount specified
17 in paragraph (1), if the Secretary uses the 5-
18 digit postal ZIP Code where the service is fur-
19 nished, the dominant county of the postal ZIP
20 Code (as determined by the United States Post-
21 al Service, or otherwise) shall be used to deter-
22 mine whether the postal ZIP Code is in a coun-
23 ty described in subparagraph (A).

1 “(C) JUDICIAL REVIEW.—There shall be
2 no administrative or judicial review under sec-
3 tion 1869, 1878, or otherwise, respecting—

4 “(i) the identification of a county or
5 other area under subparagraph (A); or

6 “(ii) the assignment of a postal ZIP
7 Code to a county or other area under sub-
8 paragraph (B).

9 “(D) PUBLICATION OF LIST OF COUNTIES;
10 POSTING ON WEBSITE.—With respect to a year
11 for which a county or area is identified under
12 this paragraph, the Secretary shall identify
13 such counties or areas as part of the proposed
14 and final rule to implement the physician fee
15 schedule under section 1848 for the applicable
16 year. The Secretary shall post the list of coun-
17 ties identified under this paragraph on the
18 Internet website of the Centers for Medicare &
19 Medicaid Services.”.

20 **SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY**
21 **REPORTING INITIATIVE (PQRI).**

22 (a) IN GENERAL.—Section 1848(m) of the Social Se-
23 curity Act (42 U.S.C. 1395w-4(m)) is amended by adding
24 at the end the following new paragraphs:

1 “(7) FEEDBACK MECHANISM.—Not later than
2 January 1, 2011, the Secretary shall develop and
3 implement a mechanism to provide timely feedback
4 to eligible professionals who, with respect to a re-
5 porting period, report data under paragraph (1) on
6 quality measures that have been established under
7 the physician reporting system. Such feedback, upon
8 the request of a participating professional, with re-
9 spect to such a professional shall include—

10 “(A) information on the extent to which
11 such professional is reporting such data in a
12 manner consistent with this subsection and any
13 recommendations on how to correct any report-
14 ing inconsistencies; and

15 “(B) interim assessments on the prob-
16 ability of the professional receiving an incentive
17 payment under this subsection for such report-
18 ing period.

19 “(8) APPEALS PROCESS.—Not later than Janu-
20 ary 1, 2011, the Secretary shall implement a process
21 under which an eligible professional described in
22 paragraph (7) may request a review of the disputed
23 payment amounts and errors the professional be-
24 lieves were made by a contractor acting on behalf of
25 the Secretary.

1 “(9) INTEGRATION OF PHYSICIAN QUALITY RE-
2 PORTING AND EHR REPORTING.—Not later than
3 January 1, 2012, the Secretary shall develop a plan
4 to integrate clinical reporting on quality measures
5 under this subsection with reporting requirements
6 under subsection (o) relating to the meaningful use
7 of electronic health records. Such integration shall
8 consist of the following:

9 “(A) The development of measures, the re-
10 porting of which would both demonstrate—

11 “(i) meaningful use of an electronic
12 health record for purposes of subsection
13 (o); and

14 “(ii) clinical quality of care furnished
15 to an individual.

16 “(B) The collection of health data to iden-
17 tify deficiencies in the quality and coordination
18 of care for individuals eligible for benefits under
19 this part.

20 “(C) Such other activities as specified by
21 the Secretary.”.

22 (b) EXTENSION OF INCENTIVE PAYMENTS.—Section
23 1848(m)(1) of such Act (42 U.S.C. 1395w-4(m)(1)) is
24 amended—

1 (1) in subparagraph (A), by striking “2010”
2 and inserting “2012”; and

3 (2) in subparagraph (B)(ii), by striking “2009
4 and 2010” and inserting “for each of the years 2009
5 through 2012”.

6 **SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**
7 **ITIES.**

8 (a) IN GENERAL.—Section 1848(e) of the Social Se-
9 curity Act (42 U.S.C.1395w-4(e)) is amended by adding
10 at the end the following new paragraph:

11 “(6) TRANSITION TO USE OF MSAS AS FEE
12 SCHEDULE AREAS IN CALIFORNIA.—

13 “(A) IN GENERAL.—

14 “(i) REVISION.—Subject to clause (ii)
15 and notwithstanding the previous provi-
16 sions of this subsection, for services fur-
17 nished on or after January 1, 2011, the
18 Secretary shall revise the fee schedule
19 areas used for payment under this section
20 applicable to the State of California using
21 the Metropolitan Statistical Area (MSA)
22 iterative Geographic Adjustment Factor
23 methodology as follows:

24 “(I) The Secretary shall con-
25 figure the physician fee schedule areas

1 using the Core-Based Statistical
2 Areas-Metropolitan Statistical Areas
3 (each in this paragraph referred to as
4 an ‘MSA’), as defined by the Director
5 of the Office of Management and
6 Budget, as the basis for the fee sched-
7 ule areas. The Secretary shall employ
8 an iterative process to transition fee
9 schedule areas. First, the Secretary
10 shall list all MSAs within the State by
11 Geographic Adjustment Factor de-
12 scribed in paragraph (2) (in this para-
13 graph referred to as a ‘GAF’) in de-
14 scending order. In the first iteration,
15 the Secretary shall compare the GAF
16 of the highest cost MSA in the State
17 to the weighted-average GAF of the
18 group of remaining MSAs in the
19 State. If the ratio of the GAF of the
20 highest cost MSA to the weighted-av-
21 erage GAF of the rest of State is 1.05
22 or greater then the highest cost MSA
23 becomes a separate fee schedule area.

24 “(II) In the next iteration, the
25 Secretary shall compare the MSA of

1 the second-highest GAF to the weight-
2 ed-average GAF of the group of re-
3 maining MSAs. If the ratio of the sec-
4 ond-highest MSA's GAF to the
5 weighted-average of the remaining
6 lower cost MSAs is 1.05 or greater,
7 the second-highest MSA becomes a
8 separate fee schedule area. The
9 iterative process continues until the
10 ratio of the GAF of the highest-cost
11 remaining MSA to the weighted-aver-
12 age of the remaining lower-cost MSAs
13 is less than 1.05, and the remaining
14 group of lower cost MSAs form a sin-
15 gular fee schedule area, If two MSAs
16 have identical GAFs, they shall be
17 combined in the iterative comparison.

18 “(ii) TRANSITION.—For services fur-
19 nished on or after January 1, 2011, and
20 before January 1, 2016, in the State of
21 California, after calculating the work, prac-
22 tice expense, and malpractice geographic
23 indices described in clauses (i), (ii), and
24 (iii) of paragraph (1)(A) that would other-
25 wise apply through application of this

1 paragraph, the Secretary shall increase any
2 such index to the county-based fee sched-
3 ule area value on December 31, 2009, if
4 such index would otherwise be less than
5 the value on January 1, 2010.

6 “(B) SUBSEQUENT REVISIONS.—

7 “(i) PERIODIC REVIEW AND ADJUST-
8 MENTS IN FEE SCHEDULE AREAS.—Subse-
9 quent to the process outlined in paragraph
10 (1)(C), not less often than every three
11 years, the Secretary shall review and up-
12 date the California Rest-of-State fee sched-
13 ule area using MSAs as defined by the Di-
14 rector of the Office of Management and
15 Budget and the iterative methodology de-
16 scribed in subparagraph (A)(i).

17 “(ii) LINK WITH GEOGRAPHIC INDEX
18 DATA REVISION.—The revision described in
19 clause (i) shall be made effective concur-
20 rently with the application of the periodic
21 review of the adjustment factors required
22 under paragraph (1)(C) for California for
23 2012 and subsequent periods. Upon re-
24 quest, the Secretary shall make available
25 to the public any county-level or MSA de-

1 rived data used to calculate the geographic
2 practice cost index.

3 “(C) REFERENCES TO FEE SCHEDULE
4 AREAS.—Effective for services furnished on or
5 after January 1, 2010, for the State of Cali-
6 fornia, any reference in this section to a fee
7 schedule area shall be deemed a reference to an
8 MSA in the State.”.

9 (b) CONFORMING AMENDMENT TO DEFINITION OF
10 FEE SCHEDULE AREA.—Section 1848(j)(2) of the Social
11 Security Act (42 U.S.C. 1395w(j)(2)) is amended by strik-
12 ing “The term” and inserting “Except as provided in sub-
13 section (e)(6)(C), the term”.

14 **PART 2—MARKET BASKET UPDATES**
15 **SEC. 1131. INCORPORATING PRODUCTIVITY ADJUSTMENT**
16 **INTO MARKET BASKET UPDATES THAT DO**
17 **NOT ALREADY INCORPORATE SUCH ADJUST-**
18 **MENT.**

19 (a) DIALYSIS.—

20 (1) IN GENERAL.—Section 1881(b)(14)(F) of
21 the Social Security Act (42 U.S.C.
22 1395rr(b)(14)(F)) is amended by striking “minus
23 1.0 percentage points” and inserting “subject to the
24 productivity adjustment described in section

1 1886(b)(3)(B)(iii)(II)” each place it appears in
2 clauses (i) and (ii)(II).

3 (2) EFFECTIVE DATE.—The amendments made
4 by paragraph (1) shall apply to annual increases ef-
5 fected for years beginning with 2012.

6 (b) OUTPATIENT HOSPITALS.—

7 (1) IN GENERAL.—Section 1833(t)(3)(C)(iv) of
8 the Social Security Act (42 U.S.C.
9 1395l(t)(3)(C)(iv)) is amended—

10 (A) by inserting (which is subject to the
11 productivity adjustment described in section
12 1886(b)(3)(B)(iii)(II)) after
13 “1886(b)(3)(B)(iii)”;

14 (B) by inserting “(but not below 0)” after
15 “reduced”.

16 (2) EFFECTIVE DATE.—The amendments made
17 by paragraph (1) shall apply to annual increases ef-
18 fected for years beginning with 2010.

19 **PART 3—OTHER PROVISIONS**

20 **SEC. 1141. RENTAL AND PURCHASE OF POWER-DRIVEN** 21 **WHEELCHAIRS.**

22 (a) IN GENERAL.—Section 1834(a)(7) of the Social
23 Security Act (42 U.S.C. 1395m(a)(7)) is amended—

24 (1) in subparagraph (A)—

1 (A) in clause (i)(I), by striking “Except as
2 provided in clause (iii), payment” and inserting
3 “Payment”;

4 (B) by striking clause (iii); and

5 (C) in clause (iv)—

6 (i) by redesignating such clause as
7 clause (iii); and

8 (ii) by striking “or in the case of a
9 power-driven wheelchair for which a pur-
10 chase agreement has been entered into
11 under clause (iii)”;

12 (2) in subparagraph (C)(ii)(II), by striking “or
13 (A)(iii)”.

14 (b) EFFECTIVE DATE.—Subject to paragraph (1),
15 the amendments made by subsection (a) shall take effect
16 on January 1, 2011, and shall apply to power-driven
17 wheelchairs furnished on or after such date.

18 **SEC. 1142. EXTENSION OF PAYMENT RULE FOR**
19 **BRACHYTHERAPY AND THERAPEUTIC RADIO-**
20 **PHARMACEUTICALS.**

21 Section 1833(t)(16)(C) of the Social Security Act (42
22 U.S.C. 1395l(t)(16)(C)), as amended by section 142 of the
23 Medicare Improvements for Patients and Providers Act of
24 2009 (Public Law 110–275), is amended by striking

1 “January 1, 2010” and inserting “January 1, 2012” each
2 place it appears.

3 **SEC. 1143. HOME INFUSION THERAPY REPORT TO CON-**
4 **GRESS.**

5 Not later than 12 months after the date of the enact-
6 ment of this Act, the Secretary of Health and Human
7 Services shall submit to Congress a report on the fol-
8 lowing:

9 (1) The scope of coverage for home infusion
10 therapy services in each of the traditional fee-for-
11 service Medicare program under title XVIII of the
12 Social Security Act, Medicare Advantage under part
13 C of such title, the veteran’s health care program
14 under chapter 17 of title 38, United States Code,
15 and private payers.

16 (2) The benefits and costs of providing such
17 coverage under the Medicare program.

18 (3) Recommendations on the structure of a
19 payment system under the Medicare program for
20 such home infusion therapy services, including any
21 appropriate incorporation of payment for such serv-
22 ices under existing payment systems under the Medi-
23 care program.

1 (4) Recommendations to Congress for legisla-
2 tive action relating to coverage for home infusion
3 therapy services under the Medicare program.

4 **SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS**
5 **(ASCS) TO SUBMIT COST DATA AND OTHER**
6 **DATA.**

7 (a) COST REPORTING.—

8 (1) IN GENERAL.—Section 1833(i) of the Social
9 Security Act (42 U.S.C. 1395l(i)) is amended by
10 adding at the end the following new paragraph:

11 “(8) The Secretary shall require, as a condition of
12 coverage, the submission of such report on costs of the
13 facility as the Secretary may specify, taking into account
14 the requirements for such reports under section 1815(i)
15 in the case of a hospital.”.

16 (2) DEVELOPMENT OF COST REPORT.—Not
17 later than 2 years after the date of the enactment
18 of this Act, the Secretary of Health and Human
19 Services shall develop a cost report form for use
20 under section 1833(i)(8) of the Social Security Act,
21 as added by paragraph (1).

22 (3) AUDIT REQUIREMENT.—The Secretary shall
23 provide for periodic auditing of cost reports sub-
24 mitted under section 1833(i)(8) of the Social Secu-
25 rity Act, as added by paragraph (1).

1 (4) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply to payments for pay-
3 ment cost reporting periods beginning on or after
4 the date the Secretary develops the cost report form
5 under paragraph (2).

6 (b) ADDITIONAL DATA ON QUALITY.—

7 (1) IN GENERAL.—Section 1833(i)(7) of such
8 Act is amended by adding at the end the following
9 new subparagraph:

10 “(C) Under subparagraph (B) the Secretary shall re-
11 quire the reporting of such additional data relating to
12 quality of services furnished in an ambulatory surgical fa-
13 cility, such as data on health care associated infections,
14 as the Secretary may specify.”.

15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall to reporting for years begin-
17 ning with 2012.

18 **SEC. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.**

19 Section 1833(t) of the Social Security Act (42 U.S.C.
20 1395l(t)) is amended by adding at the end the following
21 new paragraph:

22 “(18) AUTHORIZATION OF ADJUSTMENT FOR
23 CANCER HOSPITALS.—

24 “(A) STUDY.—The Secretary shall conduct
25 a study to determine if, under the system under

1 this subsection, costs incurred by hospitals de-
2 scribed in section 1886(d)(1)(B)(v) with respect
3 to ambulatory payment classification groups ex-
4 ceed those costs incurred by other hospitals fur-
5 nishing services under this subsection (as deter-
6 mined appropriate by the Secretary).

7 “(B) AUTHORIZATION OF ADJUSTMENT.—
8 Insofar as the Secretary determines under sub-
9 paragraph (A) that costs incurred by hospitals
10 described in section 1886(d)(1)(B)(v) exceed
11 those costs incurred by other hospitals fur-
12 nishing services under this subsection, the Sec-
13 retary shall provide for an appropriate adjust-
14 ment under paragraph (2)(E) to reflect those
15 higher costs effective for services furnished on
16 or after January 1, 2011.”.

17 **SEC. 1146. MEDICARE IMPROVEMENT FUND.**

18 Section 1898(b)(1) of the Social Security Act (42
19 U.S.C. 1395iii(b)(1)) is amended by striking “during—”
20 and all that follows and inserting “during any fiscal year
21 is 0.”.

22 **SEC. 1147. PAYMENT FOR IMAGING SERVICES.**

23 (a) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
24 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848

1 of the Social Security Act (42 U.S.C. 1395w) is amend-
2 ed—

3 (1) in subsection (b)(4)—

4 (A) in subparagraph (B), by striking “sub-
5 paragraph (A)” and inserting “this paragraph”;
6 and

7 (B) by adding at the end the following new
8 subparagraph:

9 “(D) ADJUSTMENT IN PRACTICE EXPENSE
10 TO REFLECT HIGHER PRESUMED UTILIZA-
11 TION.—In computing the number of practice
12 expense relative value units under subsection
13 (c)(2)(C)(ii) with respect to imaging services
14 described in subparagraph (B), the Secretary
15 shall adjust such number of units so it reflects
16 a 75 percent (rather than 50 percent) presumed
17 rate of utilization of imaging equipment.”; and

18 (2) in subsection (c)(2)(B)(v)(II), by inserting
19 “AND OTHER PROVISIONS” after “OPD PAYMENT
20 CAP”.

21 (b) ADJUSTMENT IN TECHNICAL COMPONENT “DIS-
22 COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE
23 BODY PARTS.—Section 1848(b)(4) of such Act is further
24 amended by adding at the end the following new subpara-
25 graph:

1 “(E) ADJUSTMENT IN TECHNICAL COMPO-
2 NENT DISCOUNT ON SINGLE-SESSION IMAGING
3 INVOLVING CONSECUTIVE BODY PARTS.—The
4 Secretary shall increase the reduction in ex-
5 penditures attributable to the multiple proce-
6 dure payment reduction applicable to the tech-
7 nical component for imaging under the final
8 rule published by the Secretary in the Federal
9 Register on November 21, 2005 (42 CFR 405,
10 et al.) from 25 percent to 50 percent.”.

11 (c) EFFECTIVE DATE.—Except as otherwise pro-
12 vided, this section, and the amendments made by this sec-
13 tion, shall apply to services furnished on or after January
14 1, 2011.

15 **Subtitle C—Provisions Related to**
16 **Medicare Parts A and B**

17 **SEC. 1151. REDUCING POTENTIALLY PREVENTABLE HOS-**
18 **PITAL READMISSIONS.**

19 (a) HOSPITALS.—

20 (1) IN GENERAL.—Section 1886 of the Social
21 Security Act (42 U.S.C. 1395ww) is amended by
22 adding at the end the following new subsection:

23 “(o) ADJUSTMENT TO HOSPITAL PAYMENTS FOR
24 EXCESS READMISSIONS.—

1 “(1) IN GENERAL.—With respect to payment
2 for discharges from an applicable hospital (as de-
3 fined in paragraph (5)(C)) occurring during a fiscal
4 year beginning on or after October 1, 2010, in order
5 to account for excess readmissions in the hospital,
6 the Secretary shall reduce the payments that would
7 otherwise be made to such hospital under subsection
8 (d) (or section 1814(b)(3), as the case may be) to
9 an amount equal to the product of—

10 “(A) the base operating DRG payment
11 amount (as defined in paragraph (2)) for the
12 discharge; and

13 “(B) the adjustment factor (described in
14 paragraph (3)(A)) for the hospital for the fiscal
15 year.

16 “(2) BASE OPERATING DRG PAYMENT
17 AMOUNT.—

18 “(A) IN GENERAL.—Except as provided in
19 subparagraph (B), for purposes of this sub-
20 section, the term ‘base operating DRG payment
21 amount’ means, with respect to a hospital for a
22 fiscal year, the payment amount that would
23 otherwise be made under subsection (d) for a
24 discharge if this subsection did not apply, re-
25 duced by any portion of such amount that is at-

1 tributable to payments under paragraphs
2 (5)(A), (5)(B), (5)(F), and (12) of subsection
3 (d).

4 “(B) ADJUSTMENTS.—For purposes of
5 subparagraph (A)—

6 “(i) in the case of a sole community
7 hospital, the payment amount that would
8 otherwise be made under subsection (d)
9 shall be determined without regard to sub-
10 paragraphs (I) and (L) of subsection
11 (b)(3) and subparagraph (D) of subsection
12 (d)(5); and

13 “(ii) in the case of a hospital that is
14 paid under section 1814(b)(3), the term
15 ‘base operating DRG payment amount’
16 means the payment amount under such
17 section.

18 “(3) ADJUSTMENT FACTOR.—

19 “(A) IN GENERAL.—For purposes of para-
20 graph (1), the adjustment factor under this
21 paragraph for an applicable hospital for a fiscal
22 year is equal to the greater of—

23 “(i) the ratio described in subpara-
24 graph (B) for the hospital for the applica-

1 ble period (as defined in paragraph (5)(D))
2 for such fiscal year; or

3 “(ii) the floor adjustment factor speci-
4 fied in subparagraph (C)

5 “(B) RATIO.—The ratio described in this
6 subparagraph for a hospital for an applicable
7 period is equal to 1 minus the ratio of—

8 “(i) the aggregate payments for ex-
9 cess readmissions (as defined in paragraph
10 (4)(A)) with respect to an applicable hos-
11 pital for the applicable period; and

12 “(ii) the aggregate payments for all
13 discharges (as defined in paragraph
14 (4)(B)) with respect to such applicable
15 hospital for such applicable period.

16 “(C) FLOOR ADJUSTMENT FACTOR.—For
17 purposes of subparagraph (A), the floor adjust-
18 ment factor specified in this subparagraph
19 for—

20 “(i) fiscal year 2011 is **[0.99]**;

21 “(ii) fiscal year 2012 is **[0.98]**;

22 “(iii) fiscal year 2013 is **[0.97]**; or

23 “(iv) a subsequent fiscal year is
24 **[0.95]**.

1 “(4) AGGREGATE PAYMENTS, EXCESS READMIS-
2 SION RATIO DEFINED.—For purposes of this sub-
3 section:

4 “(A) AGGREGATE PAYMENTS FOR EXCESS
5 READMISSIONS.—The term ‘aggregate payments
6 for excess readmissions’ means, for a hospital
7 for a fiscal year, the sum, for applicable condi-
8 tions (as defined in paragraph (5)(A)), of the
9 product, for each applicable condition, of—

10 “(i) the base operating DRG payment
11 amount for such hospital for fiscal year for
12 such condition;

13 “(ii) the number of admissions for
14 such condition for such hospital for such
15 fiscal year; and

16 “(iii) the excess readmissions ratio (as
17 defined in subparagraph (C)) for such hos-
18 pital for the applicable period for such fis-
19 cal year minus 1.

20 “(B) AGGREGATE PAYMENTS FOR ALL DIS-
21 CHARGES.—The term ‘aggregate payments for
22 all discharges’ means, for a hospital for a fiscal
23 year, the sum of the base operating DRG pay-
24 ment amounts for all discharges for all condi-
25 tions from such hospital for such fiscal year.

1 “(C) EXCESS READMISSION RATIO.—

2 “(i) IN GENERAL.—Subject to clauses
3 (ii) and (iii), the term ‘excess readmissions
4 ratio’ means, with respect to an applicable
5 condition for a hospital for an applicable
6 period, the ratio (but not less than 1.0)
7 of—

8 “(I) the risk adjusted readmis-
9 sions based on actual readmissions, as
10 determined consistent with a readmis-
11 sion rate methodology to the extent it
12 has been endorsed under paragraph
13 (5)(A)(ii)(I), for an applicable hospital
14 for such condition with respect to the
15 applicable period; to

16 “(II) the risk adjusted expected
17 readmissions (as determined con-
18 sistent with such a methodology) for
19 such hospital for such condition with
20 respect to such applicable period.

21 “(ii) EXCLUSION OF CERTAIN RE-
22 ADMISSIONS.—For purposes of clause (i),
23 excess readmissions shall not include re-
24 admissions for an applicable condition for
25 which there are fewer than a minimum

1 number (as determined by the Secretary)
2 of discharges for such applicable condition
3 for the applicable period.

4 “(iii) ADJUSTMENT.—In order to pro-
5 mote a reduction over time in the overall
6 rate of readmissions for applicable condi-
7 tions, the Secretary may provide, beginning
8 with discharges for fiscal year 2013, for
9 the determination of the excess readmis-
10 sions ratio under subparagraph (C) to be
11 based on a ranking of hospitals by read-
12 mission ratios (from lower to higher read-
13 mission ratios) normalized to a benchmark
14 that is lower than the 50th percentile.

15 “(5) DEFINITIONS.—For purposes of this sub-
16 section:

17 “(A) APPLICABLE CONDITION.—The term
18 ‘applicable condition’ means, subject to sub-
19 paragraph (B), a condition or procedure se-
20 lected by the Secretary among conditions and
21 procedures for which—

22 “(i) readmissions (as defined in sub-
23 paragraph (E)) represent conditions or
24 procedures that are high volume or high

1 expenditures under this title (or other cri-
2 teria specified by the Secretary); and

3 “(ii) measures of such readmissions—

4 “(I) have been endorsed by the
5 entity with a contract under section
6 1890(a); and

7 “(II) have appropriate exclusions
8 for readmissions that are unrelated to
9 the prior discharge (such as a planned
10 readmission or transfer to another ap-
11 plicable hospital).

12 “(B) EXPANSION OF APPLICABLE CONDI-
13 TIONS.—The Secretary shall expand the appli-
14 cable conditions beyond the 3 conditions for
15 which measures have been endorsed as de-
16 scribed in subparagraph (A)(i) as of the date of
17 the enactment of this subsection—

18 “(i) beginning with fiscal year 2013,
19 to the additional 4 conditions that have
20 been so identified by the Medicare Pay-
21 ment Advisory Commission in its report to
22 Congress in June 2008; and

23 “(ii) beginning with fiscal year 2015,
24 to other conditions and procedures, includ-
25 ing an all-cause measure of readmissions,

1 as determined appropriate by the Sec-
2 retary.

3 In the cases described in clauses (i) and (ii),
4 the Secretary shall seek the endorsement de-
5 scribed in subparagraph (A)(ii)(I) but may
6 apply such conditions without such an endorse-
7 ment.

8 “(C) APPLICABLE HOSPITAL.—The term
9 ‘applicable hospital’ means a subsection (d) hos-
10 pital.

11 “(D) APPLICABLE PERIOD.—The term ‘ap-
12 plicable period’ means, with respect to a fiscal
13 year, such period as the Secretary shall specify
14 for purposes of determining excess readmis-
15 sions.

16 “(E) READMISSION.—The term ‘readmis-
17 sion’ means, in the case of an individual who is
18 discharged from a hospital, the admission of the
19 individual to the same or another hospital with-
20 in a time period specified by the Secretary from
21 the date of such discharge. Insofar as the dis-
22 charge relates to an applicable condition for
23 which there is an endorsed measure described
24 in subparagraph (A)(ii)(I), such time period

1 (such as 30 days) shall be consistent with the
2 time period specified for such measure.

3 “(6) LIMITATIONS ON REVIEW.—There shall be
4 no administrative or judicial review under section
5 1869, section 1878, or otherwise of—

6 “(A) the determination of base operating
7 DRG payment amounts;

8 “(B) the methodology for determining the
9 adjustment factor under paragraph (3), includ-
10 ing excess readmissions ratio under paragraph
11 (4)(C), aggregate payments for excess readmis-
12 sions under paragraph (4)(A), and aggregate
13 payments for all discharges under paragraph
14 (4)(B), and applicable periods and applicable
15 conditions under paragraph (5); and

16 “(C) the measures of readmissions as de-
17 scribed in paragraph (5)(A)(ii).

18 “(7) MONITORING INAPPROPRIATE CHANGES IN
19 ADMISSIONS PRACTICES.—The Secretary shall mon-
20 itor the activities of applicable hospitals to determine
21 if such hospitals have taken steps to avoid patients
22 at risk in order to reduce the likelihood of increasing
23 readmissions for applicable conditions. If the Sec-
24 retary determines that such a hospital has taken
25 such a step, after notice to the hospital and oppor-

1 tunity for the hospital to undertake action to allevi-
2 ate such steps, the Secretary may impose an appro-
3 priate sanction.

4 “(8) ASSISTANCE TO CERTAIN HOSPITALS.—

5 “(A) IN GENERAL.—For purposes of pro-
6 viding funds to subsection (d) hospitals to take
7 steps described in subparagraph (E) to address
8 factors that may impact readmissions of indi-
9 viduals who are discharged from such a hos-
10 pital, for fiscal years beginning on or after fis-
11 cal year 2011, the Secretary shall increase the
12 disproportionate share payments otherwise
13 made to a hospital described in subparagraph
14 (B), with respect to each such fiscal year, by a
15 percent estimated by the Secretary to be con-
16 sistent with subparagraph (C).

17 “(B) TARGETED HOSPITALS.—Subpara-
18 graph (A) shall apply to a subsection (d) hos-
19 pital that—

20 “(i) received \$10,000,000 or more in
21 disproportionate share payments in its
22 most recently settled cost report; and

23 “(ii) provides assurances satisfactory
24 to the Secretary that the increase in pay-
25 ment under this paragraph shall be used

1 for purposes described in subparagraph
2 (E).

3 “(C) CAPS.—

4 “(i) AGGREGATE CAP.—The aggregate
5 amount of increase in disproportionate
6 share payments under this paragraph for a
7 fiscal year shall not exceed 5 percent of the
8 estimated savings with respect to the hos-
9 pital readmissions policy effected under
10 paragraph (1) for the fiscal year.

11 “(ii) HOSPITAL-SPECIFIC LIMIT.—The
12 aggregate amount of the increase in dis-
13 proportionate share payments made to a
14 hospital under this paragraph shall not ex-
15 ceed the aggregate amount of payments for
16 excess readmissions, as described in para-
17 graph (3)(A)(i), for such hospital for the
18 applicable period.

19 “(D) FORM OF PAYMENT.—The Secretary
20 may make the additional payments under this
21 paragraph on a lump sum basis, a periodic
22 basis, a claim by claim basis, or otherwise.

23 “(E) USE OF ADDITIONAL PAYMENT.—
24 Funding under this paragraph shall be used by
25 targeted hospitals for transitional care activities

1 designed to address the patient noncompliance
2 issues that result in higher than normal read-
3 mission rates, such as one or more of the fol-
4 lowing:

5 “(i) Providing care coordination serv-
6 ices to assist in transitions from the tar-
7 geted hospital to other settings.

8 “(ii) Hiring translators.

9 “(iii) Increasing services offered by
10 discharge planners.

11 “(iv) Ensuring that individuals receive
12 a summary of care and medication orders
13 upon discharge.

14 “(v) Developing a quality improve-
15 ment plan to assess and remedy prevent-
16 able readmission rates.

17 “(vi) Assigning discharged individuals
18 to a medical home.

19 “(vii) Doing other activities as deter-
20 mined appropriate by the Secretary.

21 “(F) GAO REPORT ON USE OF FUNDS.—
22 Not later than 18 months after funds are first
23 made available under this paragraph, the
24 Comptroller General of the United States shall

1 submit to Congress a report on the use of such
2 funds.

3 “(G) DISPROPORTIONATE SHARE HOS-
4 PITAL PAYMENT.—In this paragraph, the term
5 ‘disproportionate share hospital payment’
6 means an additional payment amount under
7 subsection (d)(5)(F).”.

8 (b) APPLICATION TO CRITICAL ACCESS HOS-
9 PITALS.—Section 1814(l) of the Social Security Act (42
10 U.S.C. 1395f(l)) is amended—

11 (1) in paragraph (5)—

12 (A) by striking “and” at the end of sub-
13 paragraph (C);

14 (B) by striking the period at the end of
15 subparagraph (D) and inserting “; and”;

16 (C) by inserting at the end the following
17 new subparagraph:

18 “(E) The methodology for determining the ad-
19 justment factor under paragraph (5), including the
20 determination of aggregate payments for actual and
21 expected readmissions, applicable periods, applicable
22 conditions and measures of readmissions.”; and

23 (D) by redesignating such paragraph as
24 paragraph (6); and

1 (2) by inserting after paragraph (4) the fol-
2 lowing new paragraph:

3 “(5) The adjustment factor described in section
4 1886(o)(4) shall apply with respect to a critical access hos-
5 pital with respect to a cost reporting period beginning in
6 fiscal year 2011 and each subsequent fiscal year (after ap-
7 plication of paragraph (4) of this subsection) in the same
8 manner as such section applies with respect to a fiscal
9 year to an applicable hospital as described in section
10 1886(o)(2).”.

11 (c) POST ACUTE CARE PROVIDERS.—

12 (1) INTERIM POLICY.—

13 (A) IN GENERAL.—With respect to a read-
14 mission to an applicable hospital or a critical
15 access hospital (as described in section 1814(l)
16 of the Social Security Act) from a post acute
17 care provider (as defined in paragraph (3)), if
18 the claim submitted by such a post-acute care
19 provider under title XVIII of the Social Secu-
20 rity Act indicates that the individual was re-
21 admitted to a hospital from such a post-acute
22 care provider within 30 days of an initial dis-
23 charge from an 1886(d) hospital or critical ac-
24 cess hospital, the payment under such title on
25 such claim shall be the applicable percent speci-

1 fied in subparagraph (B) of the payment that
2 would otherwise be made under the respective
3 payment system under such title for such post-
4 acute care provider if this subsection did not
5 apply.

6 (B) APPLICABLE PERCENT DEFINED.—For
7 purposes of subparagraph (A), the applicable
8 percent is—

9 (i) for fiscal or rate year 2011 is
10 **[0.996]**;

11 (ii) for fiscal or rate year 2012 is
12 **[0.993]**; and

13 (iii) for fiscal or rate year 2013 is
14 **[0.99]**.

15 (C) EFFECTIVE DATE.—Subparagraph (1)
16 shall apply to discharges or services furnished
17 (as the case may be with respect to the applica-
18 ble post acute care provider) on or after the
19 first day of the rate year, beginning on or after
20 October 1, 2010, with respect to the applicable
21 post acute care provider.

22 (2) DEVELOPMENT AND APPLICATION OF PER-
23 FORMANCE MEASURES.—

24 (A) IN GENERAL.—The Secretary of
25 Health and Human Services shall develop ap-

1 appropriate measures of readmission rates for
2 post acute care providers and shall submit such
3 measures for endorsement through a consensus-
4 based entity under section 1890(b) of the Social
5 Security Act. The Secretary shall adopt and ex-
6 pand such measures in a manner similar to the
7 manner in which applicable conditions are ex-
8 panded under paragraph (5)(B) of section
9 1886(o) of the Social Security Act, as added by
10 subsection (a).

11 (B) IMPLEMENTATION.—Insofar as such
12 measures are adopted, the Secretary shall
13 apply, on or after October 1, 2013, with respect
14 to post acute care providers, policies similar to
15 the policies applied with respect to applicable
16 hospitals and critical access hospitals under the
17 amendments made by subsection (a).

18 (C) MONITORING AND PENALTIES.—The
19 provisions of paragraph (7) of such section
20 1886(o) shall apply to providers under this
21 paragraph in the same manner as they apply to
22 hospitals under such section.

23 (3) DEFINITIONS.—For purposes of this sub-
24 section:

1 (A) POST ACUTE CARE PROVIDER.—The
2 term “post acute care provider” means—

3 (i) a skilled nursing facility (as de-
4 fined in section 1819(a) of the Social Secu-
5 rity Act);

6 (ii) an inpatient rehabilitation facility
7 (described in section 1886(h)(1)(A) of such
8 Act);

9 (iii) a home health agency (as defined
10 in section 1861(o) of such Act); and

11 (iv) a long term care hospital (as de-
12 fined in section 1861(ccc) of such Act).

13 (B) OTHER TERMS .—The terms “applica-
14 ble condition”, “applicable hospital”, “applica-
15 ble period”, and “readmission” have the mean-
16 ings given such terms in section 1886(o)(5) of
17 the Social Security Act, as added by subsection
18 (a)(1).

19 (d) PHYSICIANS.—

20 (1) STUDY.—The Secretary of Health and
21 Human Services shall conduct a study to determine
22 how the readmissions policy described in the pre-
23 vious subsections could be applied to physicians.

1 (2) CONSIDERATIONS.—In conducting the
2 study, the Secretary shall consider approaches such
3 as—

4 (A) creating a new code (or codes) and
5 payment amount (or amounts) under the fee
6 schedule in section 1848 of the Social Security
7 Act (in a budget neutral manner) for services
8 furnished by an appropriate physician who sees
9 an individual within the first week after dis-
10 charge from a hospital or critical access hos-
11 pital;

12 (B) developing measures of rates of read-
13 mission for individuals treated by physicians;

14 (C) applying a payment reduction for phy-
15 sicians who treat the patient during the initial
16 admission that results in a readmission; and

17 (D) methods for attributing payments or
18 payment reductions to the appropriate physi-
19 cian or physicians.

20 (3) REPORT.—The Secretary shall issue a pub-
21 lic report on such study not later than the date that
22 is one year after the date of the enactment of this
23 Act.

24 (e) FUNDING.—For purposes of carrying out the pro-
25 visions of this section, in addition to funds otherwise avail-

1 able, out of any funds in the Treasury not otherwise ap-
2 propriated, there are appropriated to the Secretary of
3 Health and Human Services for the Center for Medicare
4 & Medicaid Services Program Management Account
5 \$25,000,000 for each fiscal year beginning with 2010.
6 Amounts appropriated under this subsection for a fiscal
7 year shall be available until expended.

8 **SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM**

9 **PLAN.**

10 (a) PLAN.—

11 (1) IN GENERAL.—The Secretary of Health and
12 Human Services (in this section referred to as the
13 “Secretary”) shall develop a detailed plan to reform
14 payment for post acute care services under the
15 Medicare program under title XVIII of the Social
16 Security Act (in this section referred to as the
17 “Medicare program”). The goals of such payment
18 reform are to—

19 (A) improve the coordination, quality, and
20 efficiency of such services; and

21 (B) improve outcomes for individuals such
22 as reducing the need for readmission to hos-
23 pitals from providers of such services.

24 (2) BUNDLING POST ACUTE SERVICES.—The
25 plan described in paragraph (1) shall include de-

1 tailed specifications for a bundled payment for post
2 acute services (in this section referred to as the
3 “post acute care bundle”), and may include other
4 approaches determined appropriate by the Secretary.

5 (3) POST ACUTE SERVICES.—For purposes of
6 this section, the term “post acute services” means
7 services for which payment may be made under the
8 Medicare program that are furnished by skilled
9 nursing facilities, inpatient rehabilitation facilities,
10 long term care hospitals, hospital based outpatient
11 rehabilitation facilities and home health agencies to
12 an individual after discharge of such individual from
13 a hospital, and such other services determined ap-
14 propriate by the Secretary.

15 (b) DETAILS.—The plan described in subsection
16 (a)(1) shall include consideration of the following issues:

17 (1) The nature of payments under a post acute
18 care bundle, including the type of provider or entity
19 to whom payment should be made, the scope of ac-
20 tivities and services included in the bundle, whether
21 payment for physician services should be included in
22 the bundle, and the period covered by the bundle.

23 (2) Whether the payment should be consoli-
24 dated with the payment under the inpatient prospec-
25 tive system under section 1886 of the Social Secu-

1 rity Act (in this section referred to as MS-DRGs) or
2 a separate payment should be established for such
3 bundle, and if a separate payment is established,
4 whether it should be made only upon use of post
5 acute care services or for every discharge.

6 (3) Whether the bundle should be applied
7 across all categories of providers of inpatient serv-
8 ices (including critical access hospitals) and post
9 acute care services or whether it should be limited
10 to certain categories of providers, services, or dis-
11 charges, such as high volume or high cost MS-
12 DRGs.

13 (4) The extent to which payment rates could be
14 established to achieve offsets for efficiencies that
15 could be expected to be achieved with a bundle pay-
16 ment, whether such rates should be established on a
17 national basis or for different geographic areas,
18 should vary according to discharge, case mix,
19 outliers, and geographic differences in wages or
20 other appropriate adjustments, and how to update
21 such rates.

22 (5) The nature of protections needed for bene-
23 ficiaries under a system of bundled payments to en-
24 sure that beneficiaries receive quality care, are fur-
25 nished the level and amount of services needed as

1 determined by an appropriate assessment instru-
2 ment, and are offered choice of provider.

3 (6) The nature of relationships that may be re-
4 quired between hospitals and providers of post acute
5 care services to facilitate bundled payments, includ-
6 ing gainsharing, anti-referral, anti-kickback, and
7 anti-trust laws.

8 (7) Quality measures that would be appropriate
9 for reporting by hospitals and post acute providers
10 (such as measures that assess changes in functional
11 status and quality measures appropriate for each
12 type of post acute services provider including how
13 the reporting of such quality measures could be co-
14 ordinated with other reporting of such quality meas-
15 ures by such providers otherwise required).

16 (8) How cost-sharing for a post acute care bun-
17 dle should be treated relative to current rules for
18 cost-sharing for inpatient hospital, home health,
19 skilled nursing facility, and other services.

20 (9) How other programmatic issues should be
21 treated in a post acute care bundle, including rules
22 specific to various types of post-acute providers such
23 as the post-acute transfer policy, three-day hospital
24 stay to qualify for services furnished by skilled nurs-
25 ing facilities, and the coordination of payments and

1 care under the Medicare program and the Medicaid
2 program.

3 (10) Such other issues as the Secretary deems
4 appropriate.

5 (c) CONSULTATIONS AND ANALYSIS.—

6 (1) CONSULTATION WITH STAKEHOLDERS.—In
7 developing the plan under subsection (a)(1), the Sec-
8 retary shall consult with relevant stakeholders and
9 shall consider experience with such research studies
10 and demonstrations that the Secretary determines
11 appropriate.

12 (2) ANALYSIS AND DATA COLLECTION.—In de-
13 veloping such plan, the Secretary shall—

14 (A) analyze the issues described in sub-
15 section (b) and other issues that the Secretary
16 determines appropriate;

17 (B) analyze the impacts (including geo-
18 graphic impacts) of post acute service reform
19 approaches, including bundling of such services
20 on beneficiaries, hospitals, post acute care pro-
21 viders, and physicians;

22 (C) use existing data (such as data sub-
23 mitted on claims) and collect such data as the
24 Secretary determines are appropriate to develop
25 such plan required in this section; and

1 (D) if patient functional status measures
2 are appropriate for the analysis, to the extent
3 practical, build upon the CARE tool being de-
4 veloped pursuant to section 5008 of the Deficit
5 Reduction Act of 2005.

6 (d) ADMINISTRATION.—

7 (1) FUNDING.—For purposes of carrying out
8 the provisions of this section, in addition to funds
9 otherwise available, out of any funds in the Treasury
10 not otherwise appropriated, there are appropriated
11 to the Secretary for the Center for Medicare & Med-
12 icaid Services Program Management Account
13 \$15,000,000 for each of the fiscal years 2010
14 through 2012. Amounts appropriated under this
15 paragraph for a fiscal year shall be available until
16 expended.

17 (2) EXPEDITED DATA COLLECTION.—Chapter
18 35 of title 44, United States Code shall not apply to
19 this section.

20 (e) PUBLIC REPORTS.—

21 (1) INTERIM REPORTS.—The Secretary shall
22 issue interim public reports on a periodic basis on
23 the plan described in subsection (a)(1), the issues
24 described in subsection (b), and impact analyses as
25 the Secretary determines appropriate.

1 (2) FINAL REPORT.—Not later than the date
2 that is 3 years after the date of the enactment of
3 this Act, the Secretary shall issue a final public re-
4 port on such plan, including analysis of issues de-
5 scribed in subsection (b) and impact analyses.

6 (f) BUNDLING DEMONSTRATIONS AND IMPLEMENTA-
7 TION.—

8 (1) EXPANDED ACUTE CARE EPISODE DEM-
9 ONSTRATION WHILE POST ACUTE CARE PLAN IS
10 BEING DEVELOPED.—

11 (A) EXPANSION TO INCLUDE POST-ACUTE
12 CARE SERVICES.—Not later than 6 months
13 after the date of the enactment of this Act, the
14 Secretary shall (to the extent practical) expand
15 the acute care episode demonstration conducted
16 under section 1866C of the Social Security Act
17 to include post-acute care services and such
18 other services the Secretary determines to be
19 appropriate.

20 (B) EXPANSION TO ADDITIONAL SITES.—
21 The Secretary may further expand such dem-
22 onstration to additional sites. Such expansion
23 may include additional geographic areas and
24 additional conditions for which individuals are

1 high users, as defined by the Secretary, of post-
2 acute services.

3 (2) AUTHORITY AFTER PLAN IS ISSUED.—After
4 making public the report described in subsection
5 (e)(2), notwithstanding any other provision of title
6 XVIII, the Secretary may (as the Secretary deter-
7 mines appropriate) conduct demonstrations of bun-
8 dling of post acute care services or other post acute
9 services payment reforms identified in the plan de-
10 scribed in subsection (a)(1).

11 **SEC. 1153. HOME HEALTH PAYMENT UPDATE FOR 2010.**

12 Section 1895(b)(3)(B)(ii) of the Social Security Act
13 (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

14 (1) in subclause (IV), by striking “and”;

15 (2) by redesignating subclause (V) as subclause
16 (VII); and

17 (3) by inserting after subclause (IV) the fol-
18 lowing new subclauses:

19 “(V) 2007, 2008, and 2009, sub-
20 ject to clause (v), the home health
21 market basket percentage increase;

22 “(VI) 2010, subject to clause (v),
23 0 percent; and”.

1 **SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH**
2 **CARE.**

3 (a) ACCELERATION OF ADJUSTMENT FOR CASE MIX
4 CHANGES.—Section 1895(b)(3)(B) of the Social Security
5 Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

6 (1) in clause (iv), by striking “Insofar as” and
7 inserting “Subject to clause (vi), insofar as”; and

8 (2) by adding at the end the following new
9 clause:

10 “(vi) SPECIAL RULE FOR CASE MIX
11 CHANGES FOR 2011.—

12 “(I) IN GENERAL.—With respect
13 to the case mix adjustments estab-
14 lished in section 484.220(a) of title
15 42, Code of Federal Regulations, the
16 Secretary shall apply, in 2010, the ad-
17 justment established in paragraph (3)
18 of such section for 2011, in addition
19 to applying the adjustment established
20 in paragraph (2) for 2010.

21 “(II) CONSTRUCTION.—Nothing
22 in this clause shall be construed as
23 limiting the amount of adjustment for
24 case mix for 2010 or 2011 if more re-
25 cent data indicate an appropriate ad-
26 justment that is greater than the

1 amount established in the section de-
2 scribed in subclause (I).”.

3 (b) REBASING HOME HEALTH PROSPECTIVE PAY-
4 MENT AMOUNT.—Section 1895(b)(3)(A) of the Social Se-
5 curity Act (42 U.S.C. 1395fff(b)(3)(A)) is amended—

6 (1) in clause (i)—

7 (A) in subclause (III), by inserting “and
8 before 2011” after “after the period described
9 in subclause (II)”; and

10 (B) by inserting after subclause (III) the
11 following new subclauses:

12 “(IV) Subject to clause (iii)(I),
13 for2011, such amount (or amounts)
14 shall be adjusted by a uniform per-
15 centage determined to be appropriate
16 by the Secretary based on analysis of
17 factors such as changes in the average
18 number and types of visits in an epi-
19 sode, the change in intensity of visits
20 in an episode, growth in cost per epi-
21 sode, and other factors that the Sec-
22 retary considers to be relevant.

23 “(V) Subject to clause (iii)(II),
24 for a year after 2011, such a amount
25 (or amounts) shall be equal to the

1 amount (or amounts) determined
2 under this clause for the previous
3 year, updated under subparagraph
4 (B).”; and

5 (2) by adding at the end the following new
6 clause:

7 “(iii) SPECIAL RULE IN CASE OF IN-
8 ABILITY TO EFFECT TIMELY REBASING.—

9 “(I) APPLICATION OF PROXY
10 AMOUNT FOR 2011.—If the Secretary
11 is not able to compute the amount (or
12 amounts) under clause (i)(IV) so as to
13 permit, on a timely basis, the applica-
14 tion of such clause for 2011, the Sec-
15 retary shall substitute for such
16 amount (or amounts) 95 percent of
17 the amount (or amounts) that would
18 otherwise be specified under clause
19 (i)(III) if it applied for 2011.

20 “(II) ADJUSTMENT FOR SUBSE-
21 QUENT YEARS BASED ON DATA.—If
22 the Secretary applies subclause (I),
23 the Secretary before July 1, 2011,
24 shall compare the amount (or
25 amounts) applied under such sub-

1 clause with the amount (or amounts)
2 that should have been applied under
3 clause (i)(IV). The Secretary shall de-
4 crease or increase the prospective pay-
5 ment amount (or amounts) under
6 clause (i)(V) for 2012 (or, at the Sec-
7 retary's discretion, over a period of
8 several years beginning with 2012) by
9 the amount (if any) by which the
10 amount (or amounts) applied under
11 subclause (I) is greater or less, re-
12 spectively, than the amount (or
13 amounts) that should have been ap-
14 plied under clause (i)(IV).”.

15 **SEC. 1155. INCORPORATING PRODUCTIVITY ADJUSTMENT**
16 **INTO MARKET BASKET UPDATE FOR HOME**
17 **HEALTH SERVICES.**

18 (a) IN GENERAL.—Section 1895(b)(3)(B) of the So-
19 cial Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amend-
20 ed—

21 (1) in clause (iii), by inserting “(including being
22 subject to the productivity adjustment described in
23 section 1886(b)(3)(B)(iii)(II))” after “in the same
24 manner”; and

1 (2) in clause (v)(I), by inserting “(but not
2 below 0)” after “reduced”.

3 (b) **EFFECTIVE DATE.**—The amendment made by
4 subsection (a) shall apply to annual increases effected for
5 years beginning with 2010.

6 **SEC. 1156. LIMITATION ON MEDICARE EXCEPTION TO THE**
7 **PROHIBITION ON CERTAIN PHYSICIAN RE-**
8 **FERRALS FOR HOSPITALS.**

9 (a) **IN GENERAL.**—Section 1877 of the Social Secu-
10 rity Act (42 U.S.C. 1395nn) is amended—

11 (1) in subsection (d)(2)—

12 (A) in subparagraph (A), by striking
13 “and” at the end;

14 (B) in subparagraph (B), by striking the
15 period at the end and inserting “; and”; and

16 (C) by adding at the end the following new
17 subparagraph:

18 “(C) in the case where the entity is a hos-
19 pital, the hospital meets the requirements of
20 paragraph (3)(D).”;

21 (2) in subsection (d)(3)—

22 (A) in subparagraph (B), by striking
23 “and” at the end;

24 (B) in subparagraph (C), by striking the
25 period at the end and inserting “; and”; and

1 (C) by adding at the end the following new
2 subparagraph:

3 “(D) the hospital meets the requirements
4 described in subsection (i)(1).”;

5 (3) by amending subsection (f) to read as fol-
6 lows:

7 “(f) REPORTING AND DISCLOSURE REQUIRE-
8 MENTS.—

9 “(1) IN GENERAL.—Each entity providing cov-
10 ered items or services for which payment may be
11 made under this title shall provide the Secretary
12 with the information concerning the entity’s owner-
13 ship, investment, and compensation arrangements,
14 including—

15 “(A) the covered items and services pro-
16 vided by the entity, and

17 “(B) the names and unique physician iden-
18 tification numbers of all physicians with an
19 ownership or investment interest (as described
20 in subsection (a)(2)(A)), or with a compensa-
21 tion arrangement (as described in subsection
22 (a)(2)(B)), in the entity, or whose immediate
23 relatives have such an ownership or investment
24 interest or who have such a compensation rela-
25 tionship with the entity.

1 Such information shall be provided in such form,
2 manner, and at such times as the Secretary shall
3 specify. The requirement of this subsection shall not
4 apply to designated health services provided outside
5 the United States or to entities which the Secretary
6 determines provides services for which payment may
7 be made under this title very infrequently.

8 “(2) REQUIREMENTS FOR HOSPITALS WITH
9 PHYSICIAN OWNERSHIP OR INVESTMENT.—In the
10 case of a hospital that meets the requirements de-
11 scribed in subsection (i)(1), the hospital shall—

12 “(A) submit to the Secretary an initial re-
13 port, and periodic updates at a frequency deter-
14 mined by the Secretary, containing a detailed
15 description of the identity of each physician
16 owner and physician investor and any other
17 owners or investors of the hospital;

18 “(B) require that any referring physician
19 owner or investor discloses to the individual
20 being referred, by a time that permits the indi-
21 vidual to make a meaningful decision regarding
22 the receipt of services, as determined by the
23 Secretary, the ownership or investment interest,
24 as applicable, of such referring physician in the
25 hospital; and

1 “(C) disclose the fact that the hospital is
2 partially or wholly owned by one or more physi-
3 cians or has one or more physician investors—

4 “(i) on any public website for the hos-
5 pital; and

6 “(ii) in any public advertising for the
7 hospital. The information to be reported or
8 disclosed under this paragraph shall be
9 provided in such form, manner, and at
10 such times as the Secretary shall specify.

11 The requirements of this paragraph shall not apply
12 to designated health services furnished outside the
13 United States or to entities which the Secretary de-
14 termines provide services for which payment may be
15 made under this title very infrequently.

16 “(3) PUBLICATION OF INFORMATION.—The
17 Secretary shall publish, and periodically update, the
18 information submitted by hospitals under paragraph
19 (2)(A) on the public Internet website of the Centers
20 for Medicare & Medicaid Services.”;

21 (4) by amending subsection (g)(5) to read as
22 follows:

23 “(5) FAILURE TO REPORT OR DISCLOSE INFOR-
24 MATION.—

1 “(A) REPORTING.—Any person who is re-
2 quired, but fails, to meet a reporting require-
3 ment of paragraphs (1) and (2)(A) of sub-
4 section (f) is subject to a civil money penalty of
5 not more than \$10,000 for each day for which
6 reporting is required to have been made.

7 “(B) DISCLOSURE.—Any physician who is
8 required, but fails, to meet a disclosure require-
9 ment of subsection (f)(2)(B) or a hospital that
10 is required, but fails, to meet a disclosure re-
11 quirement of subsection (f)(2)(C) is subject to
12 a civil money penalty of not more than \$10,000
13 for each case in which disclosure is required to
14 have been made.

15 “(C) APPLICATION.—The provisions of
16 section 1128A (other than the first sentence of
17 subsection (a) and other than subsection (b))
18 shall apply to a civil money penalty under sub-
19 paragraphs (A) and (B) in the same manner as
20 such provisions apply to a penalty or proceeding
21 under section 1128A(a).”; and

22 (5) by adding at the end the following new sub-
23 section:

1 “(i) REQUIREMENTS TO QUALIFY FOR RURAL PRO-
2 VIDER AND HOSPITAL EXCEPTIONS TO SELF-REFERRAL
3 PROHIBITION.—

4 “(1) REQUIREMENTS DESCRIBED.—For pur-
5 poses of subsection (d)(3)(D), the requirements de-
6 scribed in this paragraph for a hospital are as fol-
7 lows:

8 “(A) PROVIDER AGREEMENT.—The hos-
9 pital had—

10 “(i) physician ownership or invest-
11 ment on January 1, 2009; and

12 “(ii) a provider agreement under sec-
13 tion 1866 in effect on such date.

14 “(B) PROHIBITION ON PHYSICIAN OWNER-
15 SHIP OR INVESTMENT.—The percentage of the
16 total value of the ownership or investment in-
17 terests held in the hospital, or in an entity
18 whose assets include the hospital, by physician
19 owners or investors in the aggregate does not
20 exceed such percentage as of the date of enact-
21 ment of this subsection.

22 “(C) PROHIBITION ON EXPANSION OF FA-
23 CILITY CAPACITY.—Except as provided in para-
24 graph (2), the number of operating rooms, pro-
25 cedure rooms, or beds of the hospital at any

1 time on or after the date of the enactment of
2 this subsection are no greater than the number
3 of operating rooms, procedure rooms, or beds,
4 respectively, as of such date.

5 “(D) ENSURING BONA FIDE OWNERSHIP
6 AND INVESTMENT.—

7 “(i) Any ownership or investment in-
8 terests that the hospital offers to a physi-
9 cian owner or investor are not offered on
10 more favorable terms than the terms of-
11 fered to a person who is not in a position
12 to refer patients or otherwise generate
13 business for the hospital.

14 “(ii) The hospital (or any investors in
15 the hospital) does not directly or indirectly
16 provide loans or financing for any physi-
17 cian owner or investor in the hospital.

18 “(iii) The hospital (or any investors in
19 the hospital) does not directly or indirectly
20 guarantee a loan, make a payment toward
21 a loan, or otherwise subsidize a loan, for
22 any physician owner or investor or group
23 of physician owners or investors that is re-
24 lated to acquiring any ownership or invest-
25 ment interest in the hospital.

1 “(iv) Ownership or investment returns
2 are distributed to each owner or investor in
3 the hospital in an amount that is directly
4 proportional to the ownership or invest-
5 ment interest of such owner or investor in
6 the hospital.

7 “(v) The investment interest of the
8 owner or investor is directly proportional
9 to the owner’s or investor’s capital con-
10 tributions made at the time the ownership
11 or investment interest is obtained.

12 “(vi) Physician owners and investors
13 do not receive, directly or indirectly, any
14 guaranteed receipt of or right to purchase
15 other business interests related to the hos-
16 pital, including the purchase or lease of
17 any property under the control of other
18 owners or investors in the hospital or lo-
19 cated near the premises of the hospital.

20 “(vii) The hospital does not offer a
21 physician owner or investor the oppor-
22 tunity to purchase or lease any property
23 under the control of the hospital or any
24 other owner or investor in the hospital on
25 more favorable terms than the terms of-

1 ferred to an individual who is not a physi-
2 cian owner or investor.

3 “(viii) The hospital does not condition
4 any physician ownership or investment in-
5 terests either directly or indirectly on the
6 physician owner or investor making or in-
7 fluencing referrals to the hospital or other-
8 wise generating business for the hospital.

9 “(E) PATIENT SAFETY.—In the case of a
10 hospital that does not offer emergency services,
11 the hospital has the capacity to—

12 “(i) provide assessment and initial
13 treatment for medical emergencies; and

14 “(ii) if the hospital lacks additional
15 capabilities required to treat the emergency
16 involved, refer and transfer the patient
17 with the medical emergency to a hospital
18 with the required capability.

19 “(F) LIMITATION ON APPLICATION TO
20 CERTAIN CONVERTED FACILITIES.—The hos-
21 pital was not converted from an ambulatory
22 surgical center to a hospital on or after the date
23 of enactment of this subsection.

24 “(2) EXCEPTION TO PROHIBITION ON EXPAN-
25 SION OF FACILITY CAPACITY.—

1 “(A) PROCESS.—

2 “(i) ESTABLISHMENT.—The Secretary
3 shall establish and implement a process
4 under which a hospital may apply for an
5 exception from the requirement under
6 paragraph (1)(C).

7 “(ii) OPPORTUNITY FOR COMMUNITY
8 INPUT.—The process under clause (i) shall
9 provide individuals and entities in the com-
10 munity in which the hospital applying for
11 an exception is located with the oppor-
12 tunity to provide input with respect to the
13 application.

14 “(iii) TIMING FOR IMPLEMENTA-
15 TION.—The Secretary shall implement the
16 process under clause (i) on the date that is
17 one month after the promulgation of regu-
18 lations described in clause (iv).

19 “(iv) REGULATIONS.—Not later than
20 the first day of the month beginning 18
21 months after the date of the enactment of
22 this subsection, the Secretary shall promul-
23 gate regulations to carry out the process
24 under clause (i). The Secretary may issue

1 such regulations as interim final regula-
2 tions.

3 “(B) FREQUENCY.—The process described
4 in subparagraph (A) shall permit a hospital to
5 apply for an exception up to once every 2 years.

6 “(C) PERMITTED INCREASE.—

7 “(i) IN GENERAL.—Subject to clause
8 (ii) and subparagraph (D), an applicable
9 hospital granted an exception under the
10 process described in subparagraph (A) may
11 increase the number of operating rooms,
12 procedure rooms, or beds of the hospital
13 above the baseline number of operating
14 rooms, procedure rooms, or beds, respec-
15 tively, of the hospital (or, if the hospital
16 has been granted a previous exception
17 under this paragraph, above the number of
18 operating rooms, procedure rooms, or beds,
19 respectively, of the hospital after the appli-
20 cation of the most recent increase under
21 such an exception).

22 “(ii) 100 PERCENT INCREASE LIMITA-
23 TION.—The Secretary shall not permit an
24 increase in the number of operating rooms,
25 procedure rooms, or beds of a hospital

1 under clause (i) to the extent such increase
2 would result in the number of operating
3 rooms, procedure rooms, or beds of the
4 hospital exceeding 200 percent of the base-
5 line number of operating rooms, procedure
6 rooms, or beds of the hospital.

7 “(iii) BASELINE NUMBER OF OPER-
8 ATING ROOMS, PROCEDURE ROOMS, OR
9 BEDS.—In this paragraph, the term ‘base-
10 line number of operating rooms, procedure
11 rooms, or beds’ means the number of oper-
12 ating rooms, procedure rooms, or beds of a
13 hospital as of the date of enactment of this
14 subsection.

15 “(D) INCREASE LIMITED TO FACILITIES
16 ON THE MAIN CAMPUS OF THE HOSPITAL.—
17 Any increase in the number of operating rooms,
18 procedure rooms, or beds of a hospital pursuant
19 to this paragraph may only occur in facilities on
20 the main campus of the hospital.

21 “(E) CONDITIONS FOR APPROVAL OF AN
22 INCREASE IN FACILITY CAPACITY.—The Sec-
23 retary may grant an exception under the proc-
24 ess described in subparagraph (A) only to a
25 hospital—

1 “(i) that is located in a county in
2 which the percentage increase in the popu-
3 lation during the most recent 5-year period
4 for which data are available is estimated to
5 be at least 150 percent of the percentage
6 increase in the population growth of the
7 State in which the hospital is located dur-
8 ing that period, as estimated by Bureau of
9 the Census and available to the Secretary;

10 “(ii) whose annual percent of total in-
11 patient admissions that represent inpatient
12 admissions under the program under title
13 XIX is estimated to be equal to or greater
14 than the average percent with respect to
15 such admissions for all hospitals located in
16 the county in which the hospital is located;

17 “(iii) that does not discriminate
18 against beneficiaries of Federal health care
19 programs and does not permit physicians
20 practicing at the hospital to discriminate
21 against such beneficiaries;

22 “(iv) that is located in a State in
23 which the average bed capacity in the
24 State is estimated to be less than the na-
25 tional average bed capacity;

1 “(v) that has an average bed occu-
2 pancy rate that is estimated to be greater
3 than the average bed occupancy rate in the
4 State in which the hospital is located; and

5 “(vi) meets other conditions as deter-
6 mined by the Secretary.

7 “(F) PROCEDURE ROOMS.—In this sub-
8 section, the term ‘procedure rooms’ includes
9 rooms in which catheterizations, angiographies,
10 angiograms, and endoscopies are furnished, but
11 such term shall not include emergency rooms or
12 departments (except for rooms in which cath-
13 eterizations, angiographies, angiograms, and
14 endoscopies are furnished).

15 “(G) PUBLICATION OF FINAL DECI-
16 SIONS.—Not later than 120 days after receiving
17 a complete application under this paragraph,
18 the Secretary shall publish on the public Inter-
19 net website of the Centers for Medicare & Med-
20 icaid Services the final decision with respect to
21 such application.

22 “(H) LIMITATION ON REVIEW.—There
23 shall be no administrative or judicial review
24 under section 1869, section 1878, or otherwise
25 of the exception process under this paragraph,

1 including the establishment of such process,
2 and any determination made under such pro-
3 cess.

4 “(3) PHYSICIAN OWNER OR INVESTOR DE-
5 FINED.—For purposes of this subsection and sub-
6 section (f)(2), the term ‘physician owner or investor’
7 means a physician (or an immediate family member
8 of such physician) with a direct or an indirect own-
9 ership or investment interest in the hospital.

10 “(4) PATIENT SAFETY REQUIREMENT.—In the
11 case of a hospital to which the requirements of para-
12 graph (1) apply, insofar as the hospital admits a pa-
13 tient and does not have any physician available on
14 the premises 24 hours per day, 7 days a week, be-
15 fore admitting the patient—

16 “(A) the hospital shall disclose such fact to
17 the patient; and

18 “(B) following such disclosure, the hospital
19 shall receive from the patient a signed acknowl-
20 edgment that the patient understands such fact.

21 “(5) CLARIFICATION.—Nothing in this sub-
22 section shall be construed as preventing the Sec-
23 retary from terminating a hospital’s provider agree-
24 ment if the hospital is not in compliance with regu-
25 lations pursuant to section 1866.”.

1 (b) VERIFYING COMPLIANCE.—The Secretary of
2 Health and Human Services shall establish policies and
3 procedures to verify compliance with the requirements de-
4 scribed in subsections (i)(1) and (i)(4) of section 1877 of
5 the Social Security Act, as added by subsection (a)(5).
6 The Secretary may use unannounced site reviews of hos-
7 pitals and audits to verify compliance with such require-
8 ments.

9 (c) IMPLEMENTATION.—

10 (1) FUNDING.—For purposes of carrying out
11 the amendments made by subsection (a) and the
12 provisions of subsection (b), in addition to funds
13 otherwise available, out of any funds in the Treasury
14 not otherwise appropriated there are appropriated to
15 the Secretary of Health and Human Services for the
16 Centers for Medicare & Medicaid Services Program
17 Management Account \$5,000,000 for each fiscal
18 year beginning with fiscal year 2010. Amounts ap-
19 propriated under this paragraph for a fiscal year
20 shall be available until expended.

21 (2) ADMINISTRATION.—Chapter 35 of title 44,
22 United States Code, shall not apply to the amend-
23 ments made by subsection (a) and the provisions of
24 subsection (b).

1 **Subtitle D—Medicare Advantage**
2 **Reforms**

3 **PART 1—PAYMENT AND ADMINISTRATION**

4 **SEC. 1161. PHASE-IN OF PAYMENT BASED ON FEE-FOR-**
5 **SERVICE COSTS.**

6 Section 1853 of the Social Security Act (42 U.S.C.
7 1395w-23) is amended—

8 (1) in subsection (j)(1)(A)—

9 (A) by striking “beginning with 2007” and
10 inserting “for 2007, 2008, 2009, and 2010”;
11 and

12 (B) by inserting after “(k)(1)” the fol-
13 lowing: “, or, beginning with 2011, $\frac{1}{12}$ of the
14 blended benchmark amount determined under
15 subsection (n)(1)”;

16 (2) by adding at the end the following new sub-
17 section:

18 “(n) DETERMINATION OF BLENDED BENCHMARK
19 AMOUNT.—

20 “(1) IN GENERAL.—For purposes of subsection
21 (j), subject to paragraphs (3) and (4), the term
22 ‘blended benchmark amount’ means for an area—

23 “(A) for 2011 the sum of—

1 “(i) $\frac{2}{3}$ of the applicable amount (as
2 defined in subsection (k)) for the area and
3 year; and

4 “(ii) $\frac{1}{3}$ of the amount specified in
5 paragraph (2) for the area and year;

6 “(B) for 2012 the sum of—

7 “(i) $\frac{1}{3}$ of the applicable amount for
8 the area and year; and

9 “(ii) $\frac{2}{3}$ of the amount specified in
10 paragraph (2) for the area and year; and

11 “(C) for a subsequent year the amount
12 specified in paragraph (2) for the area and
13 year.

14 “(2) SPECIFIED AMOUNT.—The amount speci-
15 fied in this paragraph for an area and year is the
16 amount specified in subsection (c)(1)(D)(i) for the
17 area and year adjusted (in a manner specified by the
18 Secretary) to take into account the phase-out in the
19 indirect costs of medical education from capitation
20 rates described in subsection (k)(4).

21 “(3) FEE-FOR-SERVICE PAYMENT FLOOR.—In
22 no case shall the blended benchmark amount for an
23 area and year be less than the amount specified in
24 paragraph (2).

1 “(4) EXCEPTION FOR PACE PLANS.—This sub-
2 section shall not apply to payments to a PACE pro-
3 gram under section 1894.”.

4 **SEC. 1162. QUALITY BONUS PAYMENTS.**

5 (a) IN GENERAL.—Section 1853 of the Social Secu-
6 rity Act (42 U.S.C. 1395w-23), as amended by section
7 1161, is amended—

8 (1) in subsection (j), by inserting “subject to
9 subsection (o),” after “For purposes of this part”;
10 and

11 (2) by adding at the end the following new sub-
12 section:

13 “(o) QUALITY BASED PAYMENT ADJUSTMENT.—

14 “(1) HIGH QUALITY PLAN ADJUSTMENT.—For
15 years beginning with 2011, in the case of a Medicare
16 Advantage plan that is identified as a high quality
17 MA plan with respect to the year, the blended
18 benchmark amount under subsection (n)(1) shall be
19 increased—

20 “(A) for 2011, by 1.0 percent;

21 “(B) for 2012, by 2.0 percent; and

22 “(C) for a subsequent year, by 3.0 percent.

23 “(2) IMPROVED QUALITY PLAN ADJUSTMENT.—

24 For years beginning with 2011, in the case of a
25 Medicare Advantage plan that is identified as an im-

1 proved quality MA plan with respect to the year,
2 blended benchmark amount under subsection (n)(1)
3 shall be increased—

4 “(A) for 2011, by 0.33 percent;

5 “(B) for 2012, by 0.66 percent; and

6 “(C) for a subsequent year, by 1.0 percent.

7 “(3) DETERMINATIONS OF QUALITY.—

8 “(A) QUALITY PERFORMANCE.—The Sec-
9 retary shall provide for the computation of a
10 quality performance score for each Medicare
11 Advantage plan to be applied for each year be-
12 ginning with 2010.

13 “(B) COMPUTATION OF SCORE.—

14 “(i) FOR YEARS BEFORE 2014.—For
15 years before 2014, the quality performance
16 score for a Medicare Advantage plan shall
17 be computed based on the sum of the fol-
18 lowing:

19 “(I) HEDIS-BASED COMPO-
20 NENT.—The plan’s performance on
21 HEDIS effectiveness of care quality
22 measures, weighted by 75 percent.

23 “(II) CAHPS-BASED COMPO-
24 NENT.—The plan’s performance on

1 CAHPS quality measures, weighted
2 by 25 percent.

3 “(ii) ESTABLISHMENT OF OUTCOME-
4 BASED MEASURES.—By not later than for
5 2013 the Secretary shall implement report-
6 ing requirements for quality under this
7 section on measures selected under clause
8 (iii) that reflect the outcomes of care expe-
9 rienced by individuals enrolled in Medicare
10 Advantage plans (in addition to measures
11 described in clause (i)). Such measures
12 may include—

13 “(I) measures of rates of admis-
14 sion and readmission to a hospital;

15 “(II) measures of prevention
16 quality, such as those established by
17 the Agency for Healthcare Research
18 and Quality (that include hospital ad-
19 mission rates for specified conditions);

20 “(III) measures of patient mor-
21 tality and morbidity following surgery;

22 “(IV) measures of health func-
23 tioning (such as limitations on activi-
24 ties of daily living) and survival for
25 patients with chronic diseases;

1 “(V) measures of patient safety;
2 and

3 “(VI) other measure of outcomes
4 and patient quality of life as deter-
5 mined by the Secretary.

6 Such measures shall be risk-adjusted as
7 the Secretary deems appropriate. In deter-
8 mining the quality measures to be used
9 under this clause, the Secretary shall take
10 into consideration the recommendations of
11 the Medicare Payment Advisory Commis-
12 sion in its report to Congress under section
13 168 of the Medicare Improvements for Pa-
14 tients and Providers Act of 2008 (Public
15 Law 110–275) and shall provide pref-
16 erence to measures collected on and com-
17 parable to measures used in measuring
18 quality under parts A and B.

19 “(iii) RULES FOR SELECTION OF
20 MEASURES.—The Secretary shall select
21 measures for purposes of clause (ii) con-
22 sistent with the following:

23 “(I) The Secretary shall provide
24 preference to clinical quality measures
25 that have been endorsed by the entity

1 with a contract with the Secretary
2 under section 1890(a).

3 “(II) Prior to any measure being
4 selected under this clause, the Sec-
5 retary shall publish in the Federal
6 Register such measure and provide for
7 a period of public comment on such
8 measure.

9 “(iv) TRANSITIONAL USE OF
10 BLEND.—For 2014 and 2015, the Sec-
11 retary may compute the quality perform-
12 ance score for a Medicare Advantage plan
13 based on a blend of the measures specified
14 in clause (i) and the measures described in
15 clause (ii) and selected under clause (iii).

16 “(v) USE OF QUALITY OUTCOMES
17 MEASURES.—For years beginning with
18 2016, the preponderance of measures used
19 under this paragraph shall be quality out-
20 comes measures.

21 “(C) DATA USED IN COMPUTING SCORE.—

22 Such score for application for—

23 “(i) payments in 2011 shall be based
24 on quality performance data for plans for
25 2009; and

1 “(ii) payments in 2012 and a subse-
2 quent year shall be based on quality per-
3 formance data for plans for the second
4 preceding year.

5 “(D) REPORTING OF DATA.—Each Medi-
6 care Advantage organization shall provide for
7 the reporting to the Secretary of quality per-
8 formance data described in subparagraph (B)
9 (in order to determine a quality performance
10 score under this paragraph) in such time and
11 manner as the Secretary shall specify.

12 “(E) RANKING OF PLANS.—

13 “(i) INITIAL RANKING.—Based on the
14 quality performance score described in sub-
15 paragraph (B) achieved with respect to a
16 year, the Secretary shall rank plan per-
17 formance—

18 “(I) from highest to lowest based
19 on absolute scores; and

20 “(II) from highest to lowest
21 based on percentage improvement in
22 the score for the plan from the pre-
23 vious year.

24 A plan which does not report quality per-
25 formance data under subparagraph (D)

1 shall be counted, for purposes of such
2 ranking, as having the lowest plan per-
3 formance and lowest percentage improve-
4 ment.

5 “(ii) ENROLLMENT WEIGHTING.—For
6 each such plan, the Secretary shall also es-
7 timate the enrollment of the plan for the
8 year involved as a proportion of the total
9 enrollment under all Medicare Advantage
10 plans for such year.

11 “(iii) IDENTIFICATION OF QUALITY
12 PLANS IN TOP QUINTILE BASED ON PRO-
13 JECTED ENROLLMENT.—The Secretary
14 shall, based on the scores for each plan
15 under clause (i)(I) and the projected pro-
16 portional enrollment for each plan under
17 clause (ii), identify those Medicare Advan-
18 tage plans with the highest score that,
19 based upon projected enrollment, are pro-
20 jected to include in the aggregate 20 per-
21 cent of the total projected enrollment for
22 the year. For purposes of this subsection,
23 a plan so identified shall be referred to in
24 this subsection as a ‘high quality MA
25 plan’.

1 “(iv) IDENTIFICATION OF IMPROVED
2 QUALITY PLANS IN TOP QUINTILE BASED
3 ON PROJECTED ENROLLMENT.—The Sec-
4 retary shall, based on the percentage im-
5 provement score for each plan under clause
6 (i)(II) and the projected proportional en-
7 rollment for each plan under clause (ii),
8 identify those Medicare Advantage plans
9 with the greatest percentage improvement
10 score that, based upon projected enroll-
11 ment, are projected to include in the ag-
12 gregate 20 percent of the total projected
13 enrollment for the year. For purposes of
14 this subsection, a plan so identified that is
15 not a high quality plan for the year shall
16 be referred to in this subsection as a ‘im-
17 proved quality MA plan’.

18 “(F) NOTIFICATION.—The Secretary, in
19 the annual announcement required under sub-
20 section (b)(1)(B) in 2011 and each succeeding
21 year, shall notify the Medicare Advantage orga-
22 nization that is offering a high quality plan or
23 an improved quality plan of such identification
24 for the year and the quality performance pay-
25 ment adjustment for such plan for the year.

1 The Secretary shall provide for publication on
2 the website for the Medicare program of the in-
3 formation described in the previous sentence.”.

4 **SEC. 1163. EXTENSION OF SECRETARIAL CODING INTEN-**
5 **SITY ADJUSTMENT AUTHORITY.**

6 Section 1853(a)(1)(C)(ii) of the Social Security Act
7 (42 U.S.C. 1395w-23(a)(1)(C)(ii) is amended—

8 (1) in the matter before subclause (I), by strik-
9 ing “through 2010” and inserting “and each subse-
10 quent year”;

11 (2) in subclause (II), by striking “only for
12 2008, 2009, and 2010” and inserting “for 2008 and
13 subsequent years”.

14 **SEC. 1164. ADDING 2 WEEK PROCESSING PERIOD BETWEEN**
15 **OPEN ELECTION PERIODS AND EFFECTIVE**
16 **DATE OF ENROLLMENTS.**

17 Section 1851(e) of the Social Security Act (42 U.S.C.
18 1395w-21(e)) is amended—

19 (1) in paragraph (2)(C)—

20 (A) in the heading, by striking “3
21 MONTHS” and inserting “2-1/2 MONTHS”;

22 (B) in clause (i), by striking “first 3
23 months” and inserting “period beginning on
24 January 1 and ending on March 15” each place
25 it appears; and

1 (C) in clause (ii), by striking “3-month pe-
2 riod” and inserting “2-1/2-month period”; and

3 (2) in paragraph (3)(B)—

4 (A) by striking “and” at the end of clause
5 (iii);

6 (B) in clause (iv)—

7 (i) by striking “and succeeding years”
8 and inserting “, 2008, 2009, and 2010”;
9 and

10 (ii) by striking the period at the end
11 and inserting “; and”; and

12 (C) by adding at the end the following new
13 clause:

14 “(v) with respect to 2011 and suc-
15 ceeding years, the period beginning on No-
16 vember 1 and ending on December 15 of
17 the year before such year.”.

18 **SEC. 1165. EXTENSION OF REASONABLE COST CONTRACTS.**

19 Section 1876(h)(5)(C) of the Social Security Act (42
20 U.S.C. 1395mm(h)(5)(C)) is amended—

21 (1) in clause (ii), by striking “January 1,
22 2010” and inserting “January 1, 2012”; and

23 (2) in clause (iii), by striking “the service area
24 for the year” and inserting “the portion of the
25 plan’s service area for the year that is within the

1 service area of a reasonable cost reimbursement con-
2 tract”.

3 **SEC. 1166. LIMITATION OF WAIVER AUTHORITY FOR EM-**
4 **PLOYER GROUP PLANS.**

5 (a) IN GENERAL.—The first sentence of paragraph
6 (2) of section 1857(i) of the Social Security Act (42
7 U.S.C. 1395w–27(i)) is amended by inserting before the
8 period at the end the following: “, but only if 90 percent
9 of the Medicare Advantage eligible individuals enrolled
10 under such plan reside in a county in which the MA orga-
11 nization offers an MA local plan”.

12 (b) LIMITATION ON APPLICATION OF WAIVER AU-
13 THORITY.—Paragraphs (1) and (2) of such section are
14 each amended by inserting “that were in effect before the
15 date of the enactment of [short title]” after “waive or
16 modify requirements”.

17 (c) EFFECTIVE DATES.—The amendment made by
18 subsection (a) shall apply for plan years beginning on or
19 after January 1, 2011, and the amendments made by sub-
20 section (b) shall take effect on the date of the enactment
21 of this Act, except that such amendments shall not apply
22 to waivers that are in effect on the day before the date
23 of the enactment of this Act.

1 **SEC. 1167. IMPROVING RISK ADJUSTMENT FOR MA PAY-**
2 **MENTS.**

3 Not later than 1 year after the date of the enactment
4 of this Act, the Secretary of Health and Human Services
5 shall submit to Congress a report that evaluates the need
6 and feasibility of improving the adequacy of the risk ad-
7 justment system under section 1853(a)(1)(C) of the Social
8 Security Act (42 U.S.C. 1395-23(a)(1)(C)) in predicting
9 costs for non-Medicaid eligible low-income beneficiaries.

10 **SEC. 1168. ELIMINATION OF MA REGIONAL PLAN STA-**
11 **BILIZATION FUND.**

12 (a) IN GENERAL.—Section 1858 of the Social Secu-
13 rity Act (42 U.S.C. 1395w-27a) is amended by striking
14 subsection (e).

15 (b) TRANSITION.—Any amount contained in the MA
16 Regional Plan Stabilization Fund as of the date of the
17 enactment of this Act shall be transferred to the Federal
18 Supplementary Medical Insurance Trust Fund.

19 **PART 2—CONSUMER PROTECTIONS AND ANTI-**
20 **FRAUD**

21 **SEC. 1171. LIMITATION ON OUT-OF-POCKET COSTS FOR IN-**
22 **DIVIDUAL HEALTH SERVICES.**

23 (a) IN GENERAL.—Section 1852(a)(1) of the Social
24 Security Act (42 U.S.C. 1395w-22(a)(1)) is amended—

25 (1) in subparagraph (A), by inserting before the
26 period at the end the following: “with cost-sharing

1 that is no greater (and may be less) than the cost-
2 sharing that would otherwise be imposed under such
3 program option”;

4 (2) in subparagraph (B)(i), by striking “or an
5 actuarially equivalent level of cost-sharing as deter-
6 mined in this part”; and

7 (3) by amending clause (ii) of subparagraph
8 (B) to read as follows:

9 “(ii) PERMITTING USE OF FLAT CO-
10 PAYMENT OR PER DIEM RATE.—Nothing in
11 clause (i) shall be construed as prohibiting
12 a Medicare Advantage plan from using a
13 flat copayment or per diem rate, in lieu of
14 the cost-sharing that would be imposed
15 under part A or B, so long as the amount
16 of the cost-sharing imposed does not ex-
17 ceed the amount of the cost-sharing that
18 would be imposed under the respective part
19 if the individual were not enrolled in a plan
20 under this part.”.

21 (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-
22 FIED MEDICARE BENEFICIARIES.—Section 1852(a) of
23 such Act is amended by adding at the end the following
24 new paragraph:

1 “(7) LIMITATION ON COST-SHARING FOR DUAL
2 ELIGIBLES AND QUALIFIED MEDICARE BENE-
3 FICIARIES.—In the case of a individual who is a full-
4 benefit dual eligible individual (as defined in section
5 1935(e)(6)) or a qualified medicare beneficiary (as
6 defined in section 1905(p)(1)) who is enrolled in a
7 Medicare Advantage plan, the plan may not impose
8 cost-sharing that exceeds the amount of cost-sharing
9 that would be permitted with respect to the indi-
10 vidual under this title and title XIX if the individual
11 were not enrolled with such plan.”.

12 (c) EFFECTIVE DATES.—

13 (1) The amendments made by subsection (a)
14 shall apply to plan years beginning on or after Janu-
15 ary 1, 2011.

16 (2) The amendments made by subsection (b)
17 shall apply to plan years beginning on or after Janu-
18 ary 1, 2011.

19 **SEC. 1172. CONTINUOUS OPEN ENROLLMENT FOR ENROLL-**
20 **EES IN PLANS WITH ENROLLMENT SUSPEN-**
21 **SION.**

22 Section 1851(e)(4) of the Social Security Act (42
23 U.S.C. 1395w(e)(4)) is amended—

24 (1) in subparagraph (C), by striking at the end
25 “or”;

1 (2) in subparagraph (D)—

2 (A) by inserting “, taking into account the
3 health or well-being of the individual” before
4 the period; and

5 (B) by redesignating such subparagraph as
6 subparagraph (E); and

7 (3) by inserting after subparagraph (C) the fol-
8 lowing new subparagraph:

9 “(D)) the individual is enrolled in an MA
10 plan and enrollment in the plan is suspended
11 under paragraph (2)(B) or (3)(C) of section
12 1857(g) because of a failure of the plan to meet
13 applicable requirements; or”.

14 **SEC. 1173. INFORMATION FOR BENEFICIARIES ON MA PLAN**
15 **ADMINISTRATIVE COSTS.**

16 (a) **DISCLOSURE OF MEDICAL LOSS RATIOS AND**
17 **OTHER EXPENSE DATA.**—Section 1851 of the Social Se-
18 curity Act (42 U.S.C. 1395w–21), as previously amended
19 by this subtitle, is amended by adding at the end the fol-
20 lowing new subsection:

21 “(p) **PUBLICATION OF MEDICAL LOSS RATIOS AND**
22 **OTHER COST-RELATED INFORMATION.**—

23 “(1) **IN GENERAL.**—The Secretary shall pub-
24 lish, not later than November 1 of each year (begin-

1 ning with 2011), for each MA plan contract, the fol-
2 lowing:

3 “(A) The medical loss ratio of the plan in
4 the previous year.

5 “(B) The per enrollee payment under this
6 part to the plan, as adjusted to reflect a risk
7 score (based on factors described in section
8 1853(a)(1)(C)(i)) of 1.0.

9 “(C) The average risk score (as so based).

10 “(2) SUBMISSION OF DATA.—

11 “(A) IN GENERAL.—Each MA organization
12 shall submit to the Secretary, in a form and
13 manner specified by the Secretary, data nec-
14 essary for the Secretary to publish the informa-
15 tion described in paragraph (1) on a timely
16 basis, including the information described in
17 paragraph (3).

18 “(B) DATA FOR 2010 AND 2011.—The data
19 submitted under subparagraph (A) for 2010
20 and for 2011 shall be consistent in content with
21 the data reported as part of the MA plan bid
22 in June 2009 for 2010.

23 “(C) MEDICAL LOSS RATIO DATA.—The
24 data to be submitted under subparagraph (A)
25 relating to medical loss ratio for a year—

1 “(i) shall be submitted not later than
2 September 15 of the following year; and

3 “(ii) beginning with 2012, shall be
4 submitted based on the standardized ele-
5 ments and definitions developed under
6 paragraph (4).

7 “(D) AUDITED DATA.—Data submitted
8 under this paragraph shall be data that has
9 been audited by an independent third party
10 auditor.

11 “(3) MLR INFORMATION.—The information de-
12 scribed in this paragraph with respect to a MA plan
13 for a year is as follows:

14 “(A) The costs for the plan in the previous
15 year for each of the following:

16 “(i) Total medical expenses, sepa-
17 rately indicated for benefits for the original
18 medicare fee-for-service program option
19 and for supplemental benefits.

20 “(ii) Non-medical expenses, shown
21 separately for each of the following cat-
22 egories of expenses:

23 “(I) Marketing and sales.

24 “(II) Direct administration.

25 “(III) Indirect administration.

1 “(IV) Net cost of private reinsur-
2 ance.

3 “(B) Gain or loss margin.

4 “(4) DEVELOPMENT OF DATA REPORTING
5 STANDARDS.—

6 “(A) IN GENERAL.—The Secretary shall
7 develop and implement standardized data ele-
8 ments and definitions for reporting under this
9 subsection, for contract years beginning with
10 2012, of data necessary for the calculation of
11 the medical loss ratio for MA plans. Not later
12 than December 31, 2010, the Secretary shall
13 publish a report describing the elements and
14 definitions so developed.

15 “(B) CONSULTATION.—The Secretary
16 shall consult with representatives of MA organi-
17 zations, experts on health plan accounting sys-
18 tems, and representatives of the National Asso-
19 ciation of Insurance Commissioners, in the de-
20 velopment of such data elements and defini-
21 tions.

22 “(5) MEDICAL LOSS RATIO DEFINED.—For
23 purposes of this part, the term ‘medical loss ratio’
24 means, with respect to an MA plan for a year, the
25 ratio of—

1 “(A) the aggregate benefits (excluding
2 nonmedical expenses described in paragraph
3 (3)(A)(ii)) paid under the plan for the year, to

4 “(B) the aggregate amount of premiums
5 (including basic and supplemental beneficiary
6 premiums) and payments made under sections
7 1853 and 1860D–15) collected for the plan and
8 year.

9 Such ratio shall be computed without regard to
10 whether the benefits or premiums are for required or
11 supplemental benefits under the plan.”.

12 (b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLI-
13 ANCE WITH THE FEDERAL ACQUISITION REGULATION.—

14 (1) IN GENERAL.—Section 1857(d)(2)(B) of
15 such Act (42 U.S.C. 1395w–27(d)(2)(B)) is amend-
16 ed—

17 (A) by striking “or (ii)” and inserting
18 “(ii)”; and

19 (B) by inserting before the period at the
20 end the following: “, or (iii) to compliance with
21 the requirements of subsection (e)(4) and the
22 extent to which administrative costs comply
23 with the applicable requirements for such costs
24 under the Federal Acquisition Regulation”.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall apply for contract years be-
3 ginning after the date of the enactment of this Act.

4 (c) MINIMUM MEDICAL LOSS RATIO.—Section
5 1857(e) of the Social Security Act (42 U.S.C. 1395w-
6 27(e)) is amended by adding at the end the following new
7 paragraph:

8 “(4) REQUIREMENT FOR MINIMUM MEDICAL
9 LOSS RATIO.—If the Secretary determines for a con-
10 tract year (beginning with 2012) that an MA plan
11 has failed to have a medical loss ratio (as defined in
12 section 1851(p)(5)) of at least .85—

13 “(A) the Secretary shall require the Medi-
14 care Advantage organization offering the plan
15 to give enrollees a rebate of premiums under
16 this part (or part B or part D, if applicable) by
17 such amount as would provide for a benefits
18 ratio of at least .85;

19 “(B) for 3 consecutive contract years, the
20 Secretary shall not permit the enrollment of
21 new enrollees under the plan for coverage dur-
22 ing the second succeeding contract year; and

23 “(C) the Secretary shall terminate the plan
24 contract if the plan fails to have such a medical
25 loss ratio for 5 consecutive contract years.”.

1 **SEC. 1174. STRENGTHENING AUDIT AUTHORITY .**

2 (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—

3 Section 1857(d)(1) of the Social Security Act (42 U.S.C.
4 1395w-27(d)(1)) is amended by inserting after “section
5 1858(c)” the following: “, and data submitted with re-
6 spect to risk adjustment under section 1853(a)(3)”.

7 (b) ENFORCEMENT OF AUDITS AND DEFICI-
8 CIENCIES.—

9 (1) IN GENERAL.—Section 1857(e) of such Act,
10 as amended by section 1173, is amended by adding
11 at the end the following new paragraph:

12 “(5) ENFORCEMENT OF AUDITS AND DEFICI-
13 CIENCIES.—

14 “(A) INFORMATION IN CONTRACT.—The
15 Secretary shall require that each contract with
16 an MA organization under this section shall in-
17 clude terms that inform the organization of the
18 provisions in subsection (d).

19 “(B) ENFORCEMENT AUTHORITY.—The
20 Secretary is authorized, in connection with con-
21 ducting audits and other activities under sub-
22 section (d), to take such actions, including pur-
23 suit of financial recoveries, necessary to address
24 deficiencies identified in such audits or other
25 activities.”.

1 (2) APPLICATION UNDER PART D.—For provi-
2 sion applying the amendment made by paragraph
3 (1) to prescription drug plans under part D, see sec-
4 tion 1860D–12(b)(3)(D) of the Social Security Act.

5 (c) EFFECTIVE DATE.—The amendments made by
6 this section shall take effect the date of the enactment
7 of this Act and shall apply to audits and activities con-
8 ducted for contract years beginning on or after January
9 1, 2011.

10 **SEC. 1175. AUTHORITY TO DENY PLAN BIDS.**

11 Section 1854(a)(5) of the Social Security Act (42
12 U.S.C. 1395w–24(a)(5)) is amended by adding at the end
13 the following new subparagraph:

14 “(C) REJECTION OF BIDS.—Nothing in
15 this section shall be construed as requiring the
16 Secretary to accept any or every bid by an MA
17 organization under this subsection.”.

1 **PART 3—TREATMENT OF SPECIAL NEEDS**
2 **INDIVIDUALS; MEDICAID INTEGRATION**
3 **SEC. 1176. LIMITATION ON ENROLLMENT OUTSIDE OPEN**
4 **ENROLLMENT PERIOD OF INDIVIDUALS INTO**
5 **CHRONIC CARE SPECIALIZED MA PLANS FOR**
6 **SPECIAL NEEDS INDIVIDUALS.**

7 Section 1859(f)(4) of the Social Security Act (42
8 U.S.C. 1395w-28(f)(4)) is amended by adding at the end
9 the following new subparagraph:

10 “(C) The plan does not enroll an individual
11 on or after January 1, 2011, other than during
12 an annual, coordinated open enrollment period
13 or when at the time of the diagnosis of the dis-
14 ease or condition that qualifies the individual as
15 an individual described in subsection
16 (b)(6)(B)(iii).”.

17 **SEC. 1177. EXTENSION OF AUTHORITY OF SPECIAL NEEDS**
18 **PLANS TO RESTRICT ENROLLMENT.**

19 Section 1859(f)(1) of the Social Security Act (42
20 U.S.C. 1395w-28(f)(1)) is amended by striking “January
21 1, 2011” and inserting “January 1, 2013 (or January 1,
22 2016, in the case of a plan designated as a fully integrated
23 dual eligible special needs plan under section 1894A)”.

1 **SEC. 1178. FULLY INTEGRATED DUAL ELIGIBLE SPECIAL**
2 **NEEDS PLANS.**

3 Title XVIII of the Social Security Act is amended by
4 inserting after section 1894 the following new section:

5 “FULLY INTEGRATED DUAL ELIGIBLE SPECIAL NEEDS
6 PLANS

7 “SEC. 1894A. (a) DESIGNATION.—

8 “(1) IN GENERAL.—The Secretary shall des-
9 ignate Medicare Advantage plans as fully integrated
10 dual eligible special needs plans (each in this section
11 referred to as a ‘FIDESNP’) for purposes of ad-
12 vancing fully integrated Medicare and Medicaid ben-
13 efits and services for dual eligibles, including State
14 designated dual subsets, during the 5-year period be-
15 ginning in 2011.

16 “(2) CRITERIA.—The Secretary may not des-
17 ignate an MA plan as a FIDESNP unless the plan
18 is a specialized MA plan for special needs individuals
19 described in section 1859(b)(6)(B)(ii) that, in addi-
20 tion to meeting applicable requirements under part
21 C for offering of such a plan, meets the following
22 criteria:

23 “(A) The plan provides dual eligibles ac-
24 cess to Medicare and Medicaid benefits through
25 a single managed care organization.

1 “(B) The plan has a contract with a state
2 Medicaid agency that includes coverage of spec-
3 ified primary, acute, and long-term care bene-
4 fits and services, consistent with State policy,
5 under risk-based financing.

6 “(C) The plan coordinates the delivery of
7 covered Medicare and Medicaid health and long-
8 term care services, using aligned care manage-
9 ment and specialty care network methods for
10 high-risk dual eligibles.

11 “(D) The plan employs policies and proce-
12 dures approved by the Secretary and the State
13 to coordinate or integrate enrollment, member
14 materials, communications, grievance and ap-
15 peals, and quality assurance.

16 “(E) The plan uses a coordinated commu-
17 nity care network (meeting the requirements of
18 subsection (b)) in delivering services to its dual
19 eligible population.

20 “(3) DUAL ELIGIBLE DEFINED.—In this sec-
21 tion, the term ‘dual eligible’ means an individual
22 who is dual eligible for benefits under title XVIII,
23 and medical assistance under title XIX, including
24 such individuals who are eligible for benefits under

1 the Medicare Savings Program (as defined in section
2 1144(e)(7)).

3 “(b) COORDINATED COMMUNITY CARE NET-
4 WORKS.—

5 “(1) IN GENERAL.—Each FIDESNP shall have
6 one or more coordinated community care networks
7 that—

8 “(A) encompass the full array of primary,
9 acute, and long-term care services, using a ro-
10 bust advanced medical home model;

11 “(B) include a network of home and com-
12 munity-based services; and

13 “(C) is accountable for the full array of fi-
14 nancing and ongoing care;

15 in order to carry out the responsibilities described in
16 paragraph (2).

17 “(2) RESPONSIBILITIES.—The responsibilities
18 of a coordinated community care network described
19 in this paragraph are—

20 “(A) to enable individuals with serious
21 chronic conditions and their family caregivers to
22 optimize their health and well-being;

23 “(B) to provide a comprehensive array of
24 patient-centered benefits and services designed
25 to meet the unique needs of dual eligibles;

1 “(C) to help individuals and their family
2 caregivers access the right care, at the right
3 time, in the right place, given the nature of
4 their condition;

5 “(D) to align the incentives of related care
6 providers to improve transitions and care con-
7 tinuity; and

8 “(E) to optimize total quality and cost per-
9 formance across time, place, and profession.

10 “(c) STATE MEDICAID AGENCIES.—

11 “(1) IN GENERAL.—The Secretary shall work
12 with State Medicaid agencies and other relevant
13 State Agencies and related FIDESNPs with Med-
14 icaid contracts to fully align financing, administra-
15 tion, delivery, and oversight of care for dual eligibles
16 served by the FIDESNPS.

17 “(2) ALIGNMENT METHODS.—The fully aligned
18 methods under paragraph (1) shall include—

19 “(A) opportunities for administering the
20 program under this section under a three-way
21 contract or memorandum of understanding
22 among the Secretary, relevant State Agencies,
23 and the organization offering the FIDESNP;
24 and

1 “(B) use of a single, integrated approach
2 to accounting and reporting.

3 “(d) PAYMENT.—Except as provided in subsection
4 (e), FIDESNPs shall be paid under this section amounts
5 consistent with an MA plan under part C. Plans will be
6 subject to other Medicare Advantage rules.

7 “(e) WAIVER AUTHORITY.—

8 “(1) IN GENERAL.—To simplify access of dual
9 eligibles to coordinated Medicare and Medicaid bene-
10 fits, through enhanced coordination of Federal and
11 State oversight of FIDESNPs, the Secretary shall
12 modify rules, policies, and procedures under titles
13 XVIII and XIX in the areas described in paragraph
14 (2) consistent with this section in order—

15 “(A) to align Medicare and Medicaid re-
16 quirements regarding marketing, enrollment,
17 care coordination, auditing, reporting, quality
18 assurance, and other relevant oversight func-
19 tions for FIDESNPs; and

20 “(B) to facilitate better coordination of
21 benefits for dual eligibles served by such plans
22 that are not fully integrated.

23 “(2) LIMITATION OF WAIVER AUTHORITY.—The
24 areas described in this section are those specified by

1 the Secretary and include marketing and quality re-
2 porting.

3 “(f) INTEGRATED REPORTING; BENCHMARKS.—

4 “(1) IN GENERAL.—The Secretary shall work
5 with relevant State agencies—

6 “(A) to establish a common regulatory ap-
7 proach for oversight of FIDESNPs; and

8 “(B) to establish a single set of quality
9 measures and reporting procedures for Medi-
10 care and Medicaid reporting that include inte-
11 gration and consolidation of current reporting
12 requirements for—

13 “(i) annual risk assessment and model
14 of care requirements; and

15 “(ii) HEDIS, plan organizational
16 structure, and quality improvement proc-
17 esses, CAHPS, HOS, QIP, and CCIP.

18 “(2) MODIFICATION OF MA REPORTING RE-
19 QUIREMENTS.—The Secretary may modify reporting
20 requirements under part C for FIDESNPs, in col-
21 laboration with relevant State agencies, and sub-
22 stitute more appropriate alternative measures.

23 “(3) OUTCOME MEASURES.—The Secretary
24 shall work with relevant State agencies to establish
25 a common set of risk adjusted quality measurement

1 benchmarks for Medicare and Medicaid to evaluate
2 performance of FIDESNPs in serving a comparable
3 group of beneficiaries under the original Medicare
4 fee-for-service program, under the Medicare Advan-
5 tage program, and under Medicaid managed care
6 plans. Such common set of benchmarks shall include
7 the following outcomes measures:

8 “(A) Emergency room use.

9 “(B) Avoidable hospitalizations and inpa-
10 tient readmissions for ambulatory care sensitive
11 conditions.

12 “(C) Medication management to prevent
13 adverse drug events and promote adherence.

14 “(D) Long-term nursing home stays.

15 “(E) Beneficiary satisfaction.

16 “(F) Such other measures as the Secretary
17 deems appropriate.

18 “(g) REPORT TO CONGRESS.—No later than Decem-
19 ber 31, 2013, the Secretary shall report to Congress on
20 the impact of integrating Medicare and Medicaid benefits
21 and services on total quality and cost performance in serv-
22 ing dual eligibles under this section. The Secretary shall
23 include in such report recommendations for changes in
24 Medicare and Medicaid law for ongoing improvements in
25 total quality and cost performance.”.

1 **SEC. 1179. IMPROVED COORDINATION FOR DUAL ELIGI-**
2 **BLES.**

3 (a) **IN GENERAL.**— The Secretary of Health and
4 Human Services shall provide, through an identifiable of-
5 fice or program within the Centers for Medicare & Med-
6 icaid Services, for a focused effort to provide for improved
7 coordination between Medicare and Medicaid in the case
8 of dual eligibles (as defined in subsection (d)).

9 (b) **ELEMENTS.**—The improved coordination under
10 this section shall include efforts—

11 (1) to simplify access of dual eligibles to bene-
12 fits and services under Medicare and Medicaid;

13 (2) to Improve care continuity for dual eligibles
14 and ensure safe and effective care transitions;

15 (3) to harmonize regulatory conflicts between
16 Medicare and Medicaid rules with regard to dual eli-
17 gibles; and

18 (4) to improve total cost and quality perform-
19 ance under Medicare and Medicaid for dual eligibles.

20 (c) **SPECIFIC RESPONSIBILITIES.**—In carrying out
21 this section, the Secretary shall provide for the develop-
22 ment of policies and procedures with respect to each of
23 the following:

24 (1) Oversight of the designation, implementa-
25 tion and oversight of fully integrated dual eligible
26 special needs plans under section 1894A of the So-

1 cial Security Act, as inserted by section 1178 (each
2 such plan in this subsection referred to as an
3 “FIDESNP”), with authority to effectively align
4 Medicare and Medicaid policy for dual eligibles.

5 (2) Support of State Medicaid agencies in
6 States where FIDESNPs have been designated and
7 other integration initiatives are being advanced to
8 coordinate and align primary, acute and long-term
9 care benefits for dual eligibles through a State plan
10 option or other means.

11 (3) Supporting coordination of State and Fed-
12 eral contracting and oversight for dual integration
13 programs supportive of the goals described in sub-
14 section (a).

15 (4) Alignment of Federal rules for Medicaid
16 managed care and Medicare Advantage plans to in-
17 clude methods for integrating marketing, enrollment,
18 grievances and appeals, auditing, reporting, quality
19 assurance, and other relevant oversight functions.

20 (5) Monitoring total combined Medicare and
21 Medicaid program costs in serving dual eligibles and
22 making recommendations for optimizing total quality
23 and cost performance across both programs.

24 (d) DEFINITIONS.—In this section:

1 (1) DUAL ELIGIBLE.—The term “dual eligible”
2 means an individual who is dual eligible for benefits
3 under title XVIII, and medical assistance under title
4 XIX, of the Social Security Act, including such indi-
5 viduals who are eligible for benefits under the Medi-
6 care Savings Program (as defined in section
7 1144(e)(7) of such Act).

8 (2) MEDICARE; MEDICAID.—The terms “Medi-
9 care” and “Medicaid” mean the programs under ti-
10 tles XVIII and XIX, respectively, of the Social Secu-
11 rity Act.

12 **Subtitle E—Improvements to** 13 **Medicare Part D**

14 **SEC. 1181. REQUIRING DRUG MANUFACTURERS TO PRO-** 15 **VIDE DRUG REBATES FOR CERTAIN FULL** 16 **PREMIUM SUBSIDY ELIGIBLE INDIVIDUALS.**

17 (a) REBATE REQUIREMENT.—

18 (1) IN GENERAL.—Subsection (b)(1) of section
19 1927 of the Social Security Act (42 U.S.C. 1396r-
20 8) is amended—

21 (A) in subparagraph (A), by inserting
22 “(excluding any amount specified in subsection
23 (c)(4))” after “subsection (c)”; and

24 (B) by adding at the end the following new
25 subparagraph:

1 “(C) REBATE FOR FULL PREMIUM SUB-
2 SIDY MEDICARE DRUG PLAN ENROLLEES.—A
3 rebate agreement under this section shall re-
4 quire the manufacturer to provide to the Sec-
5 retary a rebate for each rebate period ending
6 after December 31, 2010, in the amount speci-
7 fied in subsection (c)(4) for any covered out-
8 patient drug of the manufacturer dispensed
9 after December 31, 2010, to any full premium
10 subsidy Medicare drug plan enrollee (as defined
11 in subsection (k)(10)) for which payment was
12 made by a PDP sponsor under part D of title
13 XVIII or a MA organization under part C of
14 such title for such period. Such rebate shall be
15 paid by the manufacturer to the Secretary not
16 later than 30 days after the date of receipt of
17 the information described in section 1860D-
18 12(b)(7), including as such section is applied
19 under section 1857(f)(3).”.

20 (2) AMOUNT OF REBATE.—Subsection (c) of
21 such section is amended by adding at the end the
22 following new paragraph:

23 “(4) REBATE FOR FULL PREMIUM SUBSIDY
24 MEDICARE DRUG PLAN ENROLLEES.—

1 “(A) IN GENERAL.— For purposes of the
2 rebate under subsection (b)(1)(C), the amount
3 of the rebate specified under this paragraph for
4 a manufacturer for a rebate period, with re-
5 spect to each dosage form and strength of any
6 covered outpatient drug provided by such man-
7 ufacturer and dispensed to full premium sub-
8 sidy Medicare eligible enrollees (as defined in
9 subsection (k)(10)), shall be equal to the prod-
10 uct of—

11 “(i) the total number of units of such
12 dosage form and strength of the drug so
13 provided and dispensed for which payment
14 was made by a PDP sponsor under part D
15 of title XVIII or a MA organization under
16 part C of such title for the rebate period
17 (as reported under section 1860D-
18 12(b)(7), including as such section is ap-
19 plied under section 1857(f)(3)); and

20 “(ii) the amount (if any) by which—

21 “(I) the Medicaid rebate amount
22 (as defined in subparagraph (B)) for
23 such form, strength, and period, ex-
24 ceeds

1 “(II) the average Medicare drug
2 program full subsidy discount amount
3 (as defined in subparagraph (C)) for
4 such form, strength, and period.

5 The rebate amount under this paragraph
6 shall not be counted in the amount of the
7 rebate specified in this subsection for pur-
8 poses of paragraphs (1) through (3), ex-
9 cept that the rebate under this paragraph
10 shall be considered a rebate under this
11 subsection for purposes of paragraph
12 (1)(C)(ii)(I).

13 “(B) MEDICAID REBATE AMOUNT.—For
14 purposes of this paragraph, the term ‘Medicaid
15 rebate amount’ means, with respect to each
16 dosage form and strength of a covered out-
17 patient drug provided by the manufacturer for
18 a rebate period—

19 “(i) in the case of a single source
20 drug or an innovator multiple source drug,
21 the amount specified in paragraph
22 (1)(A)(ii) plus the amount, if any, specified
23 in paragraph (2)(A)(ii), for such form,
24 strength, and period; or

1 “(ii) in the case of any other covered
2 outpatient drug, the amount specified in
3 paragraph (3)(A)(i) for such form,
4 strength, and period.

5 “(C) AVERAGE MEDICARE DRUG PROGRAM
6 FULL SUBSIDY DISCOUNT AMOUNT.—For pur-
7 poses of this section, the term ‘average Medi-
8 care drug program full subsidy discount
9 amount’ means, with respect to each dosage
10 form and strength of a covered outpatient drug
11 provided by a manufacturer for a rebate period,
12 the sum, for all PDP sponsors under part D of
13 title XVIII and MA organizations administering
14 a MA–PD plan under part C of such title, of—

15 “(i) the product, for each such spon-
16 sor or organization, of—

17 “(I) the sum of all rebates, dis-
18 counts, or other price concessions (not
19 taking into account any rebate pro-
20 vided under subsection (b)(1)(C)) for
21 such dosage form and strength of the
22 drug dispensed, calculated on a per-
23 unit basis, but only to the extent that
24 any such rebate, discount, or other
25 price concession applies equally to

1 drugs dispensed to full premium sub-
2 sidy Medicare drug plan enrollees and
3 drugs dispensed to PDP and MA–PD
4 enrollees who are not full premium
5 subsidy Medicare drug plan enrollees;
6 and

7 “(II) the number of the units of
8 such dosage and strength of the drug
9 dispensed during the rebate period to
10 full premium subsidy Medicare drug
11 plan enrollees enrolled in the prescrip-
12 tion drug plans administered by the
13 PDP sponsor or the MA–PD plans
14 administered by the MA–PD organi-
15 zation; divided by

16 “(ii) the total number of units of such
17 dosage and strength of the drug dispensed
18 during the rebate period to full premium
19 subsidy Medicare drug plan enrollees en-
20 rolled in all prescription drug plans admin-
21 istered by PDP sponsors and all MA–PD
22 plans administered by MA–PD organiza-
23 tions.”.

24 (3) FULL PREMIUM SUBSIDY MEDICARE DRUG
25 PLAN ENROLLEE DEFINED.—Subsection (k) of such

1 section is amended by adding at the end the fol-
2 lowing new paragraph:

3 “(10) FULL PREMIUM SUBSIDY MEDICARE
4 DRUG PLAN ENROLLEE.—The term ‘full premium
5 subsidy Medicare drug plan enrollee’ means a sub-
6 sidy eligible individual described (or treated as de-
7 scribed) in section 1860D–14(a)(1).”.

8 (b) REPORTING REQUIREMENT FOR THE DETER-
9 MINATION AND PAYMENT OF REBATES BY MANUFAC-
10 TURES RELATED TO REBATE FOR FULL PREMIUM SUB-
11 SIDY MEDICARE DRUG PLAN ENROLLEES.—

12 (1) REQUIREMENTS FOR PDP SPONSORS.—Sec-
13 tion 1860D–12(b) of the Social Security Act (42
14 U.S.C. 1395w-112(b)) is amended by adding at the
15 end the following new paragraph:

16 “(7) REPORTING REQUIREMENT FOR THE DE-
17 TERMINATION AND PAYMENT OF REBATES BY MANU-
18 FACTURES RELATED TO REBATE FOR FULL PRE-
19 MIUM SUBSIDY MEDICARE DRUG PLAN ENROLL-
20 EES.—

21 “(A) IN GENERAL.—For purposes of the
22 rebate under section 1927(b)(1)(C) for contract
23 years beginning on or after January 1, 2011,
24 each contract entered into with a PDP sponsor
25 under this part with respect to a prescription

1 drug plan shall require that the sponsor comply
2 with subparagraphs (B) and (C).

3 “(B) REPORT FORM AND CONTENTS.—Not
4 later than 60 days after the end of each rebate
5 period (as defined in section 1927(k)(8)) within
6 such a contract year to which section
7 1927(b)(1)(C) applies, a PDP sponsor of a pre-
8 scription drug plan under this part shall report
9 to each manufacturer—

10 “(i) information (by National Drug
11 Code number) on the total number of units
12 of each dosage, form, and strength of each
13 drug of such manufacturer dispensed to
14 full premium subsidy Medicare drug plan
15 enrollees under any prescription drug plan
16 operated by the PDP sponsor during the
17 rebate period;

18 “(ii) information on the price dis-
19 counts, price concessions, and rebates for
20 such drugs for such form, strength, and
21 period;

22 “(iii) information on the extent to
23 which such price discounts, price conces-
24 sions, and rebates apply equally to full pre-
25 mium subsidy Medicare drug plan enrollees

1 and PDP enrollees who are not full pre-
2 mium subsidy Medicare drug plan enroll-
3 ees; and

4 “(iv) any additional information that
5 the Secretary determines is necessary to
6 enable the Secretary to calculate the aver-
7 age Medicare drug program full subsidy
8 discount amount (as defined in section
9 1927(c)(4)(C)) for such form, strength,
10 and period.

11 Such report shall be in a form consistent with
12 a standard reporting format established by the
13 Secretary.

14 “(C) SUBMISSION TO SECRETARY.—Each
15 PDP sponsor shall promptly transmit a copy of
16 the information reported under subparagraph
17 (B) to the Secretary for the purpose of over-
18 sight and evaluation.

19 “(D) CONFIDENTIALITY OF INFORMA-
20 TION.—The provisions of subparagraph (D) of
21 section 1927(b)(3), relating to confidentiality of
22 information, shall apply to information reported
23 by PDP sponsors under this paragraph in the
24 same manner that such provisions apply to in-

1 formation disclosed by manufacturers or whole-
2 salers under such section, except—

3 “(i) that any reference to ‘this sec-
4 tion’ in clause (i) of such subparagraph
5 shall be treated as including a reference to
6 section 1860D–12; and

7 “(ii) the reference to the Director of
8 the Congressional Budget Office in clause
9 (iii) of such subparagraph shall be treated
10 as including a reference to the Medicare
11 Payment Advisory Commission.

12 “(E) AUDITING.—Information reported
13 under this paragraph is subject to audit by the
14 Inspector General of the Department of Health
15 and Human Services.

16 “(F) PENALTIES FOR FAILURE TO PRO-
17 VIDE TIMELY INFORMATION AND PROVISION OF
18 FALSE INFORMATION.—In the case of a PDP
19 sponsor—

20 “(i) that fails to provide information
21 required under subparagraph (B) on a
22 timely basis, the sponsor is subject to a
23 civil money penalty in the amount of
24 \$10,000 for each day in which such infor-
25 mation has not been provided; or

1 “(ii) that knowingly provides false in-
2 formation under such subparagraph, the
3 sponsor is subject to a civil money penalty
4 in an amount not to exceed \$100,000 for
5 each item of false information.

6 Such civil money penalties are in addition to
7 other penalties as may be prescribed by law.
8 The provisions of section 1128A (other than
9 subsections (a) and (b)) shall apply to a civil
10 money penalty under this subparagraph in the
11 same manner as such provisions apply to a pen-
12 alty or proceeding under section 1128A(a).”.

13 (2) APPLICATION TO MA ORGANIZATIONS.—Sec-
14 tion 1857(f)(3) of the Social Security Act (42
15 U.S.C. 1395w-27(f)(3)) is amended by adding at
16 the end the following:

17 “(D) REPORTING REQUIREMENT RELATED
18 TO REBATE FOR FULL PREMIUM SUBSIDY MEDI-
19 CARE DRUG PLAN ENROLLEES.—Section
20 1860D-12(b)(7).”.

21 (c) DEPOSIT OF REBATES INTO MEDICARE PRE-
22 SCRIPTON DRUG ACCOUNT.—Section 1860D-16(c) of
23 such Act (42 U.S.C. 1395w-116(c)) is amended by adding
24 at the end the following new paragraph:

1 “(6) REBATE FOR FULL PREMIUM SUBSIDY
2 MEDICARE DRUG PLAN ENROLLEES.—Amounts paid
3 under section 1927(b)(1)(C) shall be deposited into
4 the Account.”.

5 **SEC. 1182. PHASED-IN ELIMINATION OF COVERAGE GAP.**

6 Section 1860D–2(b) of the Social Security Act (42
7 U.S.C. 1395w–102(b)) is amended—

8 (1) in paragraph (3)(A), by striking “paragraph
9 (4)” and inserting “paragraphs (4) and (7)”;

10 (2) in paragraph (3)(B)(i), by inserting “sub-
11 ject to paragraph (7)” after “purposes of this part”;
12 and

13 (3) by adding at the end the following new
14 paragraph:

15 “(7) PHASED-IN ELIMINATION OF COVERAGE
16 GAP.—

17 “(A) IN GENERAL.—For each year begin-
18 ning with 2011, the Secretary shall consistent
19 with this paragraph progressively increase the
20 initial coverage limit and decrease the annual
21 out-of-pocket threshold from the amounts other-
22 wise computed until there is a continuation of
23 coverage from the initial coverage limit for ex-
24 penditures incurred through the total amount of

1 expenditures at which benefits are available
2 under paragraph (4).

3 “(B) INCREASE IN INITIAL COVERAGE
4 LIMIT.—For a year beginning with 2011, the
5 initial coverage limit otherwise computed with-
6 out regard to this paragraph shall be increased
7 by $\frac{1}{2}$ of the cumulative phase-in percentage (as
8 defined in subparagraph (D)(ii) for the year) of
9 4 times the out-of-pocket gap amount (as de-
10 fined in subparagraph (E)) for the year.

11 “(C) DECREASE IN ANNUAL OUT-OF-POCK-
12 ET THRESHOLD.—For a year beginning with
13 2011, the annual out-of-pocket threshold other-
14 wise computed without regard to this paragraph
15 shall be decreased by $\frac{1}{2}$ of the cumulative
16 phase-in percentage of the out-of-pocket gap
17 amount for the year.

18 “(D) PHASE-IN.—For purposes of this
19 paragraph:

20 “(i) ANNUAL PHASE-IN PERCENT-
21 AGE.—The term ‘annual phase-in percent-
22 age’ means—

23 “(I) for 2011, 13 percent;

24 “(II) for 2012, 2013, 2014, and
25 2015, 5 percent;

1 “(III) for 2016 through 2018,
2 7.5 percent; and

3 “(IV) for 2019 and each subse-
4 quent year, 10 percent.

5 “(ii) CUMULATIVE PHASE-IN PER-
6 CENTAGE.—The term ‘cumulative phase-in
7 percentage’ means for a year the sum of
8 the annual phase-in percentage for the
9 year and the annual phase-in percentages
10 for each previous year beginning with
11 2011, but in no case more than 100 per-
12 cent.

13 “(E) OUT-OF-POCKET GAP AMOUNT.—For
14 purposes of this paragraph, the term ‘out-of-
15 pocket gap amount’ means for a year the
16 amount by which—

17 “(i) the annual out-of-pocket thresh-
18 old specified in paragraph (4)(B) for the
19 year (as determined as if this paragraph
20 did not apply), exceeds

21 “(ii) the sum of—

22 “(I) the annual deductible under
23 paragraph (1) for the year; and

24 “(II) $\frac{1}{4}$ of the amount by which
25 the initial coverage limit under para-

1 graph (3) for the year (as determined
2 as if this paragraph did not apply) ex-
3 ceeds such annual deductible.”.

4 **SEC. 1183. REPEAL OF PROVISION RELATING TO SUBMIS-**
5 **SION OF CLAIMS BY PHARMACIES LOCATED**
6 **IN OR CONTRACTING WITH LONG-TERM CARE**
7 **FACILITIES.**

8 (a) PART D SUBMISSION.—Section 1860D–12(b) of
9 the Social Security Act (42 U.S.C. 1395w–112(b)), as
10 amended by section 172(a)(1) of Public Law 110-275, is
11 amended by striking paragraph (5) and redesignating
12 paragraph (6) as paragraph (5).

13 (b) SUBMISSION TO MA-PD PLANS.—Section
14 1857(f)(3) of the Social Security Act (42 U.S.C. 1395w-
15 27(f)(3)), as added by section 171(b) of Public Law 110-
16 275 and amended by section 172(a)(2) of such Public
17 Law, is amended by striking subparagraph (B) and red-
18 ignating subparagraph (C) as subparagraph (B).

1 **SEC. 1184. INCLUDING COSTS INCURRED BY AIDS DRUG AS-**
2 **SISTANCE PROGRAMS AND INDIAN HEALTH**
3 **SERVICE IN PROVIDING PRESCRIPTION**
4 **DRUGS TOWARD THE ANNUAL OUT OF POCK-**
5 **ET THRESHOLD UNDER PART D.**

6 (a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the
7 Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is
8 amended—

9 (1) in clause (i), by striking “and” at the end;
10 (2) in clause (ii)—

11 (A) by striking “such costs shall be treated
12 as incurred only if” and inserting “subject to
13 clause (iii), such costs shall be treated as in-
14 curred only if”;

15 (B) by striking “, under section 1860D–
16 14, or under a State Pharmaceutical Assistance
17 Program”; and

18 (C) by striking the period at the end and
19 inserting “; and”; and

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

22 “(iii) such costs shall be treated as in-
23 curred and shall not be considered to be
24 reimbursed under clause (ii) if such costs
25 are borne or paid—

26 “(I) under section 1860D–14;

1 “(II) under a State Pharma-
2 ceutical Assistance Program;

3 “(III) by the Indian Health Serv-
4 ice, an Indian tribe or tribal organiza-
5 tion, or an urban Indian organization
6 (as defined in section 4 of the Indian
7 Health Care Improvement Act); or

8 “(IV) under an AIDS Drug As-
9 sistance Program under part B of
10 title XXVI of the Public Health Serv-
11 ice Act.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 subsection (a) shall apply to costs incurred on or after
14 January 1, 2011.

15 **SEC. 1185. PERMITTING MID-YEAR CHANGES IN ENROLL-**
16 **MENT FOR FORMULARY CHANGES AD-**
17 **VERSELY IMPACT AN ENROLLEE.**

18 (a) IN GENERAL.—Section 1860D–1(b)(3) of the So-
19 cial Security Act (42 U.S.C. 1395w–101(b)(3)) is amend-
20 ed by adding at the end the following new subparagraph:

21 “(F) CHANGE IN FORMULARY RESULTING
22 IN INCREASE IN COST-SHARING.—

23 “(i) IN GENERAL.—Except as pro-
24 vided in clause (ii), in the case of an indi-
25 vidual enrolled in a prescription drug plan

1 (or MA–PD plan) who has been prescribed
2 a covered part D drug while so enrolled, if
3 the formulary of the plan is materially
4 changed (other than at the end of a con-
5 tract year) so to reduce the coverage (or
6 increase the cost-sharing) of the drug
7 under the plan.

8 “(ii) EXCEPTION.—Clause (i) shall
9 not apply in the case that a drug is re-
10 moved from the formulary of a plan be-
11 cause of a recall or withdrawal of the drug
12 issued by the Food and Drug Administra-
13 tion or because the drug is replaced with
14 a generic drug that is a therapeutic equiva-
15 lent.”.

16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to contract years beginning on
18 or after January 1, 2011.

19 **Subtitle F—Medicare Rural Access** 20 **Protections**

21 **SEC. 1191. TELEHEALTH EXPANSION AND ENHANCEMENTS.**

22 The Secretary of Health and Human Services shall
23 undertake activities to expand and enhance Medicare ben-
24 efiary access to telehealth services.

1 **SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS**
2 **PROVISION.**

3 Section 1833(t)(7)(D)(i) of the Social Security Act
4 (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

5 (1) in subclause (II)—

6 (A) in the first sentence, by striking
7 “2010” and inserting “2012”; and

8 (B) in the second sentence, by striking “or
9 2009” and inserting “, 2009, 2010, or 2011”;
10 and

11 (2) in subclause (III), by striking “January 1,
12 2010” and inserting “January 1, 2012”.

13 **SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLAS-**
14 **SIFICATIONS.**

15 Subsection (a) of section 106 of division B of the Tax
16 Relief and Health Care Act of 2006 (42 U.S.C. 1395
17 note), as amended by section 117 of the Medicare, Med-
18 icaid, and SCHIP Extension Act of 2007 (Public Law
19 110–173) and section 124 of the Medicare Improvements
20 for Patients and Providers Act of 2008 (Public Law 110–
21 275), is amended by striking “September 30, 2009” and
22 inserting “September 30, 2011”.

23 **SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.**

24 Section 1848(e)(1)(E) of the Social Security Act (42
25 U.S.C. 1395w–4(e)(1)(E)) is amended by striking “before

1 January 1, 2010” and inserting “before January 1,
2 2012”.

3 **SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COM-**
4 **PONENT OF CERTAIN PHYSICIAN PATHOL-**
5 **OGY SERVICES.**

6 Section 542(c) of the Medicare, Medicaid, and
7 SCHIP Benefits Improvement and Protection Act of 2000
8 (as enacted into law by section 1(a)(6) of Public Law 106–
9 554), as amended by section 732 of the Medicare Prescrip-
10 tion Drug, Improvement, and Modernization Act of 2003
11 (42 U.S.C. 1395w–4 note), section 104 of division B of
12 the Tax Relief and Health Care Act of 2006 (42 U.S.C.
13 1395w–4 note), section 104 of the Medicare, Medicaid,
14 and SCHIP Extension Act of 2007 (Public Law 110–
15 173), and section 136 of the Medicare Improvements for
16 Patients and Providers Act of 1008 (Public Law 110–
17 275), is amended by striking “and 2009” and inserting
18 “2009, 2010, and 2011”.

19 **SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.**

20 (a) IN GENERAL.—Section 1834(l)(13) of the Social
21 Security Act (42 U.S.C. 1395m(l)(13)) is amended—

22 (1) in subparagraph (A)—

23 (A) in the matter preceding clause (i), by
24 striking “before January 1, 2010” and insert-
25 ing “before January 1, 2012”; and

1 (B) in each of clauses (i) and (ii), by strik-
2 ing “before January 1, 2010” and inserting
3 “before January 1, 2012”.

4 (b) AIR AMBULANCE IMPROVEMENTS.—Section
5 146(b)(1) of the Medicare Improvements for Patients and
6 Providers Act of 2008 (Public Law 110–275) is amended
7 by striking “ending on December 31, 2009” and inserting
8 “ending on December 31, 2011”.

9 **TITLE II—MEDICARE**
10 **BENEFICIARY IMPROVEMENTS**
11 **Subtitle A—Improving and Simpli-**
12 **fyng Financial Assistance for**
13 **Low Income Medicare Bene-**
14 **ficiaries**

15 **SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**
16 **INGS PROGRAM AND LOW-INCOME SUBSIDY**
17 **PROGRAM.**

18 (a) APPLICATION OF HIGHEST LEVEL PERMITTED
19 UNDER LIS.—

20 (1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDI-
21 VIDUALS.—Section 1860D–14(a) of the Social Secu-
22 rity Act (42 U.S.C. 1395w–114(a)) is amended—

23 (A) in paragraph (1), in the matter before
24 subparagraph (A), by inserting “(or, beginning

1 with 2009, paragraph (3)(E))” after “para-
2 graph (3)(D)”;

3 (B) in paragraph (3)(A)(iii), by striking
4 “(D) or”.

5 (2) ANNUAL INCREASE IN LIS RESOURCE
6 TEST.—Section 1860D–14(a)(3)(E)(i) of such Act
7 (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

8 (A) by striking “and” at the end of sub-
9 clause (I);

10 (B) in subclause (II), by inserting “(before
11 2012)” after “subsequent year”;

12 (C) by striking the period at the end of
13 subclause (II) and inserting a semicolon;

14 (D) by inserting after subclause (II) the
15 following new subclauses:

16 “(III) for 2012, \$17,000 (or
17 \$34,000 in the case of the combined
18 value of the individual’s assets or re-
19 sources and the assets or resources of
20 the individual’s spouse); and

21 “(IV) for a subsequent year, the
22 dollar amounts specified in this sub-
23 clause (or subclause (III)) for the pre-
24 vious year increased by the annual
25 percentage increase in the consumer

1 price index (all items; U.S. city aver-
2 age) as of September of such previous
3 year.”; and

4 (E) in the last sentence, by inserting “or
5 (IV)” after “subclause (II)”.

6 (3) APPLICATION OF LIS TEST UNDER MEDI-
7 CARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of
8 such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by
9 inserting before the period at the end the following:
10 “or, effective beginning with January 1, 2010, whose
11 resources (as so determined) do not exceed the max-
12 imum resource level applied for the year under sec-
13 tion 1860D-14(a)(3)(E) applicable to an individual
14 or to the individual and the individual’s spouse (as
15 the case may be)”.

16 (b) EFFECTIVE DATE.—The amendments made by
17 subsection (a) shall apply to eligibility determinations for
18 income-related subsidies and medicare cost-sharing fur-
19 nished for periods beginning on or after January 1, 2012.

20 **SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR**
21 **CERTAIN NON-INSTITUTIONALIZED FULL-**
22 **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

23 (a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of
24 the Social Security Act (42 U.S.C. 1395w–
25 114(a)(1)(D)(i)) is amended—

1 (1) by striking “INSTITUTIONALIZED INDIVID-
2 UALS.—In” and inserting “ELIMINATION OF COST-
3 SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGI-
4 BLE INDIVIDUALS.—

5 “(I) INSTITUTIONALIZED INDI-
6 VIDUALS.—In”; and

7 (2) by adding at the end the following new sub-
8 clause:

9 “(II) CERTAIN OTHER INDIVID-
10 UALS.—In the case of an individual
11 who is a full-benefit dual eligible indi-
12 vidual and with respect to whom there
13 has been a determination that but for
14 the provision of home and community
15 based care (whether under section
16 1915 or under a waiver under section
17 1115) the individual would require the
18 level of care provided in a hospital or
19 a nursing facility or intermediate care
20 facility for the mentally retarded the
21 cost of which could be reimbursed
22 under the State plan under title XIX,
23 the elimination of any beneficiary co-
24 insurance described in section 1860D-
25 2(b)(2) (for all amounts through the

1 total amount of expenditures at which
2 benefits are available under section
3 1860D–2(b)(4)).”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 subsection (a) shall apply to drugs dispensed on or after
6 January 1, 2011.

7 **SEC. 1203. ELIMINATING BARRIERS TO ENROLLMENT.**

8 (a) ADMINISTRATIVE VERIFICATION OF INCOME AND
9 RESOURCES UNDER THE LOW-INCOME SUBSIDY PRO-
10 GRAM.—Clause (iii) of section 1860D–14(a)(3)(E) of the
11 Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is
12 amended to read as follows:

13 “(iii) CERTIFICATION OF INCOME AND
14 RESOURCES.—For purposes of applying
15 this section—

16 “(I) an individual shall be per-
17 mitted to apply on the basis of self-
18 certification of income and resources;
19 and

20 “(II) matters attested to in the
21 application shall be subject to appro-
22 priate methods of verification without
23 the need of the individual to provide
24 additional documentation, except in

1 extraordinary situations as determined
2 by the Commissioner.”.

3 (b) AUTOMATIC REENROLLMENT WITHOUT NEED TO
4 REAPPLY UNDER LOW-INCOME SUBSIDY PROGRAM.—
5 Section 1860D–14(a)(3) of such Act (42 U.S.C. 1395w–
6 114(a)(3)) is amended by adding at the end the following
7 new subparagraph:

8 “(H) AUTOMATIC REENROLLMENT.—For
9 purposes of applying this section, in the case of
10 an individual who has been determined to be a
11 subsidy eligible individual (and within a par-
12 ticular class of such individuals, such as a full-
13 subsidy eligible individual or a partial subsidy
14 eligible individual), the individual shall be
15 deemed to continue to be so determined without
16 the need for any annual or periodic application
17 unless and until the individual notifies a Fed-
18 eral or State official responsible for such deter-
19 minations (or such a Federal or State official
20 determines) that the individual’s eligibility con-
21 ditions have changed so that the individual is
22 no longer a subsidy eligible individual (or is no
23 longer within such class of such individuals).”.

24 (c) DISCLOSURES TO FACILITATE IDENTIFICATION
25 OF INDIVIDUALS LIKELY TO BE ELIGIBLE FOR THE LOW-

1 INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIP-
2 TION DRUG PROGRAM.—

3 (1) IN GENERAL.—

4 Subsection (l) of section 6103 of the Inter-
5 nal Revenue Code of 1986 is amended by add-
6 ing at the end the following new paragraph:

7 “(21) DISCLOSURE OF RETURN INFORMATION
8 TO FACILITATE IDENTIFICATION OF INDIVIDUALS
9 LIKELY TO BE ELIGIBLE FOR LOW-INCOME SUB-
10 SIDIES UNDER MEDICARE PRESCRIPTION DRUG PRO-
11 GRAM.—

12 “(A) IN GENERAL.—The Secretary, upon
13 written request from the Commissioner of So-
14 cial Security, shall disclose to officers and em-
15 ployees of the Social Security Administration,
16 with respect to any individual identified by the
17 Commissioner—

18 “(i) whether, based on the criterion
19 determined under subparagraph (B), such
20 individual is likely to be eligible for low-in-
21 come assistance under section 1860D–14
22 of the Social Security Act, or

23 “(ii) that, based on such criterion,
24 there is insufficient information available

1 to the Secretary to make the determination
2 described in clause (i).

3 “(B) CRITERION.—Not later than 360
4 days after the date of the enactment of this
5 paragraph, the Secretary, in consultation with
6 the Commissioner of Social Security, shall de-
7 velop the criterion by which the determination
8 under subparagraph (A)(i) shall be made (and
9 the criterion for determining that insufficient
10 information is available to make such deter-
11 mination). Such criterion may include analysis
12 of information available on such individual’s re-
13 turn, the return of such individual’s spouse,
14 and any information related to such individual
15 or such individual’s spouse which is available on
16 any information return.

17 “(C) GAO REPORT TO CONGRESS.—Not
18 later than 2 years after the date of the first
19 submission to the Secretary of the Treasury de-
20 scribed in paragraph (1)(B), the Comptroller
21 General of the United States shall submit to
22 Congress a report, with respect to the 18-month
23 period following the establishment of the proc-
24 ess described in paragraph (1)(A), on—

1 “(i) the extent to which the percent-
2 age of individuals who are eligible for low-
3 income assistance under this section but
4 not enrolled under this part has decreased
5 during such period;

6 “(ii) the effectiveness of using infor-
7 mation from the Secretary of the Treasury
8 in accordance with section 6103(l)(21) of
9 the Internal Revenue Code of 1986 for
10 purposes of indicating whether individuals
11 are eligible for low-income assistance under
12 this section; and

13 “(iii) the effectiveness of the outreach
14 conducted by the Commissioner of Social
15 Security based on the data described in
16 subparagraph (C).”.

17 (2) PROCEDURES AND RECORDKEEPING RE-
18 LATED TO DISCLOSURES.—Paragraph (4) of section
19 6103(p) of such Code is amended by striking “or
20 (17)” each place it appears and inserting “(17), or
21 (21)”.

22 (3) EFFECTIVE DATE.—The amendments made
23 by this paragraph shall apply to disclosures made
24 after the date of the enactment of this Act.

1 **SEC. 1204. ENHANCED OVERSIGHT RELATING TO REIM-**
2 **BURSEMENTS FOR RETROACTIVE LOW IN-**
3 **COME SUBSIDY ENROLLMENT.**

4 (a) IN GENERAL.—In the case of a retroactive LIS
5 enrollment beneficiary who is enrolled under a prescription
6 drug plan under part D of title XVIII of the Social Secu-
7 rity Act (or an MA-PD plan under part C of such title),
8 the beneficiary (or any eligible third party) is entitled to
9 reimbursement by the plan for covered drug costs incurred
10 by the beneficiary during the retroactive coverage period
11 of the beneficiary in accordance with subsection (b) and
12 in the case of such a beneficiary described in subsection
13 (c)(4)(A)(i), such reimbursement shall be made automati-
14 cally by the plan upon receipt of appropriate notice the
15 beneficiary is eligible for assistance described in such sub-
16 section (c)(4)(A)(i) without further information required
17 to be filed with the plan by the beneficiary.

18 (b) ADMINISTRATIVE REQUIREMENTS RELATING TO
19 REIMBURSEMENTS.—

20 (1) LINE-ITEM DESCRIPTION.—Each reimburse-
21 ment made by a prescription drug plan or MA-PD
22 plan under subsection (a) shall include a line-item
23 description of the items for which the reimbursement
24 is made.

25 (2) TIMING OF REIMBURSEMENTS.—A prescrip-
26 tion drug plan or MA-PD plan must make a reim-

1 bursement under subsection (a) to a retroactive LIS
2 enrollment beneficiary, with respect to a claim, not
3 later than 45 days after—

4 (A) in the case of a beneficiary described
5 in subsection (c)(4)(A)(i), the date on which the
6 plan receives notice from the Secretary that the
7 beneficiary is eligible for assistance described in
8 such subsection; or

9 (B) in the case of a beneficiary described
10 in subsection (c)(4)(A)(ii), the date on which
11 the beneficiary files the claim with the plan.

12 (c) DEFINITIONS.—For purposes of this section:

13 (1) COVERED DRUG COSTS.—The term “cov-
14 ered drug costs” means, with respect to a retroactive
15 LIS enrollment beneficiary enrolled under a pre-
16 scription drug plan under part D of title XVIII of
17 the Social Security Act (or an MA-PD plan under
18 part C of such title), the amount by which—

19 (A) the costs incurred by such beneficiary
20 during the retroactive coverage period of the
21 beneficiary for covered part D drugs, premiums,
22 and cost-sharing under such title; exceeds

23 (B) such costs that would have been in-
24 curred by such beneficiary during such period if
25 the beneficiary had been both enrolled in the

1 plan and recognized by such plan as qualified
2 during such period for the low income subsidy
3 under section 1860D-14 of the Social Security
4 Act to which the individual is entitled.

5 (2) ELIGIBLE THIRD PARTY.—The term “eligi-
6 ble third party” means, with respect to a retroactive
7 LIS enrollment beneficiary, an organization or other
8 third party that paid on behalf of such beneficiary
9 for covered drug costs incurred by such beneficiary
10 during the retroactive coverage period of such bene-
11 ficiary.

12 (3) RETROACTIVE COVERAGE PERIOD.—The
13 term “retroactive coverage period” means—

14 (A) with respect to a retroactive LIS en-
15 rollment beneficiary described in paragraph
16 (4)(A)(i), the period—

17 (i) beginning on the effective date of
18 the assistance described in such paragraph
19 for which the individual is eligible; and

20 (ii) ending on the date the plan effec-
21 tuates the status of such individual as so
22 eligible; and

23 (B) with respect to a retroactive LIS en-
24 rollment beneficiary described in paragraph
25 (4)(A)(ii), the period—

1 (i) beginning on the date the indi-
2 vidual is both entitled to benefits under
3 part A, or enrolled under part B, of title
4 XVIII of the Social Security Act and eligi-
5 ble for medical assistance under a State
6 plan under title XIX of such Act; and

7 (ii) ending on the date the plan effec-
8 tuates the status of such individual as a
9 full-benefit dual eligible individual (as de-
10 fined in section 1935(c)(6) of such Act).

11 (4) RETROACTIVE LIS ENROLLMENT BENE-
12 FICIARY.—

13 (A) IN GENERAL.—The term “retroactive
14 LIS enrollment beneficiary” means an indi-
15 vidual who—

16 (i) is enrolled in a prescription drug
17 plan under part D of title XVIII of the So-
18 cial Security Act (or an MA-PD plan
19 under part C of such title) and subse-
20 quently becomes eligible as a full-benefit
21 dual eligible individual (as defined in sec-
22 tion 1935(c)(6) of such Act), an individual
23 receiving a low-income subsidy under sec-
24 tion 1860D-14 of such Act, an individual
25 receiving assistance under the Medicare

1 Savings Program implemented under
2 clauses (i), (ii), (iii), and (iv) of section
3 1902(a)(10)(E) of such Act, or an indi-
4 vidual receiving assistance under the sup-
5 plemental security income program under
6 section 1611 of such Act; or

7 (ii) subject to subparagraph (B)(i), is
8 a full-benefit dual eligible individual (as
9 defined in section 1935(c)(6) of such Act)
10 who is automatically enrolled in such a
11 plan under section 1860D-1(b)(1)(C) of
12 such Act.

13 (B) EXCEPTION FOR BENEFICIARIES EN-
14 ROLLED IN RFP PLAN.—

15 (i) IN GENERAL.—In no case shall an
16 individual described in subparagraph
17 (A)(ii) include an individual who is en-
18 rolled, pursuant to a RFP contract de-
19 scribed in clause (ii), in a prescription
20 drug plan offered by the sponsor of such
21 plan awarded such contract.

22 (ii) RFP CONTRACT DESCRIBED.—
23 The RFP contract described in this section
24 is a contract entered into between the Sec-
25 retary and a sponsor of a prescription drug

1 plan pursuant to the Centers for Medicare
2 & Medicaid Services' request for proposals
3 issued on February 17, 2009, relating to
4 Medicare part D retroactive coverage for
5 certain low income beneficiaries, or a simi-
6 lar subsequent request for proposals.

7 **SEC. 1205. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

8 (a) IN GENERAL.—Section 1860D–1(b)(1)(C) of the
9 Social Security Act (42 U.S.C. 1395w–101(b)(1)(C)) is
10 amended by adding after “PDP region” the following: “or
11 through use of an intelligent assignment process that is
12 designed to maximize the access of such individual to nec-
13 essary prescription drugs while minimizing costs to such
14 individual and to the program under this part to the max-
15 imum extent possible. In the case the Secretary enrolls
16 such individuals through use of an intelligent assignment
17 process, such process shall take into account the extent
18 to which prescription drugs necessary for the individual
19 are covered in the case of a PDP sponsor of a prescription
20 drug plan that uses a formulary, the use of prior author-
21 ization or other restrictions on access to coverage of such
22 prescription drugs by such a sponsor, and the overall qual-
23 ity of a prescription drug plan as measured by quality rat-
24 ings established by the Secretary.”

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect for enrollments effected on
3 or after November 1, 2011.

4 **SEC. 1206. AUTOMATIC ENROLLMENT PROCESS FOR CER-**
5 **TAIN SUBSIDY ELIGIBLE INDIVIDUALS.**

6 (a) IN GENERAL.—Section 1860D–1(b)(1) of the So-
7 cial Security Act (42 U.S.C. 1395w–101(b)(1)) is amend-
8 ed by adding at the end the following new subparagraph:

9 “(D) SPECIAL RULE FOR SUBSIDY ELIGI-
10 BLE INDIVIDUALS.—The process established
11 under subparagraph (A) shall include, in the
12 case of an applicable subsidy eligible individual
13 (as defined in clause (ii) of paragraph (3)(F))
14 who fails to enroll in a prescription drug plan
15 or an MA–PD plan during the special enroll-
16 ment period described in clause (iii) of such
17 paragraph applicable to such individual, an in-
18 telligent assignment process described in sub-
19 paragraph (C) to facilitate enrollment of such
20 individual in the prescription drug plan or MA-
21 PD plan that is most appropriate for such indi-
22 vidual (as determined by the Secretary). Noth-
23 ing in the previous sentence shall prevent an in-
24 dividual described in such sentence from declin-
25 ing enrollment in a plan determined appropriate

1 by the Secretary (or in the program under this
2 part) or from changing such enrollment.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to subsidy determinations made
5 for months beginning with January 2011.

6 **SEC. 1207. APPLICATION OF MA PREMIUMS PRIOR TO RE-**
7 **BATE IN CALCULATION OF LOW INCOME SUB-**
8 **SIDY BENCHMARK.**

9 (a) IN GENERAL.—Section 1860D–14(b)(2)(B)(iii)
10 of the Social Security Act (42 U.S.C. 1395w–
11 114(b)(2)(B)(iii)) is amended by inserting before the pe-
12 riod the following: “before the application of the monthly
13 rebate computed under section 1854(b)(1)(C)(i) for that
14 plan and year involved”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to subsidy determinations made
17 for months beginning with January 2011.

18 **Subtitle B—Reducing Health**
19 **Disparities**

20 **SEC. 1221. ENSURING EFFECTIVE COMMUNICATION IN**
21 **MEDICARE.**

22 (a) ENSURING EFFECTIVE COMMUNICATION BY THE
23 CENTERS FOR MEDICARE & MEDICAID SERVICES.—

24 (1) STUDY ON MEDICARE PAYMENTS FOR LAN-
25 GUAGE SERVICES.—The Secretary of Health and

1 Human Services shall conduct a study that examines
2 the extent to which Medicare service providers uti-
3 lize, offer, or make available language services for
4 beneficiaries who are limited English proficient and
5 ways that Medicare should develop payment systems
6 for language services.

7 (2) ANALYSES.—The study shall include an
8 analysis of each of the following:

9 (A) How to develop and structure appro-
10 priate payment systems for language services
11 for all Medicare service providers.

12 (B) The feasibility of adopting a payment
13 methodology for on-site interpreters, including
14 interpreters who work as independent contrac-
15 tors and interpreters who work for agencies
16 that provide on-site interpretation, pursuant to
17 which such interpreters could directly bill Medi-
18 care for services provided in support of physi-
19 cian office services for an LEP Medicare pa-
20 tient.

21 (C) The feasibility of Medicare contracting
22 directly with agencies that provide off-site inter-
23 pretation including telephonic and video inter-
24 pretation pursuant to which such contractors
25 could directly bill Medicare for the services pro-

1 vided in support of physician office services for
2 an LEP Medicare patient.

3 (D) The feasibility of modifying the exist-
4 ing Medicare resource-based relative value scale
5 (RBRVS) by using adjustments (such as multi-
6 pliers or add-ons) when a patient is LEP.

7 (E) How each of options described in a
8 previous paragraph would be funded and how
9 such funding would affect physician payments,
10 a physician's practice, and beneficiary cost-
11 sharing.

12 (F) The extent to which providers under
13 parts A and B of title XVIII of the Social Secu-
14 rity Act, MA organizations offering Medicare
15 Advantage plans under part C of such title and
16 PDP sponsors of a prescription drug plan
17 under part D of such title utilize, offer, or make
18 available language services for beneficiaries with
19 limited English proficiency.

20 (G) The nature and type of language serv-
21 ices provided by States under title XIX of the
22 Social Security Act and the extent to which
23 such services could be utilized by beneficiaries
24 and providers under title XVIII of the such Act.

1 (3) VARIATION IN PAYMENT SYSTEM DE-
2 SCRIBED.—The payment systems described in sub-
3 section (b) may allow variations based upon types of
4 service providers, available delivery methods, and
5 costs for providing language services including such
6 factors as—

7 (A) the type of language services provided
8 (such as provision of health care or health care
9 related services directly in a non-English lan-
10 guage by a bilingual provider or use of an inter-
11 preter);

12 (B) type of interpretation services provided
13 (such as in-person, telephonic, video interpreta-
14 tion);

15 (C) the methods and costs of providing
16 language services (including the costs of pro-
17 viding language services with internal staff or
18 through contract with external independent con-
19 tractors or agencies, or both);

20 (D) providing services for languages not
21 frequently encountered in the United States;
22 and

23 (E) providing services in rural areas.

24 (4) REPORT.—The Secretary shall submit a re-
25 port on the study conducted under subsection (a) to

1 appropriate committees of Congress not later than
2 12 months after the date of the enactment of this
3 Act.

4 (5) EXEMPTION FROM PAPERWORK REDUCTION
5 ACT.—Chapter 35 of title 44, United States Code
6 (commonly known as the “Paperwork Reduction
7 Act”), shall not apply for purposes of carrying out
8 this subsection.

9 (6) AUTHORIZATION OF APPROPRIATIONS.—
10 There is authorized to be appropriated to carry out
11 this subsection such sums as are necessary.

12 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-
13 cial Security Act (42 U.S.C. 1395w–27(g)(1)) is amend-
14 ed—

15 (1) by striking “or” at the end of subparagraph
16 (F);

17 (2) by adding “or” at the end of subparagraph
18 (G); and

19 (3) by inserting after subparagraph (G) the fol-
20 lowing new subparagraph:

21 “(H) fails substantially to provide lan-
22 guage services to limited English proficient
23 beneficiaries enrolled in the plan that are re-
24 quired under law;”.

1 **SEC. 1222. DEMONSTRATION TO PROMOTE ACCESS FOR**
2 **MEDICARE BENEFICIARIES WITH LIMITED**
3 **ENGLISH PROFICIENCY BY PROVIDING REIM-**
4 **BURSEMENT FOR CULTURALLY AND LINGUIS-**
5 **TICALLY APPROPRIATE SERVICES.**

6 (a) IN GENERAL.—Not later than 6 months after the
7 date of the completion of the study described in section
8 1221(a), the Secretary, acting through the Centers for
9 Medicare & Medicaid Services, shall carry out a dem-
10 onstration program under which the Secretary shall award
11 not fewer than 24 3-year grants to eligible Medicare serv-
12 ice providers (as described in subsection (b)(1)) to improve
13 effective communication between such providers and Medi-
14 care beneficiaries who are living in communities where ra-
15 cial and ethnic minorities, including populations that face
16 language barriers, are underserved with respect to such
17 services. In designing and carrying out the demonstration
18 the Secretary shall take into consideration the results of
19 the study conducted under section 1221(a) and adjust, as
20 appropriate, the distribution of grants so as to better tar-
21 get Medicare beneficiaries who are in the greatest need
22 of language services. The Secretary shall not authorize a
23 grant larger than \$500,000 over three years for any grant-
24 ee.

25 (b) ELIGIBILITY; PRIORITY.—

1 (1) ELIGIBILITY.—To be eligible to receive a
2 grant under subsection (a) an entity shall—

3 (A) be—

4 (i) a provider of services under part A
5 of title XVIII of the Social Security Act;

6 (ii) a service provider under part B of
7 such title;

8 (iii) a part C organization offering a
9 Medicare part C plan under part C of such
10 title; or

11 (iv) a PDP sponsor of a prescription
12 drug plan under part D of such title; and

13 (B) prepare and submit to the Secretary
14 an application, at such time, in such manner,
15 and accompanied by such additional informa-
16 tion as the Secretary may require.

17 (2) PRIORITY.—

18 (A) DISTRIBUTION.—To the extent fea-
19 sible, in awarding grants under this section, the
20 Secretary shall award—

21 (i) at least 6 grants to providers of
22 services described in paragraph (1)(A)(i);

23 (ii) at least 6 grants to service pro-
24 viders described in paragraph (1)(A)(ii);

1 (iii) at least 6 grants to organizations
2 described in paragraph (1)(A)(iii); and

3 (iv) at least 6 grants to sponsors de-
4 scribed in paragraph (1)(A)(iv).

5 (B) FOR COMMUNITY ORGANIZATIONS.—

6 The Secretary shall give priority to applicants
7 that have developed partnerships with commu-
8 nity organizations or with agencies with experi-
9 ence in language access.

10 (C) VARIATION IN GRANTEES.—The Sec-
11 retary shall also ensure that the grantees under
12 this section represent, among other factors,
13 variations in—

14 (i) different types of language services
15 provided and of service providers and orga-
16 nizations under parts A through D of title
17 XVIII of the Social Security Act;

18 (ii) languages needed and their fre-
19 quency of use;

20 (iii) urban and rural settings;

21 (iv) at least two geographic regions,
22 as defined by the Secretary; and

23 (v) at least two large metropolitan
24 statistical areas with diverse populations.

25 (c) USE OF FUNDS.—

1 (1) IN GENERAL.—A grantee shall use grant
2 funds received under this section to pay for the pro-
3 vision of competent language services to Medicare
4 beneficiaries who are limited English proficient.
5 Competent interpreter services may be provided
6 through on-site interpretation, telephonic interpreta-
7 tion, or video interpretation or direct provision of
8 health care or health care related services by a bilin-
9 gual health care provider. A grantee may use bilin-
10 gual providers, staff, or contract interpreters. A
11 grantee may use grant funds to pay for competent
12 translation services. A grantee may use up to 10
13 percent of the grant funds to pay for administrative
14 costs associated with the provision of competent lan-
15 guage services and for reporting required under sub-
16 section (e).

17 (2) ORGANIZATIONS.—Grantees that are part C
18 organizations or PDP sponsors must ensure that
19 their network providers receive at least 50 percent of
20 the grant funds to pay for the provision of com-
21 petent language services to Medicare beneficiaries
22 who are limited English proficient, including physi-
23 cians and pharmacies.

24 (3) DETERMINATION OF PAYMENTS FOR LAN-
25 GUAGE SERVICES.—Payments to grantees shall be

1 calculated based on the estimated numbers of lim-
2 ited English proficient Medicare beneficiaries in a
3 grantee's service area utilizing—

4 (A) data on the numbers of limited
5 English proficient individuals who speak
6 English less than “very well” from the most re-
7 cently available data from the Bureau of the
8 Census or other State-based study the Sec-
9 retary determines likely to yield accurate data
10 regarding the number of such individuals served
11 by the grantee; or

12 (B) the grantee's own data if the grantee
13 routinely collects data on Medicare bene-
14 ficiaries' primary language in a manner deter-
15 mined by the Secretary to yield accurate data
16 and such data shows greater numbers of limited
17 English proficient individuals than the data list-
18 ed in subparagraph (A).

19 (4) LIMITATIONS.—

20 (A) REPORTING.—Payments shall only be
21 provided under this section to grantees that re-
22 port their costs of providing language services
23 as required under subsection (e) and may be
24 modified annually at the discretion of the Sec-
25 retary. If a grantee fails to provide the reports

1 under such section for the first year of a grant,
2 the Secretary may terminate the grant and so-
3 licit applications from new grantees to partici-
4 pate in the subsequent two years of the dem-
5 onstration program.

6 (B) TYPE OF SERVICES.—

7 (i) IN GENERAL.—Subject to clause
8 (ii), payments shall be provided under this
9 section only to grantees that utilize com-
10 petent bilingual staff or competent inter-
11 preter or translation services which—

12 (I) if the grantee operates in a
13 State that has statewide health care
14 interpreter standards, meet the State
15 standards currently in effect; or

16 (II) if the grantee operates in a
17 State that does not have statewide
18 health care interpreter standards, uti-
19 lizes competent interpreters who fol-
20 low the National Council on Inter-
21 preting in Health Care's Code of Eth-
22 ics and Standards of Practice.

23 (ii) EXEMPTIONS.—The requirements
24 of clause (i) shall not apply—

1 (I) in the case of a Medicare ben-
2 eficiary who is limited English pro-
3 ficient (who has been informed in the
4 beneficiary's primary language of the
5 availability of free interpreter and
6 translation services) and who requests
7 the use of family, friends, or other
8 persons untrained in interpretation or
9 translation and the grantee documents
10 the request in the beneficiary's record;
11 and

12 (II) in the case of a medical
13 emergency where the delay directly as-
14 sociated with obtaining a competent
15 interpreter or translation services
16 would jeopardize the health of the pa-
17 tient.

18 Nothing in clause (ii)(II) shall be con-
19 strued to exempt emergency rooms or simi-
20 lar entities that regularly provide health
21 care services in medical emergencies from
22 having in place systems to provide com-
23 petent interpreter and translation services
24 without undue delay.

1 (d) ASSURANCES.—Grantees under this section
2 shall—

3 (1) ensure that appropriate clinical and support
4 staff receive ongoing education and training in lin-
5 guistically appropriate service delivery; ensure the
6 linguistic competence of bilingual providers;

7 (2) offer and provide appropriate language serv-
8 ices at no additional charge to each patient with lim-
9 ited English proficiency at all points of contact, in
10 a timely manner during all hours of operation;

11 (3) notify Medicare beneficiaries of their right
12 to receive language services in their primary lan-
13 guage;

14 (4) post signage in the languages of the com-
15 monly encountered group or groups present in the
16 service area of the organization; and

17 (5) ensure that—

18 (A) primary language data are collected
19 for recipients of language services; and

20 (B) consistent with the privacy protections
21 provided under the regulations promulgated
22 pursuant to section 264(c) of the Health Insur-
23 ance Portability and Accountability Act of 1996
24 (42 U.S.C. 1320d–2 note), if the recipient of
25 language services is a minor or is incapacitated,

1 the primary language of the parent or legal
2 guardian is collected and utilized.

3 (e) REPORTING REQUIREMENTS.—Grantees under
4 this section shall provide the Secretary with reports at the
5 conclusion of the each year of a grant under this section.
6 Each report shall include at least the following informa-
7 tion:

8 (1) The number of Medicare beneficiaries to
9 whom language services are provided.

10 (2) The languages of those Medicare bene-
11 ficiaries.

12 (3) The types of language services provided
13 (such as provision of services directly in non-English
14 language by a bilingual health care provider or use
15 of an interpreter).

16 (4) Type of interpretation (such as in-person,
17 telephonic, or video interpretation).

18 (5) The methods of providing language services
19 (such as staff or contract with external independent
20 contractors or agencies).

21 (6) The length of time for each interpretation
22 encounter.

23 (7) The costs of providing language services
24 (which may be actual or estimated, as determined by
25 the Secretary).

1 (f) NO COST SHARING.—Limited English proficient
2 Medicare beneficiaries shall not have to pay cost-sharing
3 or co-pays for language services provided through this
4 demonstration program.

5 (g) EVALUATION AND REPORT.—The Secretary shall
6 conduct an evaluation of the demonstration program
7 under this section and shall submit to the appropriate
8 committees of Congress a report not later than 1 year
9 after the completion of the program. The report shall in-
10 clude the following:

11 (1) An analysis of the patient outcomes and
12 costs of furnishing care to the limited English pro-
13 ficient Medicare beneficiaries participating in the
14 project as compared to such outcomes and costs for
15 limited English proficient Medicare beneficiaries not
16 participating.

17 (2) The effect of delivering culturally and lin-
18 guistically appropriate services on beneficiary access
19 to care, utilization of services, efficiency and cost-ef-
20 fectiveness of health care delivery, patient satisfac-
21 tion, and select health outcomes.

22 (3) Recommendations regarding the extension
23 of such project to the entire Medicare program.

24 (h) GENERAL PROVISIONS.—Nothing in this section
25 shall be construed to limit otherwise existing obligations

1 of recipients of Federal financial assistance under title VI
2 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et
3 seq.) or any other statute.

4 (i) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated to carry out this section
6 \$16,000,000 for each fiscal year of the demonstration pro-
7 gram.

8 **SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**
9 **SERVICES.**

10 (a) IN GENERAL.—The Secretary of Health and
11 Human Services shall enter into an arrangement with the
12 Institute of Medicine under which the Institute will pre-
13 pare and publish, not later than 3 years after the date
14 of the enactment of this Act, a report on the impact of
15 language access services on the health and health care of
16 limited English proficient populations.

17 (b) CONTENTS.—Such report shall include—

18 (1) recommendations on the development and
19 implementation of policies and practices by health
20 care organizations and providers for limited English
21 proficient patient populations;

22 (2) a description of the effect of providing lan-
23 guage access services on quality of health care and
24 access to care and reduced medical error; and

1 (3) a description of the costs associated with or
2 savings related to provision of language access serv-
3 ices.

4 **SEC. 1224. DEFINITIONS.**

5 In this subtitle:

6 (1) **BILINGUAL.**—The term “bilingual” with re-
7 spect to an individual means a person who has suffi-
8 cient degree of proficiency in two languages and can
9 ensure effective communication can occur in both
10 languages.

11 (2) **COMPETENT INTERPRETER SERVICES.**—The
12 term “competent interpreter services” means a
13 trans-language rendition of a spoken message in
14 which the interpreter comprehends the source lan-
15 guage and can speak comprehensively in the target
16 language to convey the meaning intended in the
17 source language. The interpreter knows health and
18 health-related terminology and provides accurate in-
19 terpretations by choosing equivalent expressions that
20 convey the best matching and meaning to the source
21 language and captures, to the greatest possible ex-
22 tent, all nuances intended in the source message.

23 (3) **COMPETENT TRANSLATION SERVICES.**—The
24 term “competent translation services” means a
25 trans-language rendition of a written document in

1 which the translator comprehends the source lan-
2 guage and can write comprehensively in the target
3 language to convey the meaning intended in the
4 source language. The translator knows health and
5 health-related terminology and provides accurate
6 translations by choosing equivalent expressions that
7 convey the best matching and meaning to the source
8 language and captures, to the greatest possible ex-
9 tent, all nuances intended in the source document.

10 (4) **EFFECTIVE COMMUNICATION.**—The term
11 “effective communication” means an exchange of in-
12 formation between the provider of health care or
13 health care-related services and the limited English
14 proficient recipient of such services that enables lim-
15 ited English proficient individuals to access, under-
16 stand, and benefit from health care or health care-
17 related services.

18 (5) **INTERPRETING/INTERPRETATION.**—The
19 terms “interpreting” and “interpretation” mean the
20 transmission of a spoken message from one language
21 into another, faithfully, accurately, and objectively.

22 (6) **HEALTH CARE SERVICES.**—The term
23 “health care services” means services that address
24 physical as well as mental health conditions in all
25 care settings.

1 (7) HEALTH CARE-RELATED SERVICES.—The
2 term “health care-related services” means human or
3 social services programs or activities that provide ac-
4 cess, referrals or links to health care.

5 (8) LANGUAGE ACCESS.—The term “language
6 access” means the provision of language services to
7 an LEP individual designed to enhance that individ-
8 ual’s access to, understanding of or benefit from
9 health care or health care-related services.

10 (9) LANGUAGE SERVICES.—The term “lan-
11 guage services” means provision of health care serv-
12 ices directly in a non-English language, interpreta-
13 tion, translation, and non-English signage.

14 (10) LIMITED ENGLISH PROFICIENT.—The
15 term “limited English proficient” or “LEP” with re-
16 spect to an individual means an individual who
17 speaks a primary language other than English and
18 who cannot speak, read, write or understand the
19 English language at a level that permits the indi-
20 vidual to effectively communicate with clinical or
21 nonclinical staff at an entity providing health care or
22 health care related services.

23 (11) MEDICARE BENEFICIARY.—The term
24 “Medicare beneficiary” means an individual entitled

1 to benefits under part A of title XVIII of the Social
2 Security Act or enrolled under part B of such title.

3 (12) MEDICARE PROGRAM.—The term “Medi-
4 care program” means the programs under parts A
5 through D of title XVIII of the Social Security Act.

6 (13) SERVICE PROVIDER.—The term “service
7 provider” includes all suppliers, providers of services,
8 or entities under contract to provide coverage, items
9 or services under any part of title XVIII of the So-
10 cial Security Act.

11 **Subtitle C—Miscellaneous** 12 **Improvements**

13 **SEC. 1231. EXTENSION OF THERAPY CAPS EXCEPTIONS** 14 **PROCESS.**

15 Section 1833(g)(5) of the Social Security Act (42
16 U.S.C. 1395l(g)(5)), as amended by section 141 of the
17 Medicare Improvements for Patients and Providers Act of
18 2008 (Public Law 110–275), is amended by striking “De-
19 cember 31, 2009” and inserting “December 31, 2011”.

1 **SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNO-**
2 **SUPPRESSIVE DRUGS FOR KIDNEY TRANS-**
3 **PLANT PATIENTS AND OTHER RENAL DIALY-**
4 **SIS PROVISIONS.**

5 (a) PROVISION OF APPROPRIATE COVERAGE OF IM-
6 MUNOSUPPRESSIVE DRUGS UNDER THE MEDICARE PRO-
7 GRAM FOR KIDNEY TRANSPLANT RECIPIENTS.—

8 (1) CONTINUED ENTITLEMENT TO IMMUNO-
9 SUPPRESSIVE DRUGS.—

10 (A) KIDNEY TRANSPLANT RECIPIENTS.—

11 Section 226A(b)(2) of the Social Security Act
12 (42 U.S.C. 426-1(b)(2)) is amended by insert-
13 ing “(except for coverage of immunosuppressive
14 drugs under section 1861(s)(2)(J))” before “,
15 with the thirty-sixth month”.

16 (B) APPLICATION.—Section 1836 of such
17 Act (42 U.S.C. 1395o) is amended—

18 (i) by striking “Every individual who”
19 and inserting “(a) IN GENERAL.—Every in-
20 dividual who”; and

21 (ii) by adding at the end the following
22 new subsection:

23 “(b) SPECIAL RULES APPLICABLE TO INDIVIDUALS
24 ONLY ELIGIBLE FOR COVERAGE OF IMMUNOSUPPRESSIVE
25 DRUGS.—

1 “(1) IN GENERAL.—In the case of an individual
2 whose eligibility for benefits under this title has
3 ended on or after January 1, 2010, except for the
4 coverage of immunosuppressive drugs by reason of
5 section 226A(b)(2), the following rules shall apply:

6 “(A) The individual shall be deemed to be
7 enrolled under this part for purposes of receiv-
8 ing coverage of such drugs.

9 “(B) The individual shall be responsible
10 for the providing for payment of portion of the
11 premium under section 1839 which is not cov-
12 ered under the Medicare savings program (as
13 defined in section 1144(c)(7)) in order to re-
14 ceive such coverage.

15 “(C) The provision of such drugs shall be
16 subject to the application of—

17 “(i) the deductible under section
18 1833(b); and

19 “(ii) the coinsurance amount applica-
20 ble for such drugs (as determined under
21 this part).

22 “(D) If the individual is an inpatient of a
23 hospital or other entity, the individual is enti-
24 tled to receive coverage of such drugs under
25 this part.

1 “(2) ESTABLISHMENT OF PROCEDURES IN
2 ORDER TO IMPLEMENT COVERAGE.—The Secretary
3 shall establish procedures for—

4 “(A) identifying beneficiaries that are enti-
5 tled to coverage of immunosuppressive drugs by
6 reason of section 226A(b)(2); and

7 “(B) distinguishing such beneficiaries from
8 beneficiaries that are enrolled under this part
9 for the complete package of benefits under this
10 part.”.

11 (C) TECHNICAL AMENDMENT TO CORRECT
12 DUPLICATE SUBSECTION DESIGNATION.—Sub-
13 section (c) of section 226A of such Act (42
14 U.S.C. 426-1), as added by section
15 201(a)(3)(D)(ii) of the Social Security Inde-
16 pendence and Program Improvements Act of
17 1994 (Public Law 103-296; 108 Stat. 1497), is
18 redesignated as subsection (d).

19 (2) EXTENSION OF SECONDARY PAYER RE-
20 QUIREMENTS FOR ESRD BENEFICIARIES.—Section
21 1862(b)(1)(C) of such Act (42 U.S.C.
22 1395y(b)(1)(C)) is amended by adding at the end
23 the following new sentence: “With regard to im-
24 munosuppressive drugs furnished on or after the
25 date of the enactment of the *[insert short title]*, this

1 subparagraph shall be applied without regard to any
2 time limitation.”.

3 (b) MEDICARE COVERAGE FOR ESRD PATIENTS.—

4 Section 1881 of such Act is further amended—

5 (1) in subsection (b)(14)(B)(iii), by inserting “,
6 including oral drugs that are not the oral equivalent
7 of an intravenous drug (such as oral phosphate bind-
8 ers and calcimimetics),” after “other drugs and
9 biologicals”;

10 (2) in subsection (b)(14)(E)(ii)—

11 (A) in the first sentence—

12 (i) by striking “a one-time election to
13 be excluded from the phase-in” and insert-
14 ing “an election, with respect to 2011,
15 2012, or 2013, to be excluded from the
16 phase-in (or the remainder of the phase-
17 in)”;

18 (ii) by adding at the end the fol-
19 lowing: “for such year and for each subse-
20 quent year during the phase-in described
21 in clause (i)”;

22 (B) in the second sentence—

23 (i) by striking “January 1, 2011” and
24 inserting “the first date of such year”; and

1 (ii) by inserting “and at a time” after
2 “form and manner”; and
3 (3) in subsection (h)(4)(E), by striking “lesser”
4 and inserting “greater”.

5 **SEC. 1233. PART B PREMIUM.**

6 (a) COMPUTATION FOR 2010.—

7 (1) IN GENERAL.—Section 1839(f) of the Social
8 Security Act (42 U.S.C. 1395r(f)) is amended—

9 (A) by inserting “(1)” after “(f)”; and

10 (B) by adding at the end the following new
11 paragraphs:

12 “(2) Insofar as the application of paragraph (1) in
13 a year for individuals is estimated to result in a decrease
14 in aggregate premium receipts for the year, such decrease
15 shall not be taken into account in computing the actuarial
16 rate applied under subsection (a)(2) for purposes of com-
17 puting the premiums for other individuals to which such
18 paragraph does not apply. With respect to a calendar year
19 in the case of an individual who, in December of the pre-
20 ceding year or during any month of the year, is enrolled
21 in the Medicare Savings Program (as defined in section
22 1144(c)(7)), paragraph (1) shall be applied, for any
23 months of the calendar year in which the individual is not
24 enrolled in such Program, as if the individual had not been
25 so enrolled.”.

1 (2) CONFORMING AMENDMENT.—Section 1844
2 of such Act (42 U.S.C. 1395w) is amended—

3 (A) in subsection (a)—

4 (i) by inserting “(A)” after “(2)” in
5 paragraph (2);

6 (ii) by adding at the end of paragraph
7 (2) the following new subparagraph:

8 “(B) monthly government contribution equal to
9 the monthly premium increase not paid because of
10 the application of section 1839(f); plus”; and

11 (iii) by adding after and below para-
12 graph (3) the following:

13 “The government contribution under paragraph (2)(B)
14 shall be treated as premiums payable and deposited for
15 purposes of subparagraphs (A) and (B) of paragraph
16 (1).”; and

17 (B) in subsection (c), by striking “section
18 1839(i)” and inserting “subsections (f) and (i)
19 of section 1839”.

20 (3) APPLICATION TO 2010 ONLY.—The amend-
21 ments made by this subsection shall apply to pre-
22 miums and payments for 2010.

23 (b) EXCLUSION OF CERTAIN GAINS FROM COUNTING
24 TOWARD PART B INCOME-RELATED PREMIUM.—

1 (1) IN GENERAL.—Section 1839(i)(4)(A) of the
2 Social Security Act (42 U.S.C. 1395r(i)(4)(A)) is
3 amended—

4 (A) by striking “and” at the end of clause
5 (i);

6 (B) by striking the period at the end of
7 clause (ii) and inserting “; and”; and

8 (C) by adding at the end the following new
9 clause:

10 “(iii) by excluding from income the
11 portion of gain attributable to the sale of
12 a primary residence.”.

13 (2) EFFECTIVE DATE.—The amendments made
14 by paragraph (1) shall apply to premiums and pay-
15 ments for years beginning with 2010.

16 **SEC. 1234. REQUIRING GUARANTEED ISSUE FOR CERTAIN**
17 **INDIVIDUALS UNDER MEDIGAP.**

18 (a) ACCESS FOR DISABLED MEDICARE BENE-
19 FICIARIES.—

20 (1) IN GENERAL.—Section 1882(s)(2)(A) of the
21 Social Security Act (42 U.S.C. 1395ss(s)(2)(A)) is
22 amended by inserting “, or is eligible for hospital in-
23 surance benefits under part A on the basis of section
24 226(b)” after “65 years of age or older”.

1 (2) EFFECTIVE DATE.—The amendment made
2 by paragraph (1) shall apply to individuals who be-
3 come eligible for hospital insurance benefits on or
4 after the first day of the first month that begins
5 more than one year after the date of the enactment
6 of this Act.

7 (b) ACCESS TO MEDIGAP COVERAGE FOR INDIVID-
8 UALS WHO LEAVE MA PLANS.—

9 (1) IN GENERAL.—Section 1882(s)(3) of the
10 Social Security Act (42 U.S.C. 1395ss(s)(3)) is
11 amended—

12 (A) in each of clauses (v)(III) and (vi) of
13 subparagraph (B), by striking “12 months”
14 and inserting “24 months”; and

15 (B) in each of subclauses (I) and (II) of
16 subparagraph (F)(i), by striking “12 months”
17 and inserting “24 months”.

18 (2) EFFECTIVE DATE.—The amendments made
19 by paragraph (1) shall apply to terminations of en-
20 rollments in MA plans occurring on or after the date
21 of the enactment of this Act.

22 **SEC. 1235. CONSULTATION AND INFORMATION REGARDING**
23 **END-OF-LIFE PLANNING.**

24 (a) IN GENERAL.—Section 1861 of the Social Secu-
25 rity Act (42 U.S.C. 1395x) is amended—

1 (1) in subsection (s)(2)—

2 (A) by striking “and” at the end of sub-
3 paragraph (DD);

4 (B) by adding “and” at the end of sub-
5 paragraph (EE); and

6 (C) by adding at the end the following new
7 subparagraph:

8 “(FF) consultations regarding an order for
9 life sustaining treatment (as defined in sub-
10 section (hhh)(1)) for qualified individuals (as
11 defined in subsection (hhh)(3));” and

12 (2) by adding at the end the following new sub-
13 section:

14 “Consultation Regarding an Order for Life Sustaining
15 Treatment

16 “(hhh)(1) The term ‘consultation regarding an order
17 for life sustaining treatment’ means, with respect to a
18 qualified individual, consultations between the individual
19 and the individual’s physician (as defined in subsection
20 (r)(1)) (or other health care professional described in
21 paragraph (2)(A)) and, to the extent applicable, registered
22 nurses, nurse practitioners, physicians’ assistants, and so-
23 cial workers, regarding the establishment, implementation,
24 and changes in an order regarding life sustaining treat-
25 ment (as defined in paragraph (2)) for that individual.

1 Such a consultation may include a consultation regard-
2 ing—

3 “(A) the reasons why the development of
4 such an order is beneficial to the individual and
5 the individual’s family and the reasons why
6 such an order should be updated periodically as
7 the health of the individual changes;

8 “(B) the information needed for an indi-
9 vidual or legal surrogate to make informed deci-
10 sions regarding the completion of such an
11 order; and

12 “(C) the identification of resources that an
13 individual may use to determine the require-
14 ments of the State in which such individual re-
15 sides so that the treatment wishes of that indi-
16 vidual will be carried out if the individual is un-
17 able to communicate those wishes, including re-
18 quirements regarding the designation of a sur-
19 rogate decisionmaker (also known as a health
20 care proxy).

21 The Secretary may limit consultations regarding an
22 order regarding life sustaining treatment to con-
23 sultations furnished in States, localities, or other ge-
24 ographic areas in which such orders have been wide-
25 ly adopted.

1 “(2) The terms ‘order regarding life sustaining treat-
2 ment’ means, with respect to an individual, an actionable
3 medical order relating to the treatment of that individual
4 that—

5 “(A) is signed and dated by a physician (as de-
6 fined in subsection (r)(1)) or another health care
7 professional (as specified by the Secretary and who
8 is acting within the scope of the professional’s au-
9 thority under State law in signing such an order)
10 and is in a form that permits it to stay with the pa-
11 tient and be followed by health care professionals
12 and providers across the continuum of care, includ-
13 ing home care, hospice, long-term care, community
14 and assisted living residences, skilled nursing facili-
15 ties, inpatient rehabilitation facilities, hospitals, and
16 emergency medical services;

17 “(B) effectively communicates the individual’s
18 preferences regarding life sustaining treatment, in-
19 cluding an indication of the treatment and care de-
20 sired by the individual;

21 “(C) is uniquely identifiable and standardized
22 within a given locality, region, or State (as identified
23 by the Secretary);

24 “(D) is portable across care settings; and

1 “(E) may incorporate any advance directive (as
2 defined in section 1866(f)(3)) if executed by the in-
3 dividual.

4 “(3) The term ‘qualified individual’ means an indi-
5 vidual who a physician (as defined in subsection (r)(1))
6 (or other health care professional described in paragraph
7 (2)(A)) determines has a chronic, progressive illness and,
8 as a consequence of such illness, is as likely as not to die
9 within 1 year.

10 “(4) The level of treatment indicated under para-
11 graph (2)(B) may range from an indication for full treat-
12 ment to an indication to limit some or all or specified
13 interventions. Such indicated levels of treatment may in-
14 clude indications respecting, among other items—

15 “(A) the intensity of medical intervention if the
16 patient is pulseless, apneic, or, has serious cardiac
17 or pulmonary problems;

18 “(B) the individual’s desire regarding transfer
19 to a hospital or remaining at the current care set-
20 ting;

21 “(C) the use of antibiotics; and

22 “(D) the use of artificially administered nutri-
23 tion and hydration.”.

24 (b) PAYMENT.—

1 (1) IN GENERAL.—Section 1848(j)(3) of such
2 Act (42 U.S.C. 1395w-4(j)(3)) by inserting
3 “(2)(FF),” after “(2)(EE),”.

4 (2) CONSTRUCTION.—Nothing in this section
5 shall be construed as preventing the payment for a
6 consultation regarding an order regarding life sus-
7 taining treatment to be made to multiple health care
8 providers if they are providing such consultation as
9 a team, so long as the total amount of payment is
10 not increased by reason of the payment to multiple
11 providers.

12 (c) INCLUSION OF INFORMATION IN MEDICARE AND
13 YOU MATERIALS.—

14 (1) MEDICARE & YOU HANDBOOK.—

15 (A) IN GENERAL.—Not later than 1 year
16 after the date of enactment of this Act, the Sec-
17 retary of Health and Human Services shall up-
18 date the online version of the Medicare & You
19 Handbook to include the following:

20 (i) An explanation of advance care
21 planning and advance directives, includ-
22 ing—

23 (I) living wills;

24 (II) durable power of attorney;

1 (III) orders of life-sustaining
2 treatment; and

3 (IV) health care proxies.

4 (ii) A description of Federal and State
5 resources available to assist individuals
6 and their families with advance care plan-
7 ning and advance directives, including—

8 (I) available State legal service
9 organizations to assist individuals
10 with advance care planning, including
11 those organizations that receive fund-
12 ing pursuant to the Older Americans
13 Act of 1965 (42 U.S.C. 93001 et
14 seq.);

15 (II) website links or addresses for
16 State-specific advance directive forms;
17 and

18 (III) any additional information,
19 as determined by the Secretary.

20 (B) UPDATE OF PAPER AND SUBSEQUENT
21 VERSIONS.—The Secretary shall include the in-
22 formation described in subparagraph (A) in all
23 paper and electronic versions of the Medicare &
24 You Handbook that are published on or after

1 the date that is 1 year after the date of the en-
2 actment of this Act.

3 (d) **EFFECTIVE DATE.**—The amendments made by
4 subsections (a) and (b) shall apply to consultations fur-
5 nished on or after January 1, 2011.

6 **SEC. 1236. PART B SPECIAL ENROLLMENT PERIOD AND**
7 **WAIVER OF LIMITED ENROLLMENT PENALTY**
8 **FOR TRICARE BENEFICIARIES.**

9 (a) **SPECIAL ENROLLMENT PERIOD.**—

10 (1) **IN GENERAL.**—Section 1837 of the Social
11 Security Act (42 U.S.C. 1395p) is amended by add-
12 ing at the end the following new subsection:

13 “(1)(1) In the case of any individual who is a covered
14 beneficiary (as defined in section 1072(5) of title 10,
15 United States Code) at the time the individual is entitled
16 to Part A under Section 226(b) or Section 226A and who
17 is eligible to enroll but who has elected not to enroll (or
18 to be deemed enrolled) during the individual’s initial en-
19 rollment period, there shall be a special enrollment period
20 described in paragraph (2).

21 “(2) The special enrollment period described in this
22 paragraph, with respect to an individual, is the 12-month
23 period beginning on the day after the last day of the initial
24 enrollment period of the individual or, if later, the 12-

1 month period beginning with the month the individual is
2 notified of enrollment under this section.

3 “(3) In the case of an individual who enrolls during
4 the special enrollment period provided under paragraph
5 (1), the coverage period under this part shall begin on the
6 first day of the month following the month in which the
7 individual enrolls or the first month that the individual
8 is eligible to enroll.”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by paragraph (1) shall apply to elections made with
11 respect to initial enrollment periods that end after
12 the date of the enactment of this Act.

13 (b) WAIVER OF INCREASE OF PREMIUM.—

14 (1) IN GENERAL.—Section 1839(b) of the So-
15 cial Security Act (42 U.S.C. 1395r(b)) is amended
16 by striking “section 1837(i)(4)” and inserting “sub-
17 section (i)(4) or (l) of section 1837”.

18 (2) EFFECTIVE DATE; REBATES.—

19 (A) EFFECTIVE DATE.—The amendment
20 made by paragraph (1) shall apply with respect
21 to premiums for months beginning with Janu-
22 ary 2005.

23 (B) REBATES.—The Secretary of Health
24 and Human Services shall establish a method
25 for providing rebates of premium increases paid

1 for months on or after January 2005, and be-
2 fore the month before the date of the enactment
3 of this Act, for which a penalty was applied
4 under section 1839(b) of the Social Security
5 Act in the case of an individual who is a cov-
6 ered beneficiary (as defined in section 1072(5)
7 of title 10, United States Code) and entitled to
8 Part A under section 226(b) or section 226A.

9 **TITLE III—PROMOTING PRI-**
10 **MARY CARE, MENTAL**
11 **HEALTH SERVICES, AND CO-**
12 **ORDINATED CARE**

13 **SEC. 1301. ACCOUNTABLE CARE ORGANIZATION PILOT**
14 **PROGRAM.**

15 Title XVIII of the Social Security Act is amended by
16 inserting after section 1866C the following new section:

17 “ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM

18 “SEC. 1866D. (a) IN GENERAL.—The Secretary shall
19 conduct a pilot program (in this section referred to as the
20 ‘pilot program’) to test different payment incentive mod-
21 els, including (to the extent practicable) the specific pay-
22 ment incentive models described in subsection (c), de-
23 signed to reduce the growth of expenditures and improve
24 health outcomes in the provision of items and services
25 under this title to applicable beneficiaries (as defined in

1 subsection (d)) by qualifying accountable care organiza-
2 tions (as defined in subsection (b)(1)) in order to—

3 “(1) promote accountability for a patient popu-
4 lation and coordinate items and services under parts
5 A and B;

6 “(2) encourage investment in infrastructure and
7 redesigned care processes for high quality and effi-
8 cient service delivery; and

9 “(3) reward physician practices for the provi-
10 sion of high quality and efficient health care serv-
11 ices.

12 “(b) QUALIFYING ACCOUNTABLE CARE ORGANIZA-
13 TIONS (ACOs).—

14 “(1) QUALIFYING ACO DEFINED.—

15 “(A) IN GENERAL.—In this section, the
16 terms ‘qualifying accountable care organization’
17 and ‘qualifying ACO’ mean a group of physi-
18 cians that—

19 “(i) is organized at least in part for
20 the purpose of providing physicians’ serv-
21 ices; and

22 “(ii) meets such criteria as the Sec-
23 retary determines to be appropriate to par-
24 ticipate in the pilot program, including the
25 criteria specified in paragraph (2).

1 “(B) INCLUSION OF OTHER PROVIDERS.—
2 Nothing in this subsection shall be construed as
3 preventing a qualifying ACO from including a
4 hospital or any other provider of services or
5 supplier furnishing items or services for which
6 payment may be made under this title that is
7 affiliated with the ACO under an arrangement
8 structured so that such provider or supplier
9 participates in the pilot program and shares in
10 any incentive payments under the pilot pro-
11 gram.

12 “(C) PHYSICIAN.—In this section, the
13 term ‘physician’ includes, except as the Sec-
14 retary may otherwise provide, any individual
15 who furnishes services for which payment may
16 be made as physicians’ services.

17 “(D) OTHER SERVICES.—Nothing in this
18 paragraph shall be construed as preventing a
19 qualifying ACO from furnishing items or serv-
20 ices, for which payment may not made under
21 this title, for purposes of achieving performance
22 goals under the pilot program.

23 “(2) QUALIFYING CRITERIA.—The following are
24 criteria described in this paragraph for an organized
25 group of physicians to be a qualifying ACO:

1 “(A) The group has a legal structure that
2 would allow the group to receive and distribute
3 incentive payments under this section.

4 “(B) The group includes a sufficient num-
5 ber of primary care physicians for the applica-
6 ble beneficiaries for whose care the group is ac-
7 countable (as determined by the Secretary).

8 “(C) The group is comprised of only par-
9 ticipating physicians.

10 “(D) The group reports on quality meas-
11 ures in such form, manner, and frequency as
12 specified by the Secretary (which may be for
13 the group, for providers of services and sup-
14 pliers, or both).

15 “(E) The group reports to the Secretary
16 (in a form, manner and frequency as specified
17 by the Secretary) such data as the Secretary
18 determines appropriate to monitor and evaluate
19 the pilot program.

20 “(F) The group provides notice to applica-
21 ble beneficiaries regarding the pilot program (as
22 determined appropriate by the Secretary).

23 “(G) The group contributes to a best prac-
24 tices network or website, that shall be main-
25 tained by the Secretary for the purpose of shar-

1 ing strategies on quality improvement, care co-
2 ordination, and efficiency that the groups be-
3 lieve are effective.

4 “(H) The group utilizes patient-centered
5 processes of care, including those that empha-
6 size patient and caregiver involvement in plan-
7 ning and monitoring of ongoing care manage-
8 ment plan.

9 “(I) The group meets other criteria deter-
10 mined to be appropriate by the Secretary.

11 “(c) SPECIFIC PAYMENT INCENTIVE MODELS.—The
12 specific payment incentive models described in this sub-
13 section are the following:

14 “(1) PERFORMANCE TARGET MODEL.—Under
15 the performance target model under this paragraph
16 (in this paragraph referred to as the ‘performance
17 target model’):

18 “(A) IN GENERAL.—A qualifying ACO
19 qualifies to receive an incentive payment if ex-
20 penditures for applicable beneficiaries are less
21 than a target spending level or a target rate of
22 growth. The incentive payment shall be made
23 only if savings are greater than would result
24 from normal variation in expenditures for items
25 and services covered under parts A and B.

1 “(B) COMPUTATION OF PERFORMANCE
2 TARGET.—

3 “(i) IN GENERAL.—The Secretary
4 shall establish a performance target for
5 each qualifying ACO comprised of a base
6 amount (described in clause (ii)) increased
7 to the current year by an adjustment fac-
8 tor (described in clause (iii)). Such a tar-
9 get may be established on a per capita
10 basis, as the Secretary determines to be
11 appropriate.

12 “(ii) BASE AMOUNT.—For purposes of
13 clause (i), the base amount in this sub-
14 paragraph is equal to the average total
15 payments (or allowed charges) under parts
16 A and B (and may include part D, if the
17 Secretary determines appropriate) for ap-
18 plicable beneficiaries for whom the quali-
19 fying ACO furnishes items and services in
20 a base period determined by the Secretary.
21 Such base amount may be determined on
22 a per capita basis.

23 “(iii) ADJUSTMENT FACTOR.—For
24 purposes of clause (i), the adjustment fac-
25 tor in this clause may equal an annual per

1 capita amount that reflects changes in ex-
2 penditures from the period of the base
3 amount to the current year that would rep-
4 resent an appropriate performance target
5 for applicable beneficiaries (as determined
6 by the Secretary). Such adjustment factor
7 may be determined as an amount or rate,
8 may be determined on a national, regional,
9 local, or organization-specific basis, and
10 may be determined on a per capita basis.
11 Such adjustment factor also may be ad-
12 justed for risk as determined appropriate
13 by the Secretary.

14 “(iv) REBASING.—Under this model
15 the Secretary shall periodically rebase the
16 base expenditure amount described in
17 clause (ii).

18 “(C) MEETING TARGET.—

19 “(i) IN GENERAL.—Subject to clause
20 (ii), a qualifying ACO that meet or exceeds
21 annual quality and performance targets for
22 a year shall receive an incentive payment
23 for such year equal to a portion (as deter-
24 mined appropriate by the Secretary) of the
25 amount by which payments under this title

1 for such year relative are estimated to be
2 below the performance target for such
3 year, as determined by the Secretary. The
4 Secretary may establish a cap on incentive
5 payments for a year for a qualifying ACO.

6 “(ii) LIMITATION.— The Secretary
7 shall limit incentive payments to each
8 qualifying ACO under this paragraph as
9 necessary to ensure that the aggregate ex-
10 penditures with respect to applicable bene-
11 ficiaries for such ACOs under this title (in-
12 clusive of incentive payments described in
13 this subparagraph do not exceed the
14 amount that the Secretary estimates would
15 be expended for such ACO for such bene-
16 ficiaries if the pilot program under this
17 section were not implemented.

18 “(D) REPORTING AND OTHER REQUIRE-
19 MENTS.—In carrying out such model, the Sec-
20 retary may (as the Secretary determines to be
21 appropriate) incorporate reporting require-
22 ments, incentive payments, and penalties re-
23 lated to the physician quality reporting initia-
24 tive (PQRI), electronic prescribing, electronic
25 health records, and other similar initiatives

1 under section 1848, and may use alternative
2 criteria than would otherwise apply under such
3 section for determining whether to make such
4 payments. The incentive payments described in
5 this subparagraph shall not be included in the
6 limit described in subparagraph (C)(ii) or in the
7 performance target model described in this
8 paragraph.

9 “(2) PARTIAL CAPITATION MODEL.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (B), a partial capitation model described
12 in this paragraph (in this paragraph referred to
13 as a ‘partial capitation model’) is a model in
14 which a qualifying ACO would be at financial
15 risk for some, but not all, of the items and serv-
16 ices covered under parts A and B, such as at
17 risk for some or all physicians’ services or all
18 items and services under part B. The Secretary
19 may limit a partial capitation model to ACOs
20 that are highly integrated systems of care and
21 to ACOs capable of bearing risk, as determined
22 to be appropriate by the Secretary.

23 “(B) NO ADDITIONAL PROGRAM EXPENDI-
24 TURES.—Payments to a qualifying ACO for ap-
25 plicable beneficiaries for a year under the par-

1 tial capitation model shall be established in a
2 manner that does not result in spending more
3 for such ACO for such beneficiaries than would
4 otherwise be expended for such ACO for such
5 beneficiaries for such year if the pilot program
6 were not implemented, as estimated by the Sec-
7 retary.

8 “(3) OTHER PAYMENT MODELS.—

9 “(A) IN GENERAL.—Subject to subpara-
10 graph (B), the Secretary may develop other
11 payment models that meet the goals of this
12 pilot program to improve quality and efficiency.

13 “(B) NO ADDITIONAL PROGRAM EXPENDI-
14 TURES.—Subparagraph (B) of paragraph (2)
15 shall apply to a payment model under subpara-
16 graph (A) in a similar manner as such subpara-
17 graph (B) applies to the payment model under
18 paragraph (2).

19 “(d) APPLICABLE BENEFICIARIES.—

20 “(1) IN GENERAL.—In this section, the term
21 ‘applicable beneficiary’ means, with respect to a
22 qualifying ACO, an individual who—

23 “(A) is enrolled under part B and entitled
24 to benefits under part A;

1 “(B) is not enrolled in a Medicare Advan-
2 tage plan under part C or a PACE program
3 under section 1894; and

4 “(C) meets such other criteria as the Sec-
5 retary determines appropriate, which may in-
6 clude criteria relating to frequency of contact
7 with physicians in the ACO

8 “(2) FOLLOWING APPLICABLE BENE-
9 FICIARIES.—The Secretary may monitor data on ex-
10 penditures and quality of services under this title
11 after an applicable beneficiary discontinues receiving
12 services under this title through a qualifying ACO.

13 “(e) IMPLEMENTATION.—

14 “(1) STARTING DATE.—The pilot program shall
15 begin no later than January 1, 2012. An agreement
16 with a qualifying ACO under the pilot program may
17 cover a multi-year period of between 3 and 5 years.

18 “(2) WAIVER.—The Secretary may waive such
19 provisions of this title and title XI as the Secretary
20 determines necessary in order implement the pilot
21 program.

22 “(3) PERFORMANCE RESULTS REPORTS.—The
23 Secretary shall report performance results to quali-
24 fying ACOs under the pilot program at least annu-
25 ally.

1 “(4) LIMITATIONS ON REVIEW.—There shall be
2 no administrative or judicial review under section
3 1869, section 1878, or otherwise of—

4 “(A) the elements, parameters, scope, and
5 duration of the pilot program;

6 “(B) the selection of qualifying ACOs for
7 the pilot program;

8 “(C) the establishment of targets, meas-
9 urement of performance, determinations with
10 respect to whether savings have been achieved
11 and the amount of savings;

12 “(D) determinations regarding whether, to
13 whom, and in what amounts incentive payments
14 are paid; and

15 “(E) decisions about the extension of the
16 program under subsection (g), expansion of the
17 program under subsection (h) or extensions
18 under subsection (i).

19 “(5) ADMINISTRATION.—Chapter 35 of title 44,
20 United States Code shall not apply to this section.

21 “(f) EVALUATION; MONITORING.—

22 “(1) IN GENERAL.—The Secretary shall evalu-
23 ate the payment incentive model for each qualifying
24 ACO under the pilot program to assess impacts on
25 beneficiaries, providers of services, suppliers and the

1 program under this title. The Secretary shall make
2 such evaluation publicly available within 60 days of
3 the date of completion of such report.

4 “(2) MONITORING.—The Inspector General of
5 the Department of Health and Human Services shall
6 provide for monitoring of the operation of ACOs
7 under the pilot program with regard to violations of
8 section 1877 (popularly known as the ‘Stark law’).

9 “(g) EXTENSION OF PILOT AGREEMENT WITH SUC-
10 CESSFUL ORGANIZATIONS.—

11 “(1) REPORTS TO CONGRESS.—Not later than
12 2 years after the date the first agreement is entered
13 into under this section, and biennially thereafter for
14 six years, the Secretary shall report to Congress on
15 the use of authorities under the pilot program. Each
16 report shall address the impact of the use of those
17 authorities on expenditures, access, and quality
18 under this title.

19 “(2) EXTENSION.—Subject to the monitoring
20 described in paragraph (1), with respect to a quali-
21 fying ACO, the Secretary may extend the duration
22 of the agreement for such ACO under the pilot pro-
23 gram as the Secretary determines appropriate if—

24 “(A) the ACO receives incentive payments
25 with respect to any of the first 4 years of the

1 pilot agreement and is consistently meeting
2 quality standards or

3 “(B) the ACO is consistently exceeding
4 quality standards and is not increasing spend-
5 ing under the program.

6 “(3) TERMINATION.—The Secretary may termi-
7 nate an agreement with a qualifying ACO under the
8 pilot program if such ACO did not receive incentive
9 payments or consistently failed to meet quality
10 standards in any of the first 3 years under the pro-
11 gram.

12 “(h) EXPANSION TO ADDITIONAL ACOs.—

13 “(1) TESTING AND REFINEMENT OF PAYMENT
14 INCENTIVE MODELS.—Subject to the evaluation de-
15 scribed in subsection (f), the Secretary may enter
16 into agreements under the pilot program with addi-
17 tional qualifying ACOs to further test and refine
18 payment incentive models with respect to qualifying
19 ACOs.

20 “(2) EXPANDING USE OF SUCCESSFUL MODELS
21 TO PROGRAM IMPLEMENTATION.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), the Secretary may issue regulations
24 to implement, on a permanent basis, the compo-
25 nents of the pilot program that are beneficial to

1 the program under this title, as determined by
2 the Secretary.

3 “(B) CERTIFICATION.—The Chief Actuary
4 of the Centers for Medicare & Medicaid Serv-
5 ices shall certify that the expansion of the com-
6 ponents of the program described in subpara-
7 graph (A) would result in estimated spending
8 that would be less than what spending would
9 otherwise be estimated to be in the absence of
10 such expansion.

11 “(i) TREATMENT OF PHYSICIAN GROUP PRACTICE
12 DEMONSTRATION.—

13 “(1) EXTENSION.—The Secretary may enter in
14 to an agreement with a qualifying ACO under the
15 demonstration under section 1866A, subject to re-
16 basing and other modifications deemed appropriate
17 by the Secretary, until the pilot program under this
18 section is operational.

19 “(2) TRANSITION.—For purposes of extension
20 of an agreement with a qualifying ACO under sub-
21 section (g)(2), the Secretary shall treat receipt of an
22 incentive payment for a year by an organization
23 under the physician group practice demonstration
24 pursuant to section 1866A as a year for which an
25 incentive payment is made under such subsection, as

1 long as such practice group practice organization
2 meets the criteria under subsection (b)(2).

3 “(j) ADDITIONAL PROVISIONS.—

4 “(1) AUTHORITY FOR SEPARATE INCENTIVE
5 ARRANGEMENTS.—The Secretary may create sepa-
6 rate incentive arrangements (including using mul-
7 tiple years of data, varying thresholds, varying
8 shared savings amounts, and varying shared savings
9 limits) for different categories of qualifying ACOs to
10 reflect natural variations in data availability, vari-
11 ation in average annual attributable expenditures,
12 program integrity, and other matters the Secretary
13 deems appropriate.

14 “(2) ENCOURAGEMENT OF PARTICIPATION OF
15 SMALLER ORGANIZATIONS.—In order to encourage
16 the participation of smaller accountable care organi-
17 zations under the pilot program, the Secretary may
18 limit a qualifying ACO’s exposure to high cost pa-
19 tients under the program.

20 “(3) INVOLVEMENT IN PRIVATE PAY ARRANGE-
21 MENTS.—Nothing in this section shall be construed
22 as preventing qualifying ACOs participating in the
23 pilot program from negotiating similar contracts
24 with private payers.

1 “(4) ANTIDISCRIMINATION LIMITATION.—The
2 Secretary shall not enter into an agreement with an
3 entity to provide health care items or services under
4 the pilot program, or with an entity to administer
5 the program, unless such entity guarantees that it
6 will not deny, limit, or condition the coverage or pro-
7 vision of benefits under the program, for individuals
8 eligible to be enrolled under such program, based on
9 any health status-related factor described in section
10 2702(a)(1) of the Public Health Service Act.

11 “(5) CONSTRUCTION.—Nothing in this section
12 shall be construed to compel or require an organiza-
13 tion to use an organization-specific target growth
14 rate for an accountable care organization under this
15 section for purposes of section 1848.”.

16 **SEC. 1302. MEDICAL HOME PILOT PROGRAM.**

17 (a) IN GENERAL.—Title XVIII of the Social Security
18 Act is amended by inserting after section 1866D, as in-
19 serted by section 1122, the following new section:

20 “MEDICAL HOME PILOT PROGRAM

21 “SEC. 1866E. (a) ESTABLISHMENT AND MEDICAL
22 HOME MODELS.—

23 “(1) ESTABLISHMENT OF PILOT PROGRAM.—
24 The Secretary shall establish a medical home pilot
25 program (in this section referred to as the ‘pilot pro-
26 gram’) for the purpose of evaluating the feasibility

1 and advisability of reimbursing qualified patient-cen-
2 tered medical homes for furnishing medical home
3 services (as defined under subsection (b)(2)) to high
4 need beneficiaries (as defined in subsection (b)(1)).

5 “(2) SCOPE.—Subject to subsection (g), the
6 pilot program shall include urban, rural, and under-
7 served areas.

8 “(3) MODELS OF MEDICAL HOMES IN THE
9 PILOT PROGRAM.—The pilot program shall evaluate
10 each of the following medical home models:

11 “(A) INDEPENDENT PATIENT-CENTERED
12 MEDICAL HOME MODEL.—Independent patient-
13 centered medical home model under subsection
14 (c).

15 “(B) COMMUNITY-BASED MEDICAL HOME
16 MODEL.—Community-based medical home
17 model under subsection (d).

18 “(4) PROJECT.—Nothing in this section shall
19 be construed as preventing a nurse practitioner from
20 leading a patient centered medical home so long
21 as—

22 “(A) all of the requirements of this section
23 are met; and

24 “(B) the nurse practitioner is acting con-
25 sistently with State law.

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

2 “(1) PATIENT-CENTERED MEDICAL HOME
3 SERVICES.—The term ‘patient-centered medical
4 home services’ means services that—

5 “(A) provide beneficiaries with direct and
6 ongoing access to a primary care or principal
7 physician or nurse practitioner who accepts re-
8 sponsibility for providing first contact, contin-
9 uous and comprehensive care to such bene-
10 ficiary;

11 “(B) coordinate the care provided to a ben-
12 efiary by a team of individuals at the practice
13 level across office, institutional and home set-
14 tings led by a primary care or principal physi-
15 cian or nurse practitioner, as needed and appro-
16 priate;

17 “(C) provide for all the patient’s health
18 care needs or take responsibility for appro-
19 priately arranging care with other qualified pro-
20 viders for all stages of life;

21 “(D) provide continuous access to care and
22 communication with participating beneficiaries;

23 “(E) integrate readily accessible, clinically
24 useful information on participating patients

1 that enables the practice to treat such patients
2 comprehensively and systematically; and

3 “(F) implement evidence-based guidelines
4 and apply such guidelines to the identified
5 needs of beneficiaries over time and with the in-
6 tensity needed by such beneficiaries.

7 “(2) PRIMARY CARE.—The term ‘primary care’
8 means health care that is provided by a physician or
9 nurse practitioner who practices in the field of fam-
10 ily medicine, general internal medicine, geriatric
11 medicine, or pediatric medicine.

12 “(3) PRINCIPAL CARE.—The term ‘principal
13 care’ means integrated, accessible health care that is
14 provided by a physician who is a medical sub-
15 specialist that addresses the majority of the personal
16 health care needs of patients with chronic conditions
17 requiring the subspecialist’s expertise, and for whom
18 the subspecialist assumes care management.

19 “(c) INDEPENDENT PATIENT-CENTERED MEDICAL
20 HOME MODEL.—

21 “(1) IN GENERAL.—

22 “(A) PAYMENT AUTHORITY.—Under the
23 independent patient-centered medical home
24 model under this subsection, the Secretary shall
25 make payments for medical home services fur-

1 nished by an independent patient-centered med-
2 ical home (as defined in subparagraph (B)) to
3 a targeted high need beneficiary (as defined in
4 subparagraph (C)).

5 “(B) INDEPENDENT PATIENT-CENTERED
6 MEDICAL HOME DEFINED.—In this section, the
7 term ‘independent patient-centered medical
8 home’ means a physician-directed or nurse-
9 practitioner-directed practice that is certified
10 under paragraph (2) as—

11 “(i) providing beneficiaries with pa-
12 tient-centered medical home services; and

13 “(ii) meets such other requirements as
14 the Secretary may specify.

15 “(C) TARGETED HIGH NEED BENEFICIARY
16 DEFINED.—For purposes of this subsection, the
17 term ‘targeted high need beneficiary’ means a
18 high need beneficiary who, based on measures
19 of the number and severity of the beneficiary’s
20 chronic illnesses and the beneficiary’s need for
21 regular medical monitoring, advising, or treat-
22 ment, is generally within the upper 50th per-
23 centile of Medicare beneficiaries.

24 “(D) BENEFICIARY ELECTION TO PARTICI-
25 PATE.—The Secretary shall determine an ap-

1 appropriate method of ensuring that beneficiaries
2 have agreed to participate in the pilot program.

3 “(E) IMPLEMENTATION.—The pilot pro-
4 gram under this subsection shall begin no later
5 than 6 months after the date of the enactment
6 of this section.

7 “(2) STANDARD SETTING AND QUALIFICATION
8 PROCESS FOR PATIENT-CENTERED MEDICAL
9 HOMES.—The Secretary shall review alternative
10 models for standard setting and qualification, and
11 shall establish a process—

12 “(A) to establish standards to enable med-
13 ical practices to qualify as patient-centered
14 medical homes; and

15 “(B) to provide for the review and certifi-
16 cation of medical practices as meeting such
17 standards.

18 “(3) PAYMENT.—

19 “(A) ESTABLISHMENT OF METHOD-
20 ODOLOGY.—The Secretary shall establish a meth-
21 odology for the payment for medical home serv-
22 ices furnished by independent patient-centered
23 medical homes.

24 “(B) PER BENEFICIARY PER MONTH PAY-
25 MENTS.—Under such payment methodology, the

1 Secretary shall pay independent patient-cen-
2 tered medical homes a monthly fee for each tar-
3 geted high need beneficiary who consents to re-
4 ceive medical home services through such med-
5 ical home.

6 “(C) PROSPECTIVE PAYMENT.—The fee
7 under subparagraph (B) shall be paid on a pro-
8 spective basis.

9 “(D) AMOUNT OF PAYMENT.—In deter-
10 mining the amount of such fee, the Secretary
11 shall consider the following:

12 “(i) The clinical work and practice ex-
13 penses involved in providing the medical
14 home services provided by the independent
15 patient-centered medical home (such as
16 providing increased access, care coordina-
17 tion, population disease management, and
18 teaching self-care skills for managing
19 chronic illnesses) for which payment is not
20 made under this title as of the date of the
21 enactment of this section.

22 “(ii) Allow for differential payments
23 based on capabilities of the independent
24 patient-centered medical home.

1 “(iii) Use appropriate risk-adjustment
2 in determining the amount of the per bene-
3 ficiary per month payment under this
4 paragraph.

5 “(4) ENCOURAGING PARTICIPATION OF VARI-
6 ETY OF PRACTICES.—The pilot program under this
7 subsection shall be designed to include the participa-
8 tion of physicians in practices with fewer than 10
9 full-time equivalent physicians, as well as physicians
10 in larger practices, particularly in underserved and
11 rural areas, as well as federally qualified community
12 health centers, and rural health centers.

13 “(5) NO DUPLICATION IN PILOT PARTICIPA-
14 TION.—A physician in a group practice that partici-
15 pates in the accountable care organization pilot pro-
16 gram under section 1866D shall not be eligible to
17 participate in the pilot program under this sub-
18 section.

19 “(d) COMMUNITY-BASED MEDICAL HOME MODEL.—

20 “(1) IN GENERAL.—

21 “(A) AUTHORITY FOR PAYMENTS.—Under
22 the community-based medical home model
23 under this subsection (in this section referred to
24 as the ‘CBMH model’), the Secretary shall
25 make payments for the furnishing of medical

1 home services by a community-based medical
2 home (as defined in subparagraph (B)) to a
3 high need beneficiary.

4 “(B) COMMUNITY-BASED MEDICAL HOME
5 DEFINED.—In this section, the term ‘commu-
6 nity-based medical home’ means a nonprofit
7 community-based or State-based organization
8 that is certified under paragraph (2) as meeting
9 the following requirements:

10 “(i) The organization provides bene-
11 ficiaries with medical home services.

12 “(ii) The organization provides med-
13 ical home services under the supervision of
14 the primary care or principal care physi-
15 cian or nurse practitioner designated by
16 the beneficiary as his or her community-
17 based medical home provider.

18 “(iii) The organization employs com-
19 munity health workers, including nurses or
20 other non-physician practitioners, lay
21 health workers, or other persons as deter-
22 mined appropriate by the Secretary, that
23 assist the primary or principal care physi-
24 cian or nurse practitioner in chronic care
25 management activities such as teaching

1 self-care skills for managing chronic ill-
2 nesses, medication therapy management
3 services for patients with multiple chronic
4 diseases, or help beneficiaries access the
5 health care and community-based resources
6 in their local geographic area.

7 “(iv) The organization meets such
8 other requirements as the Secretary may
9 specify.

10 “(C) HIGH NEED BENEFICIARY.—In this
11 section, the term ‘high need beneficiary’ means
12 an individual with multiple chronic illnesses
13 that require regular medical monitoring, advis-
14 ing, or treatment.

15 “(2) STANDARD SETTING AND QUALIFICATION
16 PROCESS FOR COMMUNITY-BASED MEDICAL
17 HOMES.—The Secretary shall establish a process—

18 “(A) to establish standards for the certifi-
19 cation of community-based or State-based orga-
20 nizations as community-based medical homes;
21 and

22 “(B) to provide for the review and certifi-
23 cation of such community-based and State-
24 based organizations as meeting such standards,

1 including through the use of certification orga-
2 nizations approved by the Secretary.

3 “(3) DURATION.—The pilot program for com-
4 munity-based medical homes under this subsection
5 shall start no later than 2 years after the date of the
6 enactment of this section. Each such demonstration
7 shall operate for a period of up to 5 years after the
8 initial implementation phase, without regard to the
9 receipt of a initial implementation funding under
10 subsection (i).

11 “(4) PREFERENCE.—In selecting sites for the
12 CBMH model, the Secretary may give preference
13 to—

14 “(A) applications from geographic areas
15 that propose to coordinate health care services
16 for chronically ill beneficiaries across a variety
17 of health care settings, such as primary care
18 physician practices with fewer than 10 physi-
19 cians, specialty physicians, nurse practitioner
20 practices, Federally qualified health centers,
21 rural health clinics, and other settings; and

22 “(B) applications from States that propose
23 to use networks to coordinate health care serv-
24 ices for chronically ill Medicare, Medicaid, and

1 dual eligible individuals across a variety of
2 health care delivery.

3 “(5) PAYMENTS.—

4 “(A) ESTABLISHMENT OF METHODOLOGY.—The Secretary shall establish a meth-
5 odology for the payment for medical home serv-
6 ices furnished under the CBMH model.

8 “(B) PER MEMBER PER MONTH PAY-
9 MENTS.—Under such payment methodology, the
10 Secretary shall make two separate monthly pay-
11 ments for each high need beneficiary who con-
12 sents to receive medical home services through
13 such medical home, as follows:

14 “(i) PAYMENT TO COMMUNITY-BASED
15 ORGANIZATION.—One monthly payment to
16 a community-based or State-based organi-
17 zation.

18 “(ii) PAYMENT TO PRIMARY OR PRIN-
19 CIPAL CARE PRACTICE.—One monthly pay-
20 ment to the primary or principal care prac-
21 tice for such beneficiary.

22 “(C) PROSPECTIVE PAYMENT.—The pay-
23 ments under subparagraph (B) shall be paid on
24 a prospective basis.

1 “(D) AMOUNT OF PAYMENT.—In deter-
2 mining the amount of such payment, the Sec-
3 retary shall consider the following:

4 “(i) The clinical work and practice ex-
5 penses involved in providing the medical
6 home services provided by the community-
7 based medical home (such as providing in-
8 creased access, care coordination, popu-
9 lation disease management, and teaching
10 self-care skills for managing chronic ill-
11 nesses) for which payment is not made
12 under this title as of the date of the enact-
13 ment of this section.

14 “(ii) Use appropriate risk-adjustment
15 in determining the amount of the per bene-
16 ficiary per month payment under this
17 paragraph.

18 “(6) INITIAL IMPLEMENTATION FUNDING.—
19 The Secretary may make available initial implemen-
20 tation funding to a community based or State-based
21 organization or a State that is participating in the
22 pilot program under this subsection. Such organiza-
23 tion shall provide the Secretary with a detailed im-
24 plementation plan that includes how such funds will
25 be used.

1 “(e) EXPANSION OF PROGRAM.—

2 “(1) EVALUATION OF COST AND QUALITY.—

3 The Secretary shall evaluate the pilot program to
4 determine—

5 “(A) the extent to which medical homes re-
6 sult in—

7 “(i) improvement in the quality and
8 coordination of health care services;

9 “(ii) improvement in reducing health
10 disparities;

11 “(iii) reductions in preventable hos-
12 pitalizations;

13 “(iv) prevention of readmissions;

14 “(v) reductions in emergency room
15 visits;

16 “(vi) improvement in health outcomes;

17 “(vii) improvement in patient satisfac-
18 tion;

19 “(viii) improved efficiency of care such
20 as reducing duplicative diagnostic tests and
21 laboratory tests; and

22 “(ix) reductions in health care ex-
23 penditures; and

1 “(B) the feasibility and advisability of re-
2 imbursing medical homes for medical home
3 services under this title on a permanent basis.

4 “(2) REPORT.—Not later than 60 days after
5 the date of completion of the evaluation under para-
6 graph (1), the Secretary shall submit to Congress
7 and make available to the public a report on the
8 findings of the evaluation under paragraph (1).

9 “(3) EXPANSION OF PROGRAM.—

10 “(A) IN GENERAL.—Subject to the results
11 of the evaluation under paragraph (1) and sub-
12 paragraph (B), the Secretary may issue regula-
13 tions to implement, on a permanent basis, one
14 or more models, if, and to the extent that such
15 model or models, are beneficial to the program
16 under this title, as determined by the Secretary.

17 “(B) CERTIFICATION REQUIREMENT.—The
18 Secretary may not issue such regulations unless
19 the Chief Actuary of the Centers for Medicare
20 & Medicaid Services certifies that the expansion
21 of the components of the pilot program de-
22 scribed in subparagraph (A) would result in es-
23 timated spending under this title that would be
24 no more than the level of spending that the
25 Secretary estimates would otherwise be spent

1 under this title in the absence of such expan-
2 sion.

3 “(f) ADMINISTRATIVE PROVISIONS.—

4 “(1) NO DUPLICATION IN PAYMENTS.—During any
5 month, the Secretary may not make payments under this
6 section under more than one model or through more than
7 one medical home under any model for the furnishing of
8 medical home services to an individual.

9 “(2) NO EFFECT ON PAYMENT FOR EVALUATION
10 AND MANAGEMENT SERVICES.—Payments made under
11 this section are in addition to, and have no effect on the
12 amount of, payment for evaluation and management serv-
13 ices made under this title

14 “(3) ADMINISTRATION.—Chapter 35 of title 44,
15 United States Code shall not apply to this section.

16 “(g) FUNDING.—

17 “(1) OPERATIONAL COSTS.—For purposes of admin-
18 istering and carrying out the pilot program (including the
19 design, implementation, technical assistance for and eval-
20 uation of such program), in addition to funds otherwise
21 available, there shall be transferred from the Federal Sup-
22 plementary Medical Insurance Trust Fund under section
23 1841 to the Secretary for the Center for Medicare & Med-
24 icaid Services Program Management Account \$6,000,000
25 for each of fiscal years 2010 through 2014. Amounts ap-

1 appropriated under this paragraph for a fiscal year shall be
2 available until expended.

3 “(2) PATIENT-CENTERED MEDICAL HOME SERV-
4 ICES.—In addition to funds otherwise available, there shall
5 be available to the Secretary for the Center for Medicare
6 & Medicaid Services, from the Federal Supplementary
7 Medical Insurance Trust Fund under section 1841—

8 “(A) \$200,000,000 for each of fiscal years
9 2010 through 2014 for payments for medical home
10 services under subsection (c)(3); and

11 “(B) \$125,000,000 for each of fiscal years
12 2012 through 2016, for payments under subsection
13 (d)(4).

14 Amounts available under this paragraph for a fiscal year
15 shall be available until expended.

16 “(3) INITIAL IMPLEMENTATION.—In addition to
17 funds otherwise available, there shall be available to the
18 Secretary for the Center for Medicare & Medicaid Serv-
19 ices, from the Federal Supplementary Medical Insurance
20 Trust Fund under section 1841, \$2,500,000 for each of
21 fiscal years 2010 through 2012, under subsection (d)(6).

22 Amounts available under this paragraph for a fiscal year
23 shall be available until expended.

24 “(h) TREATMENT OF TRHCA MEDICARE MEDICAL
25 HOME DEMONSTRATION FUNDING.—

1 “(1) In addition to funds otherwise available for pay-
2 ment of medical home services under subsection (c)(3),
3 there shall also be available the amount provided in sub-
4 section (g) of section 204 of division B of the Tax Relief
5 and Health Care Act of 2006 (42 U.S.C. 1395b–1 note)..

6 “(2) The funding that would otherwise have been
7 available, but for the repeal of such section 204, to the
8 medical home demonstration under such section 204
9 (other than funding available under subsection (g) of such
10 section) shall be available for the independent patient-cen-
11 tered medical home model described under subsection
12 (c).”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 this section shall apply to services furnished on or after
15 the date of the enactment of this Act.

16 (c) CONFORMING REPEAL.—Section 204 of division
17 B of the Tax Relief and Health Care Act of 2006 (42
18 U.S.C. 1395b–1 note), as amended by section 133(a)(2)
19 of the Medicare Improvements for Patients and Providers
20 Act of 2008 (Public Law 110–275), is repealed.

21 **SEC. 1303. RATE INCREASE FOR SELECTED PRIMARY CARE**
22 **SERVICES.**

23 Section 1833 of the Social Security Act is amended
24 by inserting after subsection (o) the following new sub-
25 section:

1 “(p) PRIMARY CARE BONUSES.—

2 “(1) IN GENERAL.—In the case of primary care
3 services (as defined in paragraph (2)) furnished on
4 or after January 1, 2011, by a primary care practi-
5 tioner (as defined in paragraph (3)) for which
6 amounts are payable under section 1848, in addition
7 to the amount otherwise paid under this part there
8 shall also be paid to the practitioner (or to an em-
9 ployer or facility in the cases described in clause (A)
10 of section 1842(b)(6)) (on a monthly or quarterly
11 basis) from the Federal Supplementary Medical In-
12 surance Trust Fund an amount equal 5 percent (or
13 10 percent if the practitioner predominately fur-
14 nishes such services in an area that is designated
15 (under section 332(a)(1)(A) of the Public Health
16 Service Act) as a health professional shortage area.

17 “(2) PRIMARY CARE SERVICES DEFINED.—In
18 this subsection, the term ‘primary care services’
19 means physicians’ services which are classified
20 (under procedure codes under section 1848) as eval-
21 uation and management services (including new and
22 established patient office visits) and such other phy-
23 sicians’ services as the Secretary determines are as-
24 sociated with ensuring accessible, continuous, coordi-

1 nated, and comprehensive care for individuals en-
2 rolled under this part.

3 “(3) PRIMARY CARE PRACTITIONER DE-
4 FINED.—In this subsection, the term ‘primary care
5 practitioner’ means a physician or other practitioner
6 who—

7 “(A) specializes in family medicine, general
8 internal medicine, general pediatrics, or geri-
9 atrics; and

10 “(B) have allowed charges for primary
11 care services that account for at least 50 per-
12 cent of their total allowed charges under section
13 1848, as determined by the Secretary for the
14 most recent period for which data are available.

15 “(4) NO REVIEW.—There shall be no adminis-
16 trative or judicial review under section 1869, section
17 1878, or otherwise, respecting—

18 “(A) any determination or designation
19 under this subsection;

20 “(B) the identification of services as pri-
21 mary care services under this subsection; or

22 “(C) the identification of a practitioner as
23 a primary care practitioner under this sub-
24 section.

1 “(5) RELATION TO OTHER PAYMENT PROVI-
2 SIONS.—Payments under this subsection—

3 “(A) are in addition to payments made
4 under subsection (m); and

5 “(B) shall not be taken into account in de-
6 termining the amounts that would otherwise be
7 paid under this part for purposes of section
8 1834(g)(2)(B).”.

9 **SEC. 1304. INCREASED REIMBURSEMENT RATE FOR CER-**
10 **TIFIED NURSE-MIDWIVES.**

11 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-
12 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended
13 by striking “(but in no event” and all that follows through
14 “performed by a physician”).

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to services furnished on or after
17 January 1, 2011.

18 **SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR**
19 **PREVENTIVE SERVICES.**

20 (a) MEDICARE COVERED PREVENTIVE SERVICES DE-
21 FINED.—

22 (1) IN GENERAL.—Section 1861 of the Social
23 Security Act (42 U.S.C. 1395x), as amended by sec-
24 tion 1235(a)(2), is amended by adding at the end
25 the following new subsection:

1 “Medicare Covered Preventive Services

2 “(iii)(1) Subject to the succeeding provisions of this
3 subsection, the term ‘Medicare covered preventive services’
4 means the following:

5 “(A) Prostate cancer screening tests (as defined
6 in subsection (oo)).

7 “(B) Colorectal cancer screening tests (as de-
8 fined in subsection (pp)).

9 “(C) Diabetes outpatient self-management
10 training services (as defined in subsection (qq)).

11 “(D) Screening for glaucoma for certain indi-
12 viduals (as described in subsection (s)(2)(U)).

13 “(E) Medical nutrition therapy services for cer-
14 tain individuals (as described in subsection
15 (s)(2)(V)).

16 “(F) An initial preventive physical examination
17 (as defined in subsection (ww)).

18 “(G) Cardiovascular screening blood tests (as
19 defined in subsection (xx)(1)).

20 “(H) Diabetes screening tests (as defined in
21 subsection described in subsection (s)(2)(Y)).

22 “(I) Ultrasound screening for abdominal aortic
23 aneurysm for certain individuals (as described in de-
24 scribed in subsection (s)(2)(AA)).

1 “(J) Pneumococcal and influenza vaccines and
2 their administration (as described in subsection
3 (s)(10)(A)) and hepatitis B vaccine and its adminis-
4 tration for certain individuals (as described in sub-
5 section (s)(10)(B)).

6 “(K) Screening mammography (as defined in
7 subsection (jj)).

8 “(L) Screening pap smear and screening pelvic
9 exam (as described in subsection (s)(14)).

10 “(M) Bone mass measurement (as defined in
11 subsection (rr)).

12 “(N) Kidney disease education services (as de-
13 fined in subsection (ggg)).

14 “(O) Additional preventive services (as defined
15 in subsection (ddd)).

16 “(2) With respect to specific Medicare covered pre-
17 ventive services, the limitations and conditions described
18 in the provisions referenced in paragraph (1) with respect
19 to such services shall apply.”.

20 (2) CONSOLIDATION.—The Secretary of Health
21 and Human Services shall submit to Congress, by
22 not later than July 1, 2009, specifications for how
23 section 1861(s) of the Social Security Act and re-
24 lated provisions of law may be amended so as to
25 substitute a reference to Medicare covered preventive

1 services (as defined in the amendment made by
2 paragraph (1)) for all the references to specific
3 Medicare covered preventive services.

4 (b) PAYMENT AND ELIMINATION OF COST-SHAR-
5 ING.—

6 (1) IN GENERAL.—

7 (A) IN GENERAL.—Section 1833(a)(1) of
8 the Social Security Act (42 U.S.C. 1395l(a)(1))
9 is amended by adding after and below para-
10 graph (9) the following:

11 “With respect to Medicare covered preventive services, in
12 any case in which the payment rate otherwise provided
13 under this part is computed as a percent of less than 100
14 percent of an actual charge, fee schedule rate, or other
15 rate, such percentage shall be increased to 100 percent.”.

16 (B) APPLICATION TO SIGMOIDOSCOPIES
17 AND COLONOSCOPIES.—Section 1834(d) of such
18 Act (42 U.S.C. 1395m(d)) is amended—

19 (i) in paragraph (2)(C), by amending
20 clause (ii) to read as follows:

21 “(ii) NO COINSURANCE.—In the case
22 of a beneficiary who receives services de-
23 scribed in clause (i), there shall be no coin-
24 surance applied.”; and

1 (ii) in paragraph (3)(C), by amending
2 clause (ii) to read as follows:

3 “(ii) NO COINSURANCE.—In the case
4 of a beneficiary who receives services de-
5 scribed in clause (i), there shall be no coin-
6 surance applied.”.

7 (2) ELIMINATION OF COINSURANCE IN OUT-
8 PATIENT HOSPITAL SETTINGS.—

9 (A) EXCLUSION FROM OPD FEE SCHED-
10 ULE.—Section 1833(t)(1)(B)(iv) of the Social
11 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
12 amended by striking “screening mammography
13 (as defined in section 1861(jj)) and diagnostic
14 mammography” and inserting “diagnostic
15 mammograms and Medicare covered preventive
16 services (as defined in section 1861(iii)(1))”.

17 (B) CONFORMING AMENDMENTS.—Section
18 1833(a)(2) of the Social Security Act (42
19 U.S.C. 1395l(a)(2)) is amended—

20 (i) in subparagraph (F), by striking
21 “and” after the semicolon at the end;

22 (ii) in subparagraph (G)(ii), by adding
23 “and” at the end; and

24 (iii) by adding at the end the fol-
25 lowing new subparagraph:

1 “(H) with respect to additional preventive
2 services (as defined in section 1861(ddd)) fur-
3 nished by an outpatient department of a hos-
4 pital, the amount determined under paragraph
5 (1)(W);”.

6 (3) WAIVER OF APPLICATION OF DEDUCTIBLE
7 FOR ALL PREVENTIVE SERVICES.—The first sen-
8 tence of section 1833(b) of the Social Security Act
9 (42 U.S.C. 1395l(b)) is amended—

10 (A) in clause (1), by striking “items and
11 services described in section 1861(s)(10)(A)”
12 and inserting “Medicare covered preventive
13 services (as defined in section 1861(iii))”;

14 (B) by inserting “and” before “(4)”; and

15 (C) by striking clauses (5) through (8).

16 (4) APPLICATION TO PROVIDERS OF SERV-
17 ICES.—Section 1866(a)(2)(A)(ii) of such Act (42
18 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by inserting
19 “other than for Medicare covered preventive services
20 and” after “for such items and services (”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall apply to services furnished on or after
23 January 1, section 2011.

1 **SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL**
2 **CANCER SCREENING TESTS REGARDLESS OF**
3 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**
4 **LARY TISSUE REMOVAL .**

5 (a) IN GENERAL.—Section 1833(b) of the Social Se-
6 curity Act (42 U.S.C. 1395l(b)), as amended by section
7 1305(b)(3), is amended by adding at the end the following
8 new sentence: “Clause (1) of the first sentence of this sub-
9 section shall apply with respect to a colorectal cancer
10 screening test regardless of the code applied, of the estab-
11 lishment of a diagnosis as a result of the test, or of the
12 removal of tissue or other matter or other procedure that
13 is performed in connection with and as a result of the
14 screening test.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall apply to items and services furnished
17 on or after January 1, 2011.

18 **SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERV-**
19 **ICES FROM COVERAGE UNDER THE MEDI-**
20 **CARE SKILLED NURSING FACILITY PROSPEC-**
21 **TIVE PAYMENT SYSTEM AND CONSOLIDATED**
22 **PAYMENT.**

23 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the
24 Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is
25 amended by inserting “clinical social worker services,”
26 after “qualified psychologist services,”.

1 (b) CONFORMING AMENDMENT.—Section
2 1861(hh)(2) of the Social Security Act (42 U.S.C.
3 1395x(hh)(2)) is amended by striking “and other than
4 services furnished to an inpatient of a skilled nursing facil-
5 ity which the facility is required to provide as a require-
6 ment for participation”.

7 (c) EFFECTIVE DATE.—The amendments made by
8 this section shall apply to items and services furnished on
9 or after July 1, 2010.

10 **SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERA-**
11 **PIST SERVICES AND MENTAL HEALTH COUN-**
12 **SELOR SERVICES.**

13 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-
14 PIST SERVICES.—

15 (1) COVERAGE OF SERVICES.—Section
16 1861(s)(2) of the Social Security Act (42 U.S.C.
17 1395x(s)(2)), as amended by section 1235, is
18 amended—

19 (A) in subparagraph (EE), by striking
20 “and” at the end;

21 (B) in subparagraph (FF), by adding
22 “and” at the end; and

23 (C) by adding at the end the following new
24 subparagraph:

1 “(GG) marriage and family therapist services
2 (as defined in subsection (jjj));”.

3 (2) DEFINITION.—Section 1861 of the Social
4 Security Act (42 U.S.C. 1395x), as amended by sec-
5 tions 1235 and 1305, is amended by adding at the
6 end the following new subsection:

7 “Marriage and Family Therapist Services
8 “(jjj)(1) The term ‘marriage and family therapist
9 services’ means services performed by a marriage and
10 family therapist (as defined in paragraph (2)) for the diag-
11 nosis and treatment of mental illnesses, which the mar-
12 riage and family therapist is legally authorized to perform
13 under State law (or the State regulatory mechanism pro-
14 vided by State law) of the State in which such services
15 are performed, as would otherwise be covered if furnished
16 by a physician or as incident to a physician’s professional
17 service, but only if no facility or other provider charges
18 or is paid any amounts with respect to the furnishing of
19 such services.

20 “(2) The term ‘marriage and family therapist’ means
21 an individual who—

22 “(A) possesses a master’s or doctoral degree
23 which qualifies for licensure or certification as a
24 marriage and family therapist pursuant to State
25 law;

1 “(B) after obtaining such degree has performed
2 at least 2 years of clinical supervised experience in
3 marriage and family therapy; and

4 “(C) is licensed or certified as a marriage and
5 family therapist in the State in which marriage and
6 family therapist services are performed.”.

7 (3) PROVISION FOR PAYMENT UNDER PART
8 B.—Section 1832(a)(2)(B) of the Social Security
9 Act (42 U.S.C. 1395k(a)(2)(B)) is amended by add-
10 ing at the end the following new clause:

11 “(v) marriage and family therapist
12 services;”.

13 (4) AMOUNT OF PAYMENT.—

14 (A) IN GENERAL.—Section 1833(a)(1) of
15 the Social Security Act (42 U.S.C.
16 1395l(a)(1)), as amended by section 1303, is
17 amended—

18 (i) by striking “and” before “(X)”;

19 and

20 (ii) by inserting before the semicolon
21 at the end the following: “, and (Y) with
22 respect to marriage and family therapist
23 services under section 1861(s)(2)(GG), the
24 amounts paid shall be 80 percent of the
25 lesser of the actual charge for the services

1 or 75 percent of the amount determined
2 for payment of a psychologist under clause
3 (L)”.

4 (B) DEVELOPMENT OF CRITERIA WITH RE-
5 SPECT TO CONSULTATION WITH A PHYSICIAN.—
6 The Secretary of Health and Human Services
7 shall, taking into consideration concerns for pa-
8 tient confidentiality, develop criteria with re-
9 spect to payment for marriage and family ther-
10 apist services for which payment may be made
11 directly to the marriage and family therapist
12 under part B of title XVIII of the Social Secu-
13 rity Act (42 U.S.C. 1395j et seq.) under which
14 such a therapist must agree to consult with a
15 patient’s attending or primary care physician in
16 accordance with such criteria.

17 (5) EXCLUSION OF MARRIAGE AND FAMILY
18 THERAPIST SERVICES FROM SKILLED NURSING FA-
19 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section
20 1888(e)(2)(A)(ii) of the Social Security Act (42
21 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting
22 “marriage and family therapist services (as defined
23 in subsection (jjj)(1)),” after “clinical social worker
24 services,”.

1 (6) COVERAGE OF MARRIAGE AND FAMILY
2 THERAPIST SERVICES PROVIDED IN RURAL HEALTH
3 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
4 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
5 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by
6 striking “or by a clinical social worker (as defined
7 in subsection (hh)(1)),” and inserting “, by a clinical
8 social worker (as defined in subsection (hh)(1)), or
9 by a marriage and family therapist (as defined in
10 subsection (jjj)(2)),”.

11 (7) INCLUSION OF MARRIAGE AND FAMILY
12 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT
13 OF CLAIMS.—Section 1842(b)(18)(C) of the Social
14 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-
15 ed by adding at the end the following new clause:

16 “(vii) A marriage and family therapist (as de-
17 fined in section 1861(jjj)(2)).”.

18 (b) COVERAGE OF MENTAL HEALTH COUNSELOR
19 SERVICES.—

20 (1) COVERAGE OF SERVICES.—Section
21 1861(s)(2) of the Social Security Act (42 U.S.C.
22 1395x(s)(2)), as previously amended, is further
23 amended—

24 (A) in subparagraph (FF), by striking
25 “and” at the end;

1 (B) in subparagraph (GG), by inserting
2 “and” at the end; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(HH) mental health counselor services (as de-
6 fined in subsection (kk)(1));”.

7 (2) DEFINITION.—Section 1861 of the Social
8 Security Act (42 U.S.C. 1395x), as previously
9 amended, is amended by adding at the end the fol-
10 lowing new subsection:

11 “Mental Health Counselor Services

12 “(kk)(1) The term ‘mental health counselor services’
13 means services performed by a mental health counselor (as
14 defined in paragraph (2)) for the diagnosis and treatment
15 of mental illnesses which the mental health counselor is
16 legally authorized to perform under State law (or the
17 State regulatory mechanism provided by the State law) of
18 the State in which such services are performed, as would
19 otherwise be covered if furnished by a physician or as inci-
20 dent to a physician’s professional service, but only if no
21 facility or other provider charges or is paid any amounts
22 with respect to the furnishing of such services.

23 “(2) The term ‘mental health counselor’ means an
24 individual who—

1 “(A) possesses a master’s or doctor’s degree
2 which qualifies the individual for licensure or certifi-
3 cation for the practice of mental health counseling in
4 the State in which the services are performed;

5 “(B) after obtaining such a degree has per-
6 formed at least 2 years of supervised mental health
7 counselor practice; and

8 “(C) is licensed or certified as a mental health
9 counselor or professional counselor by the State in
10 which the services are performed.”.

11 (3) PROVISION FOR PAYMENT UNDER PART
12 B.—Section 1832(a)(2)(B) of the Social Security
13 Act (42 U.S.C. 1395k(a)(2)(B)), as amended by sec-
14 tion 1303 and subsection (a)(3), is further amend-
15 ed—

16 (A) by striking “and” at the end of clause
17 (iv);

18 (B) by adding “and” at the end of clause
19 (v); and

20 (C) by adding at the end the following new
21 clause:

22 “(vi) mental health counselor serv-
23 ices;”.

24 (4) AMOUNT OF PAYMENT.—

1 (A) IN GENERAL.—Section 1833(a)(1) of
2 the Social Security Act (42 U.S.C.
3 1395l(a)(1)), as amended by subsection (a), is
4 further amended—

5 (i) by striking “and” before “(Y)”; and

6 (ii) by inserting before the semicolon
7 at the end the following: “, and (Z), with
8 respect to mental health counselor services
9 under section 1861(s)(2)(HH), the
10 amounts paid shall be 80 percent of the
11 lesser of the actual charge for the services
12 or 75 percent of the amount determined
13 for payment of a psychologist under clause
14 (L)”.

15 (B) DEVELOPMENT OF CRITERIA WITH RE-
16 SPECT TO CONSULTATION WITH A PHYSICIAN.—
17 The Secretary of Health and Human Services
18 shall, taking into consideration concerns for pa-
19 tient confidentiality, develop criteria with re-
20 spect to payment for mental health counselor
21 services for which payment may be made di-
22 rectly to the mental health counselor under part
23 B of title XVIII of the Social Security Act (42
24 U.S.C. 1395j et seq.) under which such a coun-
25 selor must agree to consult with a patient’s at-

1 tending or primary care physician in accordance
2 with such criteria.

3 (5) EXCLUSION OF MENTAL HEALTH COUN-
4 SELOR SERVICES FROM SKILLED NURSING FACILITY
5 PROSPECTIVE PAYMENT SYSTEM.—Section
6 1888(e)(2)(A)(ii) of the Social Security Act (42
7 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by sub-
8 section (a), is amended by inserting “mental health
9 counselor services (as defined in section
10 1861(kkk)(1)),” after “marriage and family thera-
11 pist services (as defined in subsection (jjj)(1)),”.

12 (6) COVERAGE OF MENTAL HEALTH COUN-
13 SELOR SERVICES PROVIDED IN RURAL HEALTH
14 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
15 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
16 rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended
17 by subsection (a), is amended by striking “or by a
18 marriage and family therapist (as defined in sub-
19 section (jjj)(2)),” and inserting “by a marriage and
20 family therapist (as defined in subsection (jjj)(2)),
21 or a mental health counselor (as defined in sub-
22 section (kkk)(2)),”.

23 (7) INCLUSION OF MENTAL HEALTH COUN-
24 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF
25 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-

1 security Act (42 U.S.C. 1395u(b)(18)(C)), as amended
2 by subsection (a)(7), is amended by adding at the
3 end the following new clause:

4 “(viii) A mental health counselor (as defined in
5 section 1861(kkk)(2)).”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to items and services furnished on
8 or after January 1, 2011.

9 **SEC. 1309. EXTENSION OF PHYSICIAN FEE SCHEDULE MEN-**
10 **TAL HEALTH ADD-ON.**

11 Section 138(a)(1) of the Medicare Improvements for
12 Patients and Providers Act of 2008 (Public Law 110–275)
13 is amended by striking “December 31, 2009” and insert-
14 ing “December 31, 2011”.

15 **SEC. 1310. EXPANDING ACCESS TO VACCINES.**

16 (a) IN GENERAL.—Paragraph (10) of section
17 1861(s) of the Social Security Act (42 U.S.C. 1395w(s))
18 is amended to read as follows:

19 “(10) federally recommended vaccines (as de-
20 fined in subsection (lll)) and their respective admin-
21 istration;”.

22 (b) FEDERALLY RECOMMENDED VACCINES DE-
23 FINED.—Such section is further amended by adding at the
24 end the following new subsection:

1 “Federally Recommended Vaccines

2 “(III) The term ‘federally recommended vaccine’
3 means—

4 “(1) with respect to an adult, an approved vac-
5 cine recommended by the Advisory Committee on
6 Immunization Practices (an advisory committee es-
7 tablished by the Secretary, acting through the Direc-
8 tor of the Centers for Disease Control and Preven-
9 tion); and

10 “(2) with respect to a child, a vaccine on the
11 list referred to in section 1928(e).”.

12 (c) CONFORMING AMENDMENTS.—

13 (1) Section 1833 of such Act (42 U.S.C. 1395l)
14 is amended, in each of subsections (a)(2)(B),
15 (a)(2)(G), (a)(3)(A), (b)(1), by striking
16 “1861(s)(10)(A)” or “1861(s)(10)(B)” and insert-
17 ing “1861(s)(10)” each place it appears.

18 (2) Section 1842(o)(1)(A)(iv) of such Act (42
19 U.S.C. 1395u(o)(1)(A)(iv)) is amended by striking
20 “subparagraph (A) or (B) of”.

21 (3) Section 1847A(c)(6) of such Act (42 U.S.C.
22 1395w-3a(c)(6)) is amended by striking subpara-
23 graph (G).

24 (4) Section 1860D-2(e)(1) of such Act (42
25 U.S.C. 1395w-102(e)(1)) is amended by striking

1 “such term includes a vaccine” and all that follows
2 through “its administration) and”.

3 (5) Section 1861(w)(2)(A) of such Act (42
4 U.S.C. 1395w(w)(2)(A)) is amended by striking
5 “and hepatitis B” and inserting “hepatitis B, and
6 any other adult vaccine”.

7 (6) Section 1861(iii)(1) of such Act, as added
8 by section 1305(a)(1), is amended by amending sub-
9 paragraph (J) to read as follows:

10 “(J) Federally recommended vaccines (as de-
11 fined in subsection (ll)) and their respective admin-
12 istration.”.

13 (d) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to vaccines administered on or
15 after January 1, 2011.

16 **SEC. 1311. ELIMINATION OF 190-DAY LIFETIME LIMIT ON**
17 **PSYCHIATRIC HOSPITAL STAYS.**

18 (a) IN GENERAL.—Section 1812 of the Social Secu-
19 rity Act (42 U.S.C. 1395d) is amended—

20 (1) in subsection (b)—

21 (A) in paragraph (1), by adding “and” at
22 the end;

23 (B) in paragraph (2), by striking “; or”
24 and inserting a period; and

25 (C) by striking paragraph (3); and

1 (2) in subsection (c), by striking “(but shall not
2 be included” and all that follows through “sub-
3 section (b)(3))”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 subsection (a) shall apply to inpatient psychiatric hospital
6 services furnished on or after January 1, 2010.

7 **TITLE IV—QUALITY**
8 **Subtitle A—Comparative**
9 **Effectiveness Research**

10 **SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH.**

11 (a) IN GENERAL.—title XI of the Social Security Act
12 is amended by adding at the end the following new part:

13 “PART D—COMPARATIVE EFFECTIVENESS RESEARCH

14 “COMPARATIVE EFFECTIVENESS RESEARCH

15 “SEC. 1181. (a) CENTER FOR COMPARATIVE EFFEC-
16 TIVENESS RESEARCH ESTABLISHED.—

17 “(1) IN GENERAL.—The Secretary shall estab-
18 lish within the Agency for Healthcare Research and
19 Quality a Center for Comparative Effectiveness Re-
20 search (in this section referred to as the ‘Center’) to
21 conduct, support, and synthesize research (including
22 research conducted or supported under section 1013
23 of the Medicare Prescription Drug, Improvement,
24 and Modernization Act of 2003) with respect to the
25 outcomes, effectiveness, and appropriateness of

1 health care services and procedures in order to iden-
2 tify the manner in which diseases, disorders, and
3 other health conditions can most effectively and ap-
4 propriately be prevented, diagnosed, treated, and
5 managed clinically.

6 “(2) DUTIES.—The Center shall—

7 “(A) conduct, support, and synthesize re-
8 search relevant to the comparative effectiveness
9 of the full spectrum of health care items and
10 services, including pharmaceuticals, medical de-
11 vices, medical and surgical procedures, and
12 other medical interventions;

13 “(B) conduct and support systematic re-
14 views of clinical research, including original re-
15 search conducted subsequent to the date of the
16 enactment of this section;

17 “(C) continuously develop rigorous sci-
18 entific methodologies for conducting compara-
19 tive effectiveness studies, and use such meth-
20 odologies appropriately;

21 “(D) submit to the Comparative Effective-
22 ness Research Commission, the Secretary, and
23 Congress appropriate relevant reports described
24 in subsection (d)(2); and

1 “(E) encourage, as appropriate, the devel-
2 opment and use of clinical registries and the de-
3 velopment of clinical effectiveness research data
4 networks from electronic health records, post
5 marketing drug and medical device surveillance
6 efforts, and other forms of electronic health
7 data.

8 “(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS
9 RESEARCH COMMISSION.—

10 “(1) IN GENERAL.—The Secretary shall estab-
11 lish an independent Comparative Effectiveness Re-
12 search Commission (in this section referred to as the
13 ‘Commission’) to oversee and evaluate the activities
14 carried out by the Center under subsection (a), sub-
15 ject to the authority of the Secretary, to ensure such
16 activities result in highly credible research and infor-
17 mation resulting from such research.

18 “(2) DUTIES.—The Commission shall—

19 “(A) determine national priorities for re-
20 search described in subsection (a) and in mak-
21 ing such determinations consult with a broad
22 array of public and private stakeholders, includ-
23 ing patients and health care providers and pay-
24 ers;

1 “(B) monitor the appropriateness of use of
2 the CERTF described in subsection (f) with re-
3 spect to the timely production of comparative
4 effectiveness research determined to be a na-
5 tional priority under subparagraph (A);

6 “(C) identify highly credible research
7 methods and standards of evidence for such re-
8 search to be considered by the Center;

9 “(D) review the methodologies developed
10 by the center under subsection (a)(2)(C);

11 “(E) not later than one year after the date
12 of the enactment of this section, enter into an
13 arrangement under which the Institute of Medi-
14 cine of the National Academy of Sciences shall
15 conduct an evaluation and report on standards
16 of evidence for such research;

17 “(F) support forums to increase stake-
18 holder awareness and permit stakeholder feed-
19 back on the efforts of the Agency for
20 Healthcare Research and Quality to advance
21 methods and standards that promote highly
22 credible research;

23 “(G) make recommendations for policies
24 that would allow for public access of data pro-
25 duced under this section, in accordance with ap-

1 appropriate privacy and proprietary practices,
2 while ensuring that the information produced
3 through such data is timely and credible;

4 “(H) appoint a clinical perspective advisory
5 panel for each research priority determined
6 under subparagraph (A), which shall consult
7 with patients and advise the Center on research
8 questions and methods for the specific research
9 inquiry to be examined with respect to such pri-
10 ority to ensure that the information produced
11 from such research is clinically relevant to deci-
12 sions made by clinicians and patients at the
13 point of care;

14 “(I) make recommendations for the pri-
15 ority for periodic reviews of previous compara-
16 tive effectiveness research and studies con-
17 ducted by the Center under subsection (a);

18 “(J) routinely review processes of the Cen-
19 ter with respect to such research to confirm
20 that the information produced by such research
21 is objective, credible, consistent with standards
22 of evidence established under this section, and
23 developed through a transparent process that
24 includes consultations with appropriate stake-
25 holders;

1 “(K) make recommendations to the center
2 for the broad dissemination of the findings of
3 research conducted and supported under this
4 section that enables clinicians, consumers, and
5 payers to make more informed health care deci-
6 sions that improve quality and value;

7 “(L) provide for the public disclosure of
8 relevant reports described in subsection (d)(2);
9 and

10 “(M) submit to Congress an annual report
11 on the progress of the Center in achieving na-
12 tional priorities determined under subparagraph
13 (A) for the provision of credible comparative ef-
14 fectiveness information produced from such re-
15 search to all interested parties.

16 “(3) COMPOSITION OF COMMISSION.—

17 “(A) IN GENERAL.—The members of the
18 Commission shall consist of—

19 “(i) the Director of the Agency for
20 Healthcare Research and Quality;

21 “(ii) the Chief Medical Officer of the
22 Centers for Medicare & Medicaid Services;
23 and

24 “(iii) 15 additional members who shall
25 represent broad constituencies of stake-

1 holders including clinicians, patients, re-
2 searchers, third-party payers, consumers of
3 Federal and State beneficiary programs.

4 “(B) QUALIFICATIONS.—

5 “(i) DIVERSE REPRESENTATION OF
6 PERSPECTIVES.—The members of the
7 Commission shall represent a broad range
8 of perspectives and shall collectively have
9 experience in the following areas:

10 “(I) Epidemiology.

11 “(II) Health services research.

12 “(III) Bioethics.

13 “(IV) Decision sciences.

14 “(V) Economics.

15 “(ii) DIVERSE REPRESENTATION OF
16 HEALTH CARE COMMUNITY.—At least one
17 member shall represent each of the fol-
18 lowing health care communities:

19 “(I) Consumers.

20 “(II) Practicing physicians, in-
21 cluding surgeons.

22 “(III) Employers.

23 “(IV) Public payers.

24 “(V) Insurance plans.

1 “(VI) Clinical researchers who
2 conduct research on behalf of pharma-
3 ceutical or device manufacturers.

4 “(4) APPOINTMENT.—

5 “(A) IN GENERAL.—The Secretary shall
6 appoint the members of the Commission.

7 “(B) CONSULTATION.—In considering can-
8 didates for appointment to the Commission, the
9 Secretary may consult with the Government Ac-
10 countability Office and the Institute of Medicine
11 of the National Academy of Sciences.

12 “(5) CHAIRMAN; VICE CHAIRMAN.—The Sec-
13 retary shall designate a member of the Commission,
14 at the time of appointment of the member, as Chair-
15 man and a member as Vice Chairman for that term
16 of appointment, except that in the case of vacancy
17 of the Chairmanship or Vice Chairmanship, the Sec-
18 retary may designate another member for the re-
19 mainder of that member’s term. The Chairman shall
20 serve as an ex officio member of the National Advi-
21 sory Council of the Agency for Health Care Re-
22 search and Quality under section 931(c)(3)(B) of
23 the Public Health Service Act.

24 “(6) TERMS.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), each member of the Com-
3 mission shall be appointed for a term of 4
4 years.

5 “(B) TERMS OF INITIAL APPOINTEES.—Of
6 the members first appointed—

7 “(i) 8 shall be appointed for a term of
8 4 years; and

9 “(ii) 7 shall be appointed for a term
10 of 3 years.

11 “(7) COORDINATION.—To enhance effectiveness
12 and coordination, the Secretary is encouraged, to the
13 greatest extent possible, to seek coordination be-
14 tween the Commission and the National Advisory
15 Council of the Agency for Healthcare Research and
16 Quality.

17 “(8) CONFLICTS OF INTEREST.—

18 “(A) IN GENERAL.—In appointing the
19 members of the Commission or a clinical per-
20 spective advisory panel described in paragraph
21 (2)(H), the Secretary or the Commission, re-
22 spectively, shall take into consideration any fi-
23 nancial interest (as defined in subparagraph
24 (D)), consistent with this paragraph, and de-

1 develop a plan for managing any identified con-
2 flicts.

3 “(B) EVALUATION AND CRITERIA.—When
4 considering an appointment to the Commission
5 or a clinical perspective advisory panel de-
6 scribed paragraph (2)(H) the Secretary or the
7 Commission shall review the expertise of the in-
8 dividual and the financial disclosure report filed
9 by the individual pursuant to the Ethics in Gov-
10 ernment Act of 1978 for each individual under
11 consideration for the appointment, so as to re-
12 duce the likelihood that an appointed individual
13 will later require a written determination as re-
14 ferred to in section 208(b)(1) of title 18, United
15 States Code, a written certification as referred
16 to in section 208(b)(3) of title 18, United
17 States Code, or a waiver as referred to in sub-
18 paragraph (D)(iii) for service on the Commis-
19 sion at a meeting of the Commission.

20 “(C) DISCLOSURES; PROHIBITIONS ON
21 PARTICIPATION; WAIVERS.—

22 “(i) DISCLOSURE OF FINANCIAL IN-
23 TEREST.—Prior to a meeting of the Com-
24 mission or a clinical perspective advisory
25 panel described in paragraph (2)(H) re-

1 regarding a ‘particular matter’ (as that term
2 is used in section 208 of title 18, United
3 States Code), each member of the Commis-
4 sion or the clinical perspective advisory
5 panel who is a full-time Government em-
6 ployee or special Government employee
7 shall disclose to the Secretary financial in-
8 terests in accordance with subsection (b) of
9 such section 208.

10 “(ii) PROHIBITIONS ON PARTICIPA-
11 TION.—Except as provided under clause
12 (iii), a member of the Commission or a
13 clinical perspective advisory panel de-
14 scribed in paragraph (2)(H) may not par-
15 ticipate with respect to a particular matter
16 considered in meeting of the Commission
17 or the clinical perspective advisory panel if
18 such member (or an immediate family
19 member of such member) has a financial
20 interest that could be affected by the ad-
21 vice given to the Secretary with respect to
22 such matter, excluding interests exempted
23 in regulations issued by the Director of the
24 Office of Government Ethics as too remote
25 or inconsequential to affect the integrity of

1 the services of the Government officers or
2 employees to which such regulations apply.

3 “(iii) WAIVER.—If the Secretary de-
4 termines it necessary to afford the Com-
5 mission or a clinical perspective advisory
6 panel described in paragraph 2(H) essen-
7 tial expertise, the Secretary may grant a
8 waiver of the prohibition in clause (ii) to
9 permit a member described in such sub-
10 paragraph to—

11 “(I) participate as a non-voting
12 member with respect to a particular
13 matter considered in a Commission or
14 a clinical perspective advisory panel
15 meeting; or

16 “(II) participate as a voting
17 member with respect to a particular
18 matter considered in a Commission or
19 a clinical perspective advisory panel
20 meeting.

21 “(iv) LIMITATION ON WAIVERS AND
22 OTHER EXCEPTIONS.—

23 “(I) DETERMINATION OF ALLOW-
24 ABLE EXCEPTIONS FOR THE COMMIS-
25 SION.—The number of waivers grant-

1 ed to members of the Commission
2 cannot exceed one-half of the total
3 number of members for the Commis-
4 sion.

5 “(II) PROHIBITION ON VOTING
6 STATUS ON CLINICAL PERSPECTIVE
7 ADVISORY PANEL.—No voting member
8 of any clinical perspective advisory
9 panels shall be in receipt of a waiver.
10 No more than two nonvoting members
11 of any clinical perspective advisory
12 panel shall receive a waiver.

13 “(D) FINANCIAL INTEREST DEFINED.—
14 For purposes of this paragraph, the term ‘fi-
15 nancial interest’ means a financial interest
16 under section 208(a) of title 18, United States
17 Code.

18 “(9) COMPENSATION.—While serving on the
19 business of the Commission (including travel time),
20 a member of the Commission shall be entitled to
21 compensation at the per diem equivalent of the rate
22 provided for level IV of the Executive Schedule
23 under section 5315 of title 5, United States Code;
24 and while so serving away from home and the mem-
25 ber’s regular place of business, a member may be al-

1 lowed travel expenses, as authorized by the Director
2 of the Commission.

3 “(10) AVAILABILITY OF REPORTS.—The Com-
4 mission shall transmit to the Secretary a copy of
5 each report submitted under this subsection and
6 shall make such reports available to the public.

7 “(11) DIRECTOR AND STAFF; EXPERTS AND
8 CONSULTANTS.—Subject to such review as the Sec-
9 retary deems necessary to assure the efficient ad-
10 ministration of the Commission, the Commission
11 may—

12 “(A) employ and fix the compensation of
13 an Executive Director (subject to the approval
14 of the Secretary) and such other personnel as
15 may be necessary to carry out its duties (with-
16 out regard to the provisions of title 5, United
17 States Code, governing appointments in the
18 competitive service);

19 “(B) seek such assistance and support as
20 may be required in the performance of its du-
21 ties from appropriate Federal departments and
22 agencies;

23 “(C) enter into contracts or make other ar-
24 rangements, as may be necessary for the con-
25 duct of the work of the Commission (without

1 regard to section 3709 of the Revised Statutes
2 (41 U.S.C. 5));

3 “(D) make advance, progress, and other
4 payments which relate to the work of the Com-
5 mission;

6 “(E) provide transportation and subsist-
7 ence for persons serving without compensation;
8 and

9 “(F) prescribe such rules and regulations
10 as it deems necessary with respect to the inter-
11 nal organization and operation of the Commis-
12 sion.

13 “(12) POWERS.—

14 “(A) OBTAINING OFFICIAL DATA.—The
15 Commission may secure directly from any de-
16 partment or agency of the United States infor-
17 mation necessary to enable it to carry out this
18 section. Upon request of the Executive Director,
19 the head of that department or agency shall
20 furnish that information to the Commission on
21 an agreed upon schedule.

22 “(B) DATA COLLECTION.—In order to
23 carry out its functions, the Commission shall—

24 “(i) utilize existing information, both
25 published and unpublished, where possible,

1 collected and assessed either by its own
2 staff or under other arrangements made in
3 accordance with this section,

4 “(ii) carry out, or award grants or
5 contracts for, original research and experi-
6 mentation, where existing information is
7 inadequate, and

8 “(iii) adopt procedures allowing any
9 interested party to submit information for
10 the Commission’s use in making reports
11 and recommendations.

12 “(C) ACCESS OF GAO TO INFORMATION.—
13 The Comptroller General shall have unrestricted
14 access to all deliberations, records, and non-
15 proprietary data of the Commission, imme-
16 diately upon request.

17 “(D) PERIODIC AUDIT.—The Commission
18 shall be subject to periodic audit by the Comp-
19 troller General.

20 “(c) RESEARCH REQUIREMENTS.—Any research con-
21 ducted, supported, or synthesized under this section shall
22 meet the following requirements:

23 “(1) ENSURING TRANSPARENCY, CREDIBILITY,
24 AND ACCESS.—

1 “(A) The establishment of the agenda and
2 conduct of the research shall be insulated from
3 inappropriate political or stakeholder influence.

4 “(B) Methods of conducting such research
5 shall be scientifically based.

6 “(C) All aspects of the prioritization of re-
7 search, conduct of the research, and develop-
8 ment of conclusions based on the research shall
9 be transparent to all stakeholders.

10 “(D) The process and methods for con-
11 ducting such research shall be publicly docu-
12 mented and available to all stakeholders.

13 “(E) Throughout the process of such re-
14 search, the Center shall provide opportunities
15 for all stakeholders involved to review and pro-
16 vide public comment on the methods and find-
17 ings of such research.

18 “(2) USE OF CLINICAL PERSPECTIVE ADVISORY
19 PANELS.—The research shall meet a national re-
20 search priority determined under subsection
21 (b)(2)(A) and shall consider advice given to the Cen-
22 ter by the clinical perspective advisory panel for the
23 national research priority.

24 “(3) STAKEHOLDER INPUT.—

1 “(A) IN GENERAL.—The Commission shall
2 consider research questions and methodology
3 and consult with patients, health care providers,
4 health care consumer representatives, and other
5 appropriate stakeholders with an interest in the
6 research through a transparent process rec-
7 ommended by the Commission.

8 “(B) SPECIFIC AREAS OF CONSULTA-
9 TION.—Consultation shall include where
10 deemed appropriate by the Commission—

11 “(i) recommending research priorities;

12 and

13 “(ii) advising on and assisting with ef-
14 forts to disseminate research findings.

15 “(C) OMBUDSMAN.—The Secretary shall
16 designate a patient ombudsman. The ombuds-
17 man shall—

18 “(i) serve as an available point of con-
19 tact for any patients with an interest in
20 proposed comparative effectiveness studies
21 by the Center;

22 “(ii) serve as a non-voting member of
23 the Commission; and

24 “(iii) ensure that any comments from
25 patients regarding proposed comparative

1 effectiveness studies are reviewed by the
2 Commission.

3 “(4) TAKING INTO ACCOUNT POTENTIAL DIF-
4 FERENCES.—Research shall—

5 “(A) be designed, as appropriate, to take
6 into account the potential for differences in the
7 effectiveness of health care items and services
8 used with various subpopulations such as racial
9 and ethnic minorities, women, different age
10 groups, and individuals with different
11 comorbidities; and

12 “(B) seek, as feasible and appropriate, to
13 include members of such subpopulations as sub-
14 jects in the research.

15 “(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-
16 NESS INFORMATION.—

17 “(1) IN GENERAL.—Not later than 90 days
18 after receipt by the Center or Commission, as appli-
19 cable, of a relevant report described in paragraph
20 (2) made by the Center, Commission, or clinical per-
21 spective advisory panel under this section, appro-
22 priate information contained in such report shall be
23 posted on the official public Internet site of the Cen-
24 ter and of the Commission, as applicable.

1 “(2) RELEVANT REPORTS DESCRIBED.—For
2 purposes of this section, a relevant report is each of
3 the following submitted by the Center or a grantee
4 or contractor of the Center:

5 “(A) An interim progress report.

6 “(B) A draft final comparative effective-
7 ness review.

8 “(C) A final progress report on new re-
9 search submitted for publication by a peer re-
10 view journal.

11 “(D) Stakeholder comments.

12 “(E) A final report.

13 “(e) DISSEMINATION AND INCORPORATION OF COM-
14 PARATIVE EFFECTIVENESS INFORMATION.—

15 “(1) DISSEMINATION.—The Center shall pro-
16 vide for the dissemination of appropriate findings
17 produced by research supported, conducted, or syn-
18 thesized under this section to health care providers,
19 patients, vendors of health information technology
20 focused on clinical decision support, appropriate pro-
21 fessional associations, and Federal and private
22 health plans, and other relevant stakeholders. In dis-
23 seminating such findings the Center shall—

1 “(A) convey findings of research so that
2 they are comprehensible and useful to patients
3 and providers in making health care decisions;

4 “(B) discuss findings and other consider-
5 ations specific to certain sub-populations, risk
6 factors, and comorbidities as appropriate;

7 “(C) include considerations such as limita-
8 tions of research and what further research
9 may be needed, as appropriate;

10 “(D) not include any data that the dis-
11 semination of which would violate the privacy of
12 research participants or violate any confiden-
13 tiality agreements made with respect to the use
14 of data under this section; and

15 “(E) assist the users of health information
16 technology focused on clinical decision support
17 to promote the timely incorporation of such
18 findings into clinical practices and promote the
19 ease of use of such incorporation.

20 “(2) DISSEMINATION PROTOCOLS AND STRATE-
21 GIES.—The Center shall develop protocols and strat-
22 egies for the appropriate dissemination of research
23 findings in order to ensure effective communication
24 of findings and the use and incorporation of such
25 findings into relevant activities for the purpose of in-

1 forming higher quality and more effective and effi-
2 cient decisions regarding medical items and services.
3 In developing and adopting such protocols and strat-
4 egies, the Center shall consult with stakeholders con-
5 cerning the types of dissemination that will be most
6 useful to the end users of information and may pro-
7 vide for the utilization of multiple formats for con-
8 veying findings to different audiences, including dis-
9 semination to individuals with limited English pro-
10 ficiency.

11 “(f) REPORTS TO CONGRESS.—

12 “(1) ANNUAL REPORTS.—Beginning not later
13 than one year after the date of the enactment of this
14 section, the Director of the Agency of Healthcare
15 Research and Quality and the Commission shall sub-
16 mit to Congress an annual report on the activities
17 of the Center and the Commission, as well as the re-
18 search, conducted under this section.

19 “(2) RECOMMENDATION FOR FAIR SHARE PER
20 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-
21 ginning not later than December 31, 2011, the Sec-
22 retary shall submit to Congress an annual rec-
23 ommendation for a fair share per capita amount de-
24 scribed in subsection (c)(1) of section 9511 of the

1 Internal Revenue Code of 1986 for purposes of
2 funding the CERTF under such section.

3 “(3) ANALYSIS AND REVIEW.—Not later than
4 December 31, 2013, the Secretary, in consultation
5 with the Commission, shall submit to Congress a re-
6 port on all activities conducted or supported under
7 this section as of such date. Such report shall in-
8 clude an evaluation of the overall costs of such ac-
9 tivities and an analysis of the backlog of any re-
10 search proposals approved by the Commission but
11 not funded. Such report shall also address whether
12 Congress should expand the responsibilities of the
13 Center and of the Commission to include studies of
14 the effectiveness of various aspects of the health care
15 delivery system, including health plans and delivery
16 models, such as health plan features, benefit designs
17 and performance, and the ways in which health serv-
18 ices are organized, managed, and delivered.

19 “(g) FUNDING OF COMPARATIVE EFFECTIVENESS
20 RESEARCH.—For fiscal year 2010 and each subsequent
21 fiscal year, amounts in the Comparative Effectiveness Re-
22 search Trust Fund (referred to in this section as the
23 ‘CERTF’) under section 9511 of the Internal Revenue
24 Code of 1986 shall be available, without the need for fur-

1 ther appropriations and without fiscal year limitation, to
2 the Secretary to carry out this section.

3 “(h) CONSTRUCTION.—Nothing in this section shall
4 be construed to permit the Commission or the Center to
5 mandate coverage, reimbursement, or other policies for
6 any public or private player.”.

7 (b) COMPARATIVE EFFECTIVENESS RESEARCH
8 TRUST FUND; FINANCING FOR TRUST FUND.—

9 (1) ESTABLISHMENT OF TRUST FUND.—

10 (A) IN GENERAL.—Subchapter A of chap-
11 ter 98 of the Internal Revenue Code of 1986
12 (relating to trust fund code) is amended by
13 adding at the end the following new section:

14 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**
15 **RESEARCH TRUST FUND.**

16 “(a) CREATION OF TRUST FUND.—There is estab-
17 lished in the Treasury of the United States a trust fund
18 to be known as the ‘Health Care Comparative Effective-
19 ness Research Trust Fund’ (hereinafter in this section re-
20 ferred to as the ‘CERTF’), consisting of such amounts
21 as may be appropriated or credited to such Trust Fund
22 as provided in this section and section 9602(b).

23 “(b) TRANSFERS TO FUND.—There are hereby ap-
24 propriated to the Trust Fund the following:

25 “(1) For fiscal year 2010, \$90,000,000.

1 “(2) For fiscal year 2011, \$100,000,000.

2 “(3) For fiscal year 2012, \$110,000,000.

3 “(4) For each fiscal year beginning with fiscal
4 year 2013—

5 “(A) an amount equivalent to the net reve-
6 nues received in the Treasury from the fees im-
7 posed under subchapter B of chapter 34 (relat-
8 ing to fees on health insurance and self-insured
9 plans) for such fiscal year; and

10 “(B) subject to subsection (c)(2), amounts
11 determined by the Secretary of Health and
12 Human Services to be equivalent to the fair
13 share per capita amount computed under sub-
14 section (c)(1) for the fiscal year multiplied by
15 the average number of individuals entitled to
16 benefits under part A, or enrolled under part B,
17 of title XVIII of the Social Security Act during
18 such fiscal year.

19 The amounts appropriated under paragraphs (1), (2), (3),
20 and (4)(B) shall be transferred from the Federal Hospital
21 Insurance Trust Fund and from the Federal Supple-
22 mentary Medical Insurance Trust Fund (established
23 under section 1841 of such Act), and from the Medicare
24 Prescription Drug Account within such Trust Fund, in
25 proportion (as estimated by the Secretary) to the total ex-

1 penditures during such fiscal year that are made under
2 title XVIII of such Act from the respective trust fund or
3 account.

4 “(c) FAIR SHARE PER CAPITA AMOUNT.—

5 “(1) COMPUTATION.—

6 “(A) IN GENERAL.—Subject to subpara-
7 graph (B), the fair share per capita amount
8 under this paragraph for a fiscal year (begin-
9 ning with fiscal year 2013) is an amount com-
10 puted by the Secretary of Health and Human
11 Services for such fiscal year that, when applied
12 under this section and subchapter B of chapter
13 34 of the Internal Revenue Code of 1986, will
14 result in revenues to the CERTF of
15 \$375,000,000 for the fiscal year.

16 “(B) ALTERNATIVE COMPUTATION.—

17 “(i) IN GENERAL.—If the Secretary is
18 unable to compute the fair share per capita
19 amount under subparagraph (A) for a fis-
20 cal year, the fair share per capita amount
21 under this paragraph for the fiscal year
22 shall be the default amount determined
23 under clause (ii) for the fiscal year.

24 “(ii) DEFAULT AMOUNT.—The default
25 amount under this clause for—

1 “(I) fiscal year 2013 is equal to
2 \$2; or

3 “(II) a subsequent year is equal
4 to the default amount under this
5 clause for the preceding fiscal year in-
6 creased by the annual percentage in-
7 crease in the medical care component
8 of the consumer price index (United
9 States city average) for the 12-month
10 period ending with April of the pre-
11 ceding fiscal year.

12 Any amount determined under subclause
13 (II) shall be rounded to the nearest penny.

14 “(2) LIMITATION ON MEDICARE FUNDING.—In
15 no case shall the amount transferred under sub-
16 section (b)(4)(B) for any fiscal year exceed
17 \$90,000,000.

18 “(d) EXPENDITURES FROM FUND.—

19 “(1) IN GENERAL.—Subject to paragraph (2),
20 amounts in the CERTF are available, without the
21 need for further appropriations and without fiscal
22 year limitation, to the Secretary of Health and
23 Human Services for carrying out section 1181 of the
24 Social Security Act.

1 “(2) ALLOCATION FOR COMMISSION.—Not less
2 than the following amounts in the CERTF for a fis-
3 cal year shall be available to carry out the activities
4 of the Comparative Effectiveness Research Commis-
5 sion established under section 1181(b) of the Social
6 Security Act for such fiscal year:

7 “(A) For fiscal year 2010, \$7,000,000.

8 “(B) For fiscal year 2011, \$9,000,000.

9 “(C) For each fiscal year beginning with
10 2012, \$10,000,000.

11 Nothing in this paragraph shall be construed as pre-
12 venting additional amounts in the CERTF from
13 being made available to the Comparative Effective-
14 ness Research Commission for such activities.

15 “(e) NET REVENUES.—For purposes of this section,
16 the term ‘net revenues’ means the amount estimated by
17 the Secretary based on the excess of—

18 “(1) the fees received in the Treasury under
19 subchapter B of chapter 34, over

20 “(2) the decrease in the tax imposed by chapter
21 1 resulting from the fees imposed by such sub-
22 chapter.”.

23 (B) CLERICAL AMENDMENT.—The table of
24 sections for such subchapter A is amended by

1 adding at the end thereof the following new
2 item:

“Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.”.

3 (2) FINANCING FOR FUND FROM FEES ON IN-
4 SURED AND SELF-INSURED HEALTH PLANS.—

5 (A) GENERAL RULE.—Chapter 34 of the
6 Internal Revenue Code of 1986 is amended by
7 adding at the end the following new subchapter:

8 **“Subchapter B—Insured and Self-Insured**
9 **Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

10 **“SEC. 4375. HEALTH INSURANCE.**

11 “(a) IMPOSITION OF FEE.—There is hereby imposed
12 on each specified health insurance policy for each policy
13 year a fee equal to the fair share per capita amount deter-
14 mined under section 9511(c)(1) multiplied by the average
15 number of lives covered under the policy.

16 “(b) LIABILITY FOR FEE.—The fee imposed by sub-
17 section (a) shall be paid by the issuer of the policy.

18 “(c) SPECIFIED HEALTH INSURANCE POLICY.—For
19 purposes of this section:

20 “(1) IN GENERAL.—Except as otherwise pro-
21 vided in this section, the term ‘specified health in-
22 surance policy’ means any accident or health insur-

1 ance policy issued with respect to individuals resid-
2 ing in the United States.

3 “(2) EXEMPTION FOR CERTAIN POLICIES.—The
4 term ‘specified health insurance policy’ does not in-
5 clude any insurance if substantially all of its cov-
6 erage is of excepted benefits described in section
7 9832(e).

8 “(3) TREATMENT OF PREPAID HEALTH COV-
9 ERAGE ARRANGEMENTS.—

10 “(A) IN GENERAL.—In the case of any ar-
11 rangement described in subparagraph (B)—

12 “(i) such arrangement shall be treated
13 as a specified health insurance policy, and

14 “(ii) the person referred to in such
15 subparagraph shall be treated as the
16 issuer.

17 “(B) DESCRIPTION OF ARRANGEMENTS.—

18 An arrangement is described in this subpara-
19 graph if under such arrangement fixed pay-
20 ments or premiums are received as consider-
21 ation for any person’s agreement to provide or
22 arrange for the provision of accident or health
23 coverage to residents of the United States, re-
24 gardless of how such coverage is provided or ar-
25 ranged to be provided.

1 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

2 “(a) IMPOSITION OF FEE.—In the case of any appli-
3 cable self-insured health plan for each plan year, there is
4 hereby imposed a fee equal to the fair share per capita
5 amount determined under section 9511(c)(1) multiplied by
6 the average number of lives covered under the plan.

7 “(b) LIABILITY FOR FEE.—

8 “(1) IN GENERAL.—The fee imposed by sub-
9 section (a) shall be paid by the plan sponsor.

10 “(2) PLAN SPONSOR.—For purposes of para-
11 graph (1) the term ‘plan sponsor’ means—

12 “(A) the employer in the case of a plan es-
13 tablished or maintained by a single employer,

14 “(B) the employee organization in the case
15 of a plan established or maintained by an em-
16 ployee organization,

17 “(C) in the case of—

18 “(i) a plan established or maintained
19 by 2 or more employers or jointly by 1 or
20 more employers and 1 or more employee
21 organizations,

22 “(ii) a multiple employer welfare ar-
23 rangement, or

24 “(iii) a voluntary employees’ bene-
25 ficiary association described in section
26 501(c)(9),

1 the association, committee, joint board of trust-
2 ees, or other similar group of representatives of
3 the parties who establish or maintain the plan,
4 or

5 “(D) the cooperative or association de-
6 scribed in subsection (c)(2)(F) in the case of a
7 plan established or maintained by such a coop-
8 erative or association.

9 “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—
10 For purposes of this section, the term ‘applicable self-in-
11 sured health plan’ means any plan for providing accident
12 or health coverage if—

13 “(1) any portion of such coverage is provided
14 other than through an insurance policy, and

15 “(2) such plan is established or maintained—

16 “(A) by one or more employers for the
17 benefit of their employees or former employees,

18 “(B) by one or more employee organiza-
19 tions for the benefit of their members or former
20 members,

21 “(C) jointly by 1 or more employers and 1
22 or more employee organizations for the benefit
23 of employees or former employees,

24 “(D) by a voluntary employees’ beneficiary
25 association described in section 501(c)(9),

1 “(E) by any organization described in sec-
2 tion 501(c)(6), or

3 “(F) in the case of a plan not described in
4 the preceding subparagraphs, by a multiple em-
5 ployer welfare arrangement (as defined in sec-
6 tion 3(40) of Employee Retirement Income Se-
7 curity Act of 1974), a rural electric cooperative
8 (as defined in section 3(40)(B)(iv) of such Act),
9 or a rural telephone cooperative association (as
10 defined in section 3(40)(B)(v) of such Act).

11 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

12 “(a) DEFINITIONS.—For purposes of this sub-
13 chapter—

14 “(1) ACCIDENT AND HEALTH COVERAGE.—The
15 term ‘accident and health coverage’ means any cov-
16 erage which, if provided by an insurance policy,
17 would cause such policy to be a specified health in-
18 surance policy (as defined in section 4375(c)).

19 “(2) INSURANCE POLICY.—The term ‘insurance
20 policy’ means any policy or other instrument where-
21 by a contract of insurance is issued, renewed, or ex-
22 tended.

23 “(3) UNITED STATES.—The term ‘United
24 States’ includes any possession of the United States.

25 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

1 “(1) IN GENERAL.—For purposes of this sub-
2 chapter—

3 “(A) the term ‘person’ includes any gov-
4 ernmental entity, and

5 “(B) notwithstanding any other law or rule
6 of law, governmental entities shall not be ex-
7 empt from the fees imposed by this subchapter
8 except as provided in paragraph (2).

9 “(2) TREATMENT OF EXEMPT GOVERNMENTAL
10 PROGRAMS.—In the case of an exempt governmental
11 program, no fee shall be imposed under section 4375
12 or section 4376 on any covered life under such pro-
13 gram.

14 “(3) EXEMPT GOVERNMENTAL PROGRAM DE-
15 FINED.—For purposes of this subchapter, the term
16 ‘exempt governmental program’ means—

17 “(A) any insurance program established
18 under title XVIII of the Social Security Act,

19 “(B) the medical assistance program es-
20 tablished by title XIX or XXI of the Social Se-
21 curity Act,

22 “(C) any program established by Federal
23 law for providing medical care (other than
24 through insurance policies) to individuals (or

1 the spouses and dependents thereof) by reason
2 of such individuals being—

3 “(i) members of the Armed Forces of
4 the United States, or

5 “(ii) veterans, and

6 “(D) any program established by Federal
7 law for providing medical care (other than
8 through insurance policies) to members of In-
9 dian tribes (as defined in section 4(d) of the In-
10 dian Health Care Improvement Act).

11 “(c) TREATMENT AS TAX.—For purposes of subtitle
12 F, the fees imposed by this subchapter shall be treated
13 as if they were taxes.

14 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-
15 standing any other provision of law, no amount collected
16 under this subchapter shall be covered over to any posses-
17 sion of the United States.”

18 (B) CLERICAL AMENDMENTS.—

19 (i) Chapter 34 of such Code is amend-
20 ed by striking the chapter heading and in-
21 serting the following:

22 **“CHAPTER 34—TAXES ON CERTAIN**
23 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

1 **“Subchapter A—Policies Issued By Foreign**
2 **Insurers”.**

3 (ii) The table of chapters for subtitle
4 D of such Code is amended by striking the
5 item relating to chapter 34 and inserting
6 the following new item:

 “CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

7 (C) EFFECTIVE DATE.—The amendments
8 made by this subsection shall apply with respect
9 to policies and plans for portions of policy or
10 plan years beginning on or after October 1,
11 2012.

12 **Subtitle B.—Nursing Home**
13 **Transparency**

14 **PART 1—IMPROVING TRANSPARENCY OF INFOR-**
15 **MATION ON SKILLED NURSING FACILITIES**
16 **AND NURSING FACILITIES**

17 **SEC. 1411. REQUIRED DISCLOSURE OF OWNERSHIP AND**
18 **ADDITIONAL DISCLOSABLE PARTIES INFOR-**
19 **MATION.**

20 (a) IN GENERAL.—Section 1124 of the Social Secu-
21 rity Act (42 U.S.C. 1320a–3) is amended by adding at
22 the end the following new subsection:

23 “(c) REQUIRED DISCLOSURE OF OWNERSHIP AND
24 ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

1 “(1) DISCLOSURE.—Facility shall have the in-
2 formation described in paragraph (2) available—

3 “(A) during the period beginning on the
4 date of the enactment of this subsection and
5 ending on the date such information is made
6 available to the public under section 1411(b) of
7 the **【short title】**, for submission to the Sec-
8 retary, the Inspector General of the Depart-
9 ment of Health and Human Services, the State
10 in which the facility is located, and the State
11 long-term care ombudsman in the case where
12 the Secretary, the Inspector General, the State,
13 or the State long-term care ombudsman re-
14 quests such information; and

15 “(B) beginning on the effective date of the
16 final regulations promulgated under paragraph
17 (3)(A), for reporting such information in ac-
18 cordance with such final regulations.

19 Nothing in subparagraph (A) shall be construed as
20 authorizing a facility to dispose of or delete informa-
21 tion described in such subparagraph after the effec-
22 tive date of the final regulations promulgated under
23 paragraph (3)(A).

1 “(2) PUBLIC AVAILABILITY OF INFORMATION.—
2 During the period described in subparagraph (A)(i),
3 a facility shall—

4 “(A) make the information described in
5 paragraph (2) available to the public upon re-
6 quest; and

7 “(B) post a notice of the availability of
8 such information in the lobby of the facility in
9 a prominent manner.

10 “(2) INFORMATION DESCRIBED.—

11 “(A) IN GENERAL.—The following infor-
12 mation is described in this paragraph:

13 “(i) The information described in sub-
14 sections (a) and (b), subject to subpara-
15 graph (C).

16 “(ii) The identity of and information
17 on—

18 “(I) each member of the gov-
19 erning body of the facility, including
20 the name, title, and period of service
21 of each such member;

22 “(II) each person or entity who is
23 an officer, director, member, partner,
24 trustee, or managing employee of the
25 facility, including the name, title, and

1 period of service of each such person
2 or entity; and

3 “(III) each person or entity who
4 is an additional disclosable party of
5 the facility.

6 “(iii) The organizational structure of
7 each person and entity described in clauses
8 (II) and (III) and a description of the rela-
9 tionship of each such person or entity to
10 the facility and to one another.

11 “(B) SPECIAL RULE WHERE INFORMATION
12 IS ALREADY REPORTED OR SUBMITTED.—To
13 the extent that information reported by a facil-
14 ity to the Internal Revenue Service on Form
15 990, information submitted by a facility to the
16 Securities and Exchange Commission, or infor-
17 mation otherwise submitted to the Secretary or
18 any other Federal agency contains the informa-
19 tion described in clauses (i), (ii), or (iii) of sub-
20 paragraph (A), the facility may provide such
21 Form or such information submitted to meet
22 the requirements of paragraph (1).

23 “(C) SPECIAL RULE.—In applying sub-
24 paragraph (A)(i)—

1 “(i) with respect to subsections (a)
2 and (b), ‘ownership or control interest’
3 shall include direct or indirect interests, in-
4 cluding such interests in intermediate enti-
5 ties; and

6 “(ii) subsection (a)(3)(A)(ii) shall in-
7 clude the owner of a whole or part interest
8 in any mortgage, deed of trust, note, or
9 other obligation secured, in whole or in
10 part, by the entity or any of the property
11 or assets thereof, if the interest is equal to
12 or exceeds 5 percent of the total property
13 or assets of the entirety.

14 “(3) REPORTING.—

15 “(A) IN GENERAL.—Not later than the
16 date that is 2 years after the date of the enact-
17 ment of this subsection, the Secretary shall pro-
18 mulgate final regulations requiring, effective on
19 the date that is 90 days after the date on which
20 such final regulations are published in the Fed-
21 eral Register, a facility to report the informa-
22 tion described in paragraph (2) to the Secretary
23 in a standardized format, and such other regu-
24 lations as are necessary to carry out this sub-
25 section. Such final regulations shall ensure that

1 the facility certifies, as a condition of participa-
2 tion and payment under the program under
3 title XVIII or XIX, that the information re-
4 ported by the facility in accordance with such
5 final regulations is accurate and current.

6 “(B) GUIDANCE.—The Secretary shall pro-
7 vide guidance and technical assistance to States
8 on how to adopt the standardized format under
9 subparagraph (A).

10 “(4) NO EFFECT ON EXISTING REPORTING RE-
11 QUIREMENTS.—Nothing in this subsection shall re-
12 duce, diminish, or alter any reporting requirement
13 for a facility that is in effect as of the date of the
14 enactment of this subsection.

15 “(5) DEFINITIONS.—In this subsection:

16 “(A) ADDITIONAL DISCLOSABLE PARTY.—
17 The term ‘additional disclosable party’ means,
18 with respect to a facility, any person or entity
19 who—

20 “(i) exercises operational, financial, or
21 managerial control over the facility or a
22 part thereof, or provides policies or proce-
23 dures for any of the operations of the facil-
24 ity, or provides financial or cash manage-
25 ment services to the facility;

1 “(ii) leases or subleases real property
2 to the facility, or owns a whole or part in-
3 terest equal to or exceeding 5 percent of
4 the total value of such real property;

5 “(iii) lends funds or provides a finan-
6 cial guarantee to the facility in an amount
7 which is equal to or exceeds \$50,000; or

8 “(iv) provides management or admin-
9 istrative services, clinical consulting serv-
10 ices, or accounting or financial services to
11 the facility.

12 “(B) FACILITY.—The term ‘facility’ means
13 a disclosing entity which is—

14 “(i) a skilled nursing facility (as de-
15 fined in section 1819(a)); or

16 “(ii) a nursing facility (as defined in
17 section 1919(a)).

18 “(C) MANAGING EMPLOYEE.—The term
19 ‘managing employee’ means, with respect to a
20 facility, an individual (including a general man-
21 ager, business manager, administrator, director,
22 or consultant) who directly or indirectly man-
23 ages, advises, or supervises any element of the
24 practices, finances, or operations of the facility.

1 “(D) ORGANIZATIONAL STRUCTURE.—The
2 term ‘organizational structure’ means, in the
3 case of—

4 “(i) a corporation, the officers, direc-
5 tors, and shareholders of the corporation
6 who have an ownership interest in the cor-
7 poration which is equal to or exceeds 5
8 percent;

9 “(ii) a limited liability company, the
10 members and managers of the limited li-
11 ability company (including, as applicable,
12 what percentage each member and man-
13 ager has of the ownership interest in the
14 limited liability company);

15 “(iii) a general partnership, the part-
16 ners of the general partnership;

17 “(iv) a limited partnership, the gen-
18 eral partners and any limited partners of
19 the limited partnership who have an own-
20 ership interest in the limited partnership
21 which is equal to or exceeds 10 percent;

22 “(v) a trust, the trustees of the trust;

23 “(vi) an individual, contact informa-
24 tion for the individual; and

1 “(vii) any other person or entity, such
2 information as the Secretary determines
3 appropriate.”.

4 (b) PUBLIC AVAILABILITY OF INFORMATION.—

5 (1) IN GENERAL.—Not later than the date that
6 is 1 year after the date on which the final regula-
7 tions promulgated under section 1124(c)(3)(A) of
8 the Social Security Act, as added by subsection (a),
9 are published in the Federal Register, the informa-
10 tion reported in accordance with such final regula-
11 tions shall be made available to the public in accord-
12 ance with procedures established by the Secretary.

13 (2) DEFINITIONS.—In this subsection:

14 (A) NURSING FACILITY.—The term “nurs-
15 ing facility” has the meaning given such term
16 in section 1919(a) of the Social Security Act
17 (42 U.S.C. 1396r(a)).

18 (B) SECRETARY.—The term “Secretary”
19 means the Secretary of Health and Human
20 Services.

21 (C) SKILLED NURSING FACILITY.—The
22 term “skilled nursing facility” has the meaning
23 given such term in section 1819(a) of the Social
24 Security Act (42 U.S.C. 1395i–3(a)).

25 (c) CONFORMING AMENDMENTS.—

1 (1) SKILLED NURSING FACILITIES.—Section
2 1819(d)(1) of the Social Security Act (42 U.S.C.
3 1395i–3(d)(1)) is amended by striking subparagraph
4 (B) and redesignating subparagraph (C) as subpara-
5 graph (B).

6 (2) NURSING FACILITIES.—Section 1919(d)(1)
7 of the Social Security Act (42 U.S.C. 1396r(d)(1))
8 is amended by striking subparagraph (B) and redesi-
9 gnating subparagraph (C) as subparagraph (B).

10 **SEC. 1412. ACCOUNTABILITY REQUIREMENTS.**

11 (a) EFFECTIVE COMPLIANCE AND ETHICS PRO-
12 GRAMS.—

13 (1) SKILLED NURSING FACILITIES.—Section
14 1819(d)(1) of the Social Security Act (42 U.S.C.
15 1395i–3(d)(1)) is amended by adding at the end the
16 following new subparagraph:

17 “(D) COMPLIANCE AND ETHICS PRO-
18 GRAMS.—

19 “(i) REQUIREMENT.—On or after the
20 date that is 36 months after the date of
21 the enactment of this subparagraph, a
22 skilled nursing facility shall, with respect
23 to the entity that operates the facility (in
24 this subparagraph referred to as the ‘oper-
25 ating organization’ or ‘organization’), have

1 in operation a compliance and ethics pro-
2 gram that is effective in preventing and de-
3 tecting criminal, civil, and administrative
4 violations under this Act and in promoting
5 quality of care consistent with regulations
6 developed under clause (ii).

7 “(ii) DEVELOPMENT OF REGULA-
8 TIONS.—

9 “(I) IN GENERAL.—Not later
10 than the date that is 2 years after
11 such date of the enactment, the Sec-
12 retary, in consultation with the In-
13 spector General of the Department of
14 Health and Human Services, shall
15 promulgate regulations for an effec-
16 tive compliance and ethics program
17 for operating organizations, which
18 may include a model compliance pro-
19 gram.

20 “(II) DESIGN OF REGULA-
21 TIONS.—Such regulations with respect
22 to specific elements or formality of a
23 program may vary with the size of the
24 organization, such that larger organi-
25 zations should have a more formal

1 program and include established writ-
2 ten policies defining the standards
3 and procedures to be followed by its
4 employees. Such requirements shall
5 specifically apply to the corporate level
6 management of multi-unit nursing
7 home chains.

8 “(III) EVALUATION.—Not later
9 than 3 years after the date of promul-
10 gation of regulations under this
11 clause, the Secretary shall complete
12 an evaluation of the compliance and
13 ethics programs required to be estab-
14 lished under this subparagraph. Such
15 evaluation shall determine if such pro-
16 grams led to changes in deficiency ci-
17 tations, changes in quality perform-
18 ance, or changes in other metrics of
19 resident quality of care. The Secretary
20 shall submit to Congress a report on
21 such evaluation and shall include in
22 such report such recommendations re-
23 garding changes in the requirements
24 for such programs as the Secretary
25 determines appropriate.

1 “(iii) REQUIREMENTS FOR COMPLI-
2 ANCE AND ETHICS PROGRAMS.—In this
3 subparagraph, the term ‘compliance and
4 ethics program’ means, with respect to a
5 skilled nursing facility, a program of the
6 operating organization that—

7 “(I) has been reasonably de-
8 signed, implemented, and enforced so
9 that it generally will be effective in
10 preventing and detecting criminal,
11 civil, and administrative violations
12 under this Act and in promoting qual-
13 ity of care; and

14 “(II) includes at least the re-
15 quired components specified in clause
16 (iv).

17 “(iv) REQUIRED COMPONENTS OF
18 PROGRAM.—The required components of a
19 compliance and ethics program of an orga-
20 nization are the following:

21 “(I) The organization must have
22 established compliance standards and
23 procedures to be followed by its em-
24 ployees, contractors, and other agents
25 that are reasonably capable of reduc-

1 ing the prospect of criminal, civil, and
2 administrative violations under this
3 Act.

4 “(II) Specific individuals within
5 high-level personnel of the organiza-
6 tion must have been assigned overall
7 responsibility to oversee compliance
8 with such standards and procedures
9 and have sufficient resources and au-
10 thority to assure such compliance.

11 “(III) The organization must
12 have used due care not to delegate
13 substantial discretionary authority to
14 individuals whom the organization
15 knew, or should have known through
16 the exercise of due diligence, had a
17 propensity to engage in criminal, civil,
18 and administrative violations under
19 this Act.

20 “(IV) The organization must
21 have taken steps to communicate ef-
22 fectively its standards and procedures
23 to all employees and other agents,
24 such as by requiring participation in
25 training programs or by disseminating

1 publications that explain in a practical
2 manner what is required.

3 “(V) The organization must have
4 taken reasonable steps to achieve com-
5 pliance with its standards, such as by
6 utilizing monitoring and auditing sys-
7 tems reasonably designed to detect
8 criminal, civil, and administrative vio-
9 lations under this Act by its employ-
10 ees and other agents and by having in
11 place and publicizing a reporting sys-
12 tem whereby employees and other
13 agents could report violations by oth-
14 ers within the organization without
15 fear of retribution.

16 “(VI) The standards must have
17 been consistently enforced through ap-
18 propriate disciplinary mechanisms, in-
19 cluding, as appropriate, discipline of
20 individuals responsible for the failure
21 to detect an offense.

22 “(VII) After an offense has been
23 detected, the organization must have
24 taken all reasonable steps to respond
25 appropriately to the offense and to

1 prevent further similar offenses, in-
2 cluding any necessary modification to
3 its program to prevent and detect
4 criminal, civil, and administrative vio-
5 lations under this Act.

6 “(VIII) The organization must
7 periodically undertake reassessment of
8 its compliance program to identify
9 changes necessary to reflect changes
10 within the organization and its facili-
11 ties.”.

12 (2) NURSING FACILITIES.—Section 1919(d)(1)
13 of the Social Security Act (42 U.S.C. 1396r(d)(1))
14 is amended by adding at the end the following new
15 subparagraph:

16 “(D) COMPLIANCE AND ETHICS PRO-
17 GRAM.—

18 “(i) REQUIREMENT.—On or after the
19 date that is 36 months after the date of
20 the enactment of this subparagraph, a
21 nursing facility shall, with respect to the
22 entity that operates the facility (in this
23 subparagraph referred to as the ‘operating
24 organization’ or ‘organization’), have in op-
25 eration a compliance and ethics program

1 that is effective in preventing and detect-
2 ing criminal, civil, and administrative viola-
3 tions under this Act and in promoting
4 quality of care consistent with regulations
5 developed under clause (ii).

6 “(ii) DEVELOPMENT OF REGULA-
7 TIONS.—

8 “(I) IN GENERAL.—Not later
9 than the date that is 2 years after
10 such date of the enactment, the Sec-
11 retary, in consultation with the In-
12 spector General of the Department of
13 Health and Human Services, shall de-
14 velop regulations for an effective com-
15 pliance and ethics program for oper-
16 ating organizations, which may in-
17 clude a model compliance program.

18 “(II) DESIGN OF REGULA-
19 TIONS.—Such regulations with respect
20 to specific elements or formality of a
21 program may vary with the size of the
22 organization, such that larger organi-
23 zations should have a more formal
24 program and include established writ-
25 ten policies defining the standards

1 and procedures to be followed by its
2 employees. Such requirements may
3 specifically apply to the corporate level
4 management of multi-unit nursing
5 home chains.

6 “(III) EVALUATION.—Not later
7 than 3 years after the date of promul-
8 gation of regulations under this clause
9 the Secretary shall complete an eval-
10 uation of the compliance and ethics
11 programs required to be established
12 under this subparagraph. Such eval-
13 uation shall determine if such pro-
14 grams led to changes in deficiency ci-
15 tations, changes in quality perform-
16 ance, or changes in other metrics of
17 resident quality of care. The Secretary
18 shall submit to Congress a report on
19 such evaluation and shall include in
20 such report such recommendations re-
21 garding changes in the requirements
22 for such programs as the Secretary
23 determines appropriate.

24 “(iii) REQUIREMENTS FOR COMPLI-
25 ANCE AND ETHICS PROGRAMS.—In this

1 subparagraph, the term ‘compliance and
2 ethics program’ means, with respect to a
3 nursing facility, a program of the oper-
4 ating organization that—

5 “(I) has been reasonably de-
6 signed, implemented, and enforced so
7 that it generally will be effective in
8 preventing and detecting criminal,
9 civil, and administrative violations
10 under this Act and in promoting qual-
11 ity of care; and

12 “(II) includes at least the re-
13 quired components specified in clause
14 (iv).

15 “(iv) REQUIRED COMPONENTS OF
16 PROGRAM.—The required components of a
17 compliance and ethics program of an orga-
18 nization are the following:

19 “(I) The organization must have
20 established compliance standards and
21 procedures to be followed by its em-
22 ployees and other agents that are rea-
23 sonably capable of reducing the pros-
24 pect of criminal, civil, and administra-
25 tive violations under this Act.

1 “(II) Specific individuals within
2 high-level personnel of the organiza-
3 tion must have been assigned overall
4 responsibility to oversee compliance
5 with such standards and procedures
6 and has sufficient resources and au-
7 thority to assure such compliance.

8 “(III) The organization must
9 have used due care not to delegate
10 substantial discretionary authority to
11 individuals whom the organization
12 knew, or should have known through
13 the exercise of due diligence, had a
14 propensity to engage in criminal, civil,
15 and administrative violations under
16 this Act.

17 “(IV) The organization must
18 have taken steps to communicate ef-
19 fectively its standards and procedures
20 to all employees and other agents,
21 such as by requiring participation in
22 training programs or by disseminating
23 publications that explain in a practical
24 manner what is required.

1 “(V) The organization must have
2 taken reasonable steps to achieve com-
3 pliance with its standards, such as by
4 utilizing monitoring and auditing sys-
5 tems reasonably designed to detect
6 criminal, civil, and administrative vio-
7 lations under this Act by its employ-
8 ees and other agents and by having in
9 place and publicizing a reporting sys-
10 tem whereby employees and other
11 agents could report violations by oth-
12 ers within the organization without
13 fear of retribution.

14 “(VI) The standards must have
15 been consistently enforced through ap-
16 propriate disciplinary mechanisms, in-
17 cluding, as appropriate, discipline of
18 individuals responsible for the failure
19 to detect an offense.

20 “(VII) After an offense has been
21 detected, the organization must have
22 taken all reasonable steps to respond
23 appropriately to the offense and to
24 prevent further similar offenses, in-
25 cluding any necessary modification to

1 its program to prevent and detect
2 criminal, civil, and administrative vio-
3 lations under this Act.

4 “(VIII) The organization must
5 periodically undertake reassessment of
6 its compliance program to identify
7 changes necessary to reflect changes
8 within the organization and its facili-
9 ties.”.

10 (b) QUALITY ASSURANCE AND PERFORMANCE IM-
11 PROVEMENT PROGRAM.—

12 (1) SKILLED NURSING FACILITIES.—Section
13 1819(b)(1)(B) of the Social Security Act (42 U.S.C.
14 1396r(b)(1)(B)) is amended—

15 (A) by striking “ASSURANCE” and insert-
16 ing “ASSURANCE AND QUALITY ASSURANCE
17 AND PERFORMANCE IMPROVEMENT PROGRAM”;

18 (B) by designating the matter beginning
19 with “A nursing facility” as a clause (i) with
20 the heading “IN GENERAL.—” and the appro-
21 priate indentation; and

22 (C) by adding at the end the following new
23 clause:

24 “(ii) QUALITY ASSURANCE AND PER-
25 FORMANCE IMPROVEMENT PROGRAM.—

1 “(I) IN GENERAL.—Not later
2 than December 31, 2011, the Sec-
3 retary shall establish and implement a
4 quality assurance and performance
5 improvement program (in this clause
6 referred to as the ‘QAPI program’)
7 for skilled nursing facilities, including
8 multi-unit chains of such facilities.
9 Under the QAPI program, the Sec-
10 retary shall establish standards relat-
11 ing to such facilities and provide tech-
12 nical assistance to such facilities on
13 the development of best practices in
14 order to meet such standards. Not
15 later than 1 year after the date on
16 which the regulations are promulgated
17 under subclause (II), a skilled nursing
18 facility must submit to the Secretary
19 a plan for the facility to meet such
20 standards and implement such best
21 practices, including how to coordinate
22 the implementation of such plan with
23 quality assessment and assurance ac-
24 tivities conducted under clause (i).

1 “(II) REGULATIONS.—The Sec-
2 retary shall promulgate regulations to
3 carry out this clause.”.

4 (2) NURSING FACILITIES.—Section
5 1919(b)(1)(B) of the Social Security Act (42 U.S.C.
6 1396r(b)(1)(B)) is amended—

7 (A) by striking “ASSURANCE” and insert-
8 ing “ASSURANCE AND QUALITY ASSURANCE
9 AND PERFORMANCE IMPROVEMENT PROGRAM”;

10 (B) by designating the matter beginning
11 with “A nursing facility” as a clause (i) with
12 the heading “IN GENERAL.—” and the appro-
13 priate indentation; and

14 (C) by adding at the end the following new
15 clause:

16 “(ii) QUALITY ASSURANCE AND PER-
17 FORMANCE IMPROVEMENT PROGRAM.—

18 “(I) IN GENERAL.—Not later
19 than December 31, 2011, the Sec-
20 retary shall establish and implement a
21 quality assurance and performance
22 improvement program (in this clause
23 referred to as the ‘QAPI program’) for
24 nursing facilities, including multi-
25 unit chains of such facilities. Under

1 the QAPI program, the Secretary
2 shall establish standards relating to
3 such facilities and provide technical
4 assistance to such facilities on the de-
5 velopment of best practices in order to
6 meet such standards. Not later than 1
7 year after the date on which the regu-
8 lations are promulgated under sub-
9 clause (II), a nursing facility must
10 submit to the Secretary a plan for the
11 facility to meet such standards and
12 implement such best practices, includ-
13 ing how to coordinate the implementa-
14 tion of such plan with quality assess-
15 ment and assurance activities con-
16 ducted under clause (i).

17 “(II) REGULATIONS.—The Sec-
18 retary shall promulgate regulations to
19 carry out this clause.”.

20 (3) PROPOSAL TO REVISE QUALITY ASSURANCE
21 AND PERFORMANCE IMPROVEMENT PROGRAMS.—
22 The Secretary shall include in the proposed rule
23 published under section 1888(e) of the Social Secu-
24 rity Act (42 U.S.C. 1395yy(e)(5)(A)) for the subse-
25 quent fiscal year to the extent otherwise authorized

1 under section 1819(b)(1)(B) or 1819(d)(1)(D) of
2 the Social Security Act or other statutory or regu-
3 latory authority, one or more proposals for skilled
4 nursing facilities to modify and strengthen quality
5 assurance and performance improvement programs
6 in such facilities. At the time of publication of such
7 proposed rule and to the extent otherwise authorized
8 under section 1919(b)(1)(B) or 1919(d)(1)(D) of
9 such Act or other regulatory authority.

10 (4) FACILITY PLAN.—Not later than 1 year
11 after the date on which the regulations are promul-
12 gated under subclause (II) of clause (ii) of sections
13 1819(b)(1)(B) and 1919(b)(1)(B) of the Social Se-
14 curity Act, as added by paragraphs (1) and (2), a
15 skilled nursing facility and a nursing facility must
16 submit to the Secretary a plan for the facility to
17 meet the standards under such regulations and im-
18 plement such best practices, including how to coordi-
19 nate the implementation of such plan with quality
20 assessment and assurance activities conducted under
21 clause (i) of such sections.

22 (c) GAO STUDY ON NURSING FACILITY UNDER-
23 CAPITALIZATION.—

1 (1) IN GENERAL.—The Comptroller General of
2 the United States shall conduct a study that exam-
3 ines the following:

4 (A) The extent to which corporations that
5 own or operate large numbers of nursing facili-
6 ties, taking into account ownership type (includ-
7 ing private equity and control interests), are
8 undercapitalizing such facilities.

9 (B) The effects of such undercapitalization
10 on quality of care, including staffing and food
11 costs, at such facilities.

12 (C) Options to address such undercapital-
13 ization, such as requirements relating to surety
14 bonds, liability insurance, or minimum capital-
15 ization.

16 (2) REPORT.—Not later than 18 months after
17 the date of the enactment of this Act, the Comp-
18 troller General shall submit to Congress a report on
19 the study conducted under paragraph (1).

20 (3) NURSING FACILITY.—In this subsection, the
21 term “nursing facility” includes a skilled nursing fa-
22 cility.

23 **SEC. 1413. NURSING HOME COMPARE MEDICARE WEBSITE.**

24 (a) SKILLED NURSING FACILITIES.—

1 (1) IN GENERAL.—Section 1819 of the Social
2 Security Act (42 U.S.C. 1395i–3) is amended—

3 (A) by redesignating subsection (i) as sub-
4 section (j); and

5 (B) by inserting after subsection (h) the
6 following new subsection:

7 “(i) NURSING HOME COMPARE WEBSITE.—

8 “(1) INCLUSION OF ADDITIONAL INFORMA-
9 TION.—

10 “(A) IN GENERAL.—The Secretary shall
11 ensure that the Department of Health and
12 Human Services includes, as part of the infor-
13 mation provided for comparison of nursing
14 homes on the official Internet website of the
15 Federal Government for Medicare beneficiaries
16 (commonly referred to as the ‘Nursing Home
17 Compare’ Medicare website) (or a successor
18 website), the following information in a manner
19 that is prominent, easily accessible, readily un-
20 derstandable to consumers of long-term care
21 services, and searchable:

22 “(i) Information that is reported to
23 the Secretary under section 1124(c)(3).

24 “(ii) Information on the ‘Special
25 Focus Facility program’ (or a successor

1 program) established by the Centers for
2 Medicare and Medicaid Services, according
3 to procedures established by the Secretary.
4 Such procedures shall provide for the in-
5 clusion of information with respect to, and
6 the names and locations of, those facilities
7 that, since the previous quarter—

8 “(I) were newly enrolled in the
9 program;

10 “(II) are enrolled in the program
11 and have failed to significantly im-
12 prove;

13 “(III) are enrolled in the pro-
14 gram and have significantly improved;

15 “(IV) have graduated from the
16 program; and

17 “(V) have closed voluntarily or
18 no longer participate under this title.

19 “(iii) Staffing data for each facility
20 (including resident census data and data
21 on the hours of care provided per resident
22 per day) based on data submitted under
23 subsection (b)(8)(C), including information
24 on staffing turnover and tenure, in a for-
25 mat that is clearly understandable to con-

1 consumers of long-term care services and al-
2 lows such consumers to compare dif-
3 ferences in staffing between facilities and
4 State and national averages for the facili-
5 ties. Such format shall include—

6 “(I) concise explanations of how
7 to interpret the data (such as a plain
8 English explanation of data reflecting
9 ‘nursing home staff hours per resident
10 day’);

11 “(II) differences in types of staff
12 (such as training associated with dif-
13 ferent categories of staff);

14 “(III) the relationship between
15 nurse staffing levels and quality of
16 care; and

17 “(IV) an explanation that appro-
18 priate staffing levels vary based on
19 patient case mix

20 “(iv) Links to State Internet websites
21 with information regarding State survey
22 and certification programs, links to Form
23 2567 State inspection reports (or a suc-
24 cessor form) on such websites, information
25 to guide consumers in how to interpret and

1 understand such reports, and the facility
2 plan of correction or other response to
3 such report.

4 “(v) The standardized complaint form
5 developed under subsection (f)(8), includ-
6 ing explanatory material on what com-
7 plaint forms are, how they are used, and
8 how to file a complaint with the State sur-
9 vey and certification program and the
10 State long-term care ombudsman program.

11 “(vi) Summary information on the
12 number, type, severity, and outcome of
13 complaints.

14 “(vii) The number of adjudicated in-
15 stances of criminal violations by a nursing
16 facility—

17 “(I) that were committed inside
18 the facility;

19 “(II) with respect to such in-
20 stances of violations or crimes com-
21 mitted inside of the facility that were
22 the violations or crimes of abuse, ne-
23 glect, and exploitation, criminal sexual
24 abuse, or other violations or crimes

1 that resulted in serious bodily injury;
2 and

3 “(III) the number of civil mone-
4 tary penalties levied against the facil-
5 ity, employees, contractors, and other
6 agents.

7 “(B) DEADLINE FOR PROVISION OF INFOR-
8 MATION.—

9 “(i) IN GENERAL.—Except as pro-
10 vided in clause (ii), the Secretary shall en-
11 sure that the information described in sub-
12 paragraph (A) is included on such website
13 (or a successor website) not later than 1
14 year after the date of the enactment of this
15 subsection.

16 “(ii) EXCEPTION.—The Secretary
17 shall ensure that the information described
18 in subparagraph (A)(i) is included on such
19 website (or a successor website) not later
20 than the date on which the requirement
21 under subsection (b)(8)(C)(ii) is imple-
22 mented.

23 “(2) REVIEW AND MODIFICATION OF
24 WEBSITE.—

1 “(A) IN GENERAL.—The Secretary shall
2 establish a process—

3 “(i) to review the accuracy, clarity of
4 presentation, timeliness, and comprehen-
5 siveness of information reported on such
6 website as of the day before the date of the
7 enactment of this subsection; and

8 “(ii) not later than 1 year after the
9 date of the enactment of this subsection, to
10 modify or revamp such website in accord-
11 ance with the review conducted under
12 clause (i).

13 “(B) CONSULTATION.—In conducting the
14 review under subparagraph (A)(i), the Sec-
15 retary shall consult with—

16 “(i) State long-term care ombudsman
17 programs;

18 “(ii) consumer advocacy groups;

19 “(iii) provider stakeholder groups; and

20 “(iv) any other representatives of pro-
21 grams or groups the Secretary determines
22 appropriate.”.

23 (2) TIMELINESS OF SUBMISSION OF SURVEY
24 AND CERTIFICATION INFORMATION.—

1 (A) IN GENERAL.—Section 1819(g)(5) of
2 the Social Security Act (42 U.S.C. 1395i–
3 3(g)(5)) is amended by adding at the end the
4 following new subparagraph:

5 “(E) SUBMISSION OF SURVEY AND CER-
6 TIFICATION INFORMATION TO THE SEC-
7 RETARY.—In order to improve the timeliness of
8 information made available to the public under
9 subparagraph (A) and provided on the Nursing
10 Home Compare Medicare website under sub-
11 section (i), each State shall submit information
12 respecting any survey or certification made re-
13 specting a skilled nursing facility (including any
14 enforcement actions taken by the State) to the
15 Secretary not later than the date on which the
16 State sends such information to the facility.
17 The Secretary shall use the information sub-
18 mitted under the preceding sentence to update
19 the information provided on the Nursing Home
20 Compare Medicare website as expeditiously as
21 practicable but not less frequently than quar-
22 terly.”.

23 (B) EFFECTIVE DATE.—The amendment
24 made by this paragraph shall take effect 1 year
25 after the date of the enactment of this Act.

1 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
2 tion 1819(f) of such Act is amended by adding at
3 the end the following new paragraph:

4 “(8) SPECIAL FOCUS FACILITY PROGRAM.—

5 “(A) IN GENERAL.—The Secretary shall
6 conduct a special focus facility program for en-
7 forcement of requirements for skilled nursing
8 facilities that the Secretary has identified as
9 having substantially failed to meet applicable
10 requirement of this Act.

11 “(B) PERIODIC SURVEYS.—Under such
12 program the Secretary shall conduct surveys of
13 each facility in the program not less than once
14 every 6 months.”.

15 (b) NURSING FACILITIES.—

16 (1) IN GENERAL.—Section 1919 of the Social
17 Security Act (42 U.S.C. 1396r) is amended—

18 (A) by redesignating subsection (i) as sub-
19 section (j); and

20 (B) by inserting after subsection (h) the
21 following new subsection:

22 “(i) NURSING HOME COMPARE WEBSITE.—

23 “(1) INCLUSION OF ADDITIONAL INFORMA-
24 TION.—

1 “(A) IN GENERAL.—The Secretary shall
2 ensure that the Department of Health and
3 Human Services includes, as part of the infor-
4 mation provided for comparison of nursing
5 homes on the official Internet website of the
6 Federal Government for Medicare beneficiaries
7 (commonly referred to as the ‘Nursing Home
8 Compare’ Medicare website) (or a successor
9 website), the following information in a manner
10 that is prominent, easily accessible, readily un-
11 derstandable to consumers of long-term care
12 services, and searchable:

13 “(i) Staffing data for each facility (in-
14 cluding resident census data and data on
15 the hours of care provided per resident per
16 day) based on data submitted under sub-
17 section (b)(8)(C)(ii), including information
18 on staffing turnover and tenure, in a for-
19 mat that is clearly understandable to con-
20 sumers of long-term care services and al-
21 lows such consumers to compare dif-
22 ferences in staffing between facilities and
23 State and national averages for the facili-
24 ties. Such format shall include—

1 “(I) concise explanations of how
2 to interpret the data (such as plain
3 English explanation of data reflecting
4 ‘nursing home staff hours per resident
5 day’);

6 “(II) differences in types of staff
7 (such as training associated with dif-
8 ferent categories of staff);

9 “(III) the relationship between
10 nurse staffing levels and quality of
11 care; and

12 “(IV) an explanation that appro-
13 priate staffing levels vary based on
14 patient case mix.

15 “(ii) Links to State Internet websites
16 with information regarding State survey
17 and certification programs, links to Form
18 2567 State inspection reports (or a suc-
19 cessor form) on such websites, information
20 to guide consumers in how to interpret and
21 understand such reports, and the facility
22 plan of correction or other response to
23 such report.

24 “(iii) The standardized complaint
25 form developed under subsection (f)(10),

1 including explanatory material on what
2 complaint forms are, how they are used,
3 and how to file a complaint with the State
4 survey and certification program and the
5 State long-term care ombudsman program.

6 “(iv) The number of adjudicated in-
7 stances of criminal violations by a nursing
8 facility or crimes committed by an em-
9 ployee of a nursing facility—

10 “(I) that were committed inside
11 of the facility; and

12 “(II) with respect to such in-
13 stances of violations or crimes com-
14 mitted outside of the facility, that
15 were the violations or crimes that re-
16 sulted in the serious bodily injury of
17 an elder.

18 “(B) DEADLINE FOR PROVISION OF INFOR-
19 MATION.—

20 “(i) IN GENERAL.—Except as pro-
21 vided in clause (ii), the Secretary shall en-
22 sure that the information described in sub-
23 paragraph (A) is included on such website
24 (or a successor website) not later than 1

1 year after the date of the enactment of this
2 subsection.

3 “(ii) EXCEPTION.—The Secretary
4 shall ensure that the information described
5 in subparagraph (A)(i) is included on such
6 website (or a successor website) not later
7 than the date on which the requirement
8 under subsection (b)(8)(C)(ii) is imple-
9 mented.

10 “(2) REVIEW AND MODIFICATION OF
11 WEBSITE.—

12 “(A) IN GENERAL.—The Secretary shall
13 establish a process—

14 “(i) to review the accuracy, clarity of
15 presentation, timeliness, and comprehen-
16 siveness of information reported on such
17 website as of the day before the date of the
18 enactment of this subsection; and

19 “(ii) not later than 1 year after the
20 date of the enactment of this subsection, to
21 modify or revamp such website in accord-
22 ance with the review conducted under
23 clause (i).

1 “(B) CONSULTATION.—In conducting the
2 review under subparagraph (A)(i), the Sec-
3 retary shall consult with—

4 “(i) State long-term care ombudsman
5 programs;

6 “(ii) consumer advocacy groups;

7 “(iii) provider stakeholder groups;

8 “(iv) skilled nursing facility employees
9 and their representatives; and

10 “(v) any other representatives of pro-
11 grams or groups the Secretary determines
12 appropriate.”.

13 (2) TIMELINESS OF SUBMISSION OF SURVEY
14 AND CERTIFICATION INFORMATION.—

15 (A) IN GENERAL.—Section 1919(g)(5) of
16 the Social Security Act (42 U.S.C. 1396r(g)(5))
17 is amended by adding at the end the following
18 new subparagraph:

19 “(E) SUBMISSION OF SURVEY AND CER-
20 TIFICATION INFORMATION TO THE SEC-
21 RETARY.—In order to improve the timeliness of
22 information made available to the public under
23 subparagraph (A) and provided on the Nursing
24 Home Compare Medicare website under sub-
25 section (i), each State shall submit information

1 respecting any survey or certification made re-
2 specting a nursing facility (including any en-
3 forcement actions taken by the State) to the
4 Secretary not later than the date on which the
5 State sends such information to the facility.
6 The Secretary shall use the information sub-
7 mitted under the preceding sentence to update
8 the information provided on the Nursing Home
9 Compare Medicare website as expeditiously as
10 practicable but not less frequently than quar-
11 terly.”.

12 (B) EFFECTIVE DATE.—The amendment
13 made by this paragraph shall take effect 1 year
14 after the date of the enactment of this Act.

15 (3) SPECIAL FOCUS FACILITY PROGRAM.—Sec-
16 tion 1919(f) of such Act is amended by adding at
17 the end of the following new paragraph:

18 “(8) SPECIAL FOCUS FACILITY PROGRAM.—

19 “(A) IN GENERAL.—The secretary shall
20 conduct a special focus facility program for en-
21 forcement of requirements for nursing facilities
22 that the Secretary has identified as having sub-
23 stantially failed to meet applicable requirements
24 of this Act.

1 “(B) PERIODIC SURVEYS.—Under such
2 program the Secretary shall conduct surveys of
3 each facility in the program not less often than
4 once every 6 months.”.

5 (c) AVAILABILITY OF REPORTS ON SURVEYS, CER-
6 TIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

7 (1) SKILLED NURSING FACILITIES.—Section
8 1819(d)(1) of the Social Security Act (42 U.S.C.
9 1395i–3(d)(1)), as amended by section 1412, is
10 amended by adding at the end the following new
11 subparagraph:

12 “(E) AVAILABILITY OF SURVEY, CERTIFI-
13 CATION, AND COMPLAINT INVESTIGATION RE-
14 PORTS.—A skilled nursing facility must—

15 “(i) have reports with respect to any
16 surveys, certifications, and complaint in-
17 vestigations made respecting the facility
18 during the 3 preceding years available for
19 any individual to review upon request; and

20 “(ii) post notice of the availability of
21 such reports in areas of the facility that
22 are prominent and accessible to the public.

23 The facility shall not make available under
24 clause (i) identifying information about com-
25 plainants or residents.”.

1 (2) NURSING FACILITIES.—Section 1919(d)(1)
2 of the Social Security Act (42 U.S.C. 1396r(d)(1)),
3 as amended by section 1412, is amended by adding
4 at the end the following new subparagraph:

5 “(E) AVAILABILITY OF SURVEY, CERTIFI-
6 CATION, AND COMPLAINT INVESTIGATION RE-
7 PORTS.—A nursing facility must—

8 “(i) have reports with respect to any
9 surveys, certifications, and complaint in-
10 vestigations made respecting the facility
11 during the 3 preceding years available for
12 any individual to review upon request; and

13 “(ii) post notice of the availability of
14 such reports in areas of the facility that
15 are prominent and accessible to the public.

16 The facility shall not make available under
17 clause (i) identifying information about com-
18 plainants or residents.”.

19 (3) EFFECTIVE DATE.—The amendments made
20 by this subsection shall take effect 1 year after the
21 date of the enactment of this Act.

22 (d) GUIDANCE TO STATES ON FORM 2567 STATE IN-
23 SPECTION REPORTS AND COMPLAINT INVESTIGATION RE-
24 PORTS.—

1 (1) GUIDANCE.—The Secretary of Health and
2 Human Services (in this subtitle referred to as the
3 “Secretary”) shall provide guidance to States on
4 how States can establish electronic links to Form
5 2567 State inspection reports (or a successor form),
6 complaint investigation reports, and a facility’s plan
7 of correction or other response to such Form 2567
8 State inspection reports (or a successor form) on the
9 Internet website of the State that provides informa-
10 tion on skilled nursing facilities and nursing facili-
11 ties and the Secretary shall, if possible, include such
12 information on Nursing Home Compare.

13 (2) REQUIREMENT.—As a condition of contract
14 with a State under section 1864(d) of the Social Se-
15 curity Act, effective not later than 2 years after the
16 date of the enactment of this Act, the Secretary of
17 Health and Human Services shall require that a
18 State have, on the State’s Internet website referred
19 to in paragraph (1), the electronic links referred to
20 in such paragraph.

21 (3) DEFINITIONS.—In this subsection:

22 (A) NURSING FACILITY.—The term “nurs-
23 ing facility” has the meaning given such term
24 in section 1919(a) of the Social Security Act
25 (42 U.S.C. 1396r(a)).

1 (B) SECRETARY.—The term “Secretary”
2 means the Secretary of Health and Human
3 Services.

4 (C) SKILLED NURSING FACILITY.—The
5 term “skilled nursing facility” has the meaning
6 given such term in section 1819(a) of the Social
7 Security Act (42 U.S.C. 1395i–3(a)).

8 **SEC. 1414. REPORTING OF EXPENDITURES.**

9 Section 1888 of the Social Security Act (42 U.S.C.
10 1395yy) is amended by adding at the end the following
11 new subsection:

12 “(f) REPORTING OF DIRECT CARE EXPENDI-
13 TURES.—

14 “(1) IN GENERAL.—For cost reports submitted
15 under this title for cost reporting periods beginning
16 on or after the date that is 2 years after the date
17 of the enactment of this subsection, skilled nursing
18 facilities shall separately report expenditures for
19 wages and benefits for direct care staff (breaking
20 out (at a minimum) registered nurses, licensed pro-
21 fessional nurses, certified nurse assistants, and other
22 medical and therapy staff).

23 “(2) MODIFICATION OF FORM.—The Secretary,
24 in consultation with private sector accountants expe-
25 rienced with medicare and medicaid nursing facility

1 home cost reports, shall redesign such reports to
2 meet the requirement of paragraph (1) not later
3 than 1 year after the date of the enactment of this
4 subsection.

5 “(3) CATEGORIZATION BY FUNCTIONAL AC-
6 COUNTS.—Not later than 30 months after the date
7 of the enactment of this subsection, the Secretary,
8 working in consultation with the Medicare Payment
9 Advisory Commission, the Inspector General of the
10 Department of Health and Human Services, and
11 other expert parties the Secretary determines appro-
12 priate, shall take the expenditures listed on cost re-
13 ports, as modified under paragraph (1), submitted
14 by skilled nursing facilities and categorize such ex-
15 penditures, regardless of any source of payment for
16 such expenditures, for each skilled nursing facility
17 into the following functional accounts on an annual
18 basis:

19 “(A) Spending on direct care services (in-
20 cluding nursing, therapy, and medical services).

21 “(B) Spending on indirect care (including
22 housekeeping and dietary services).

23 “(C) Capital assets (including building and
24 land costs).

25 “(D) Administrative services costs.

1 “(4) AVAILABILITY OF INFORMATION SUB-
2 MITTED.—The Secretary shall establish procedures
3 to make information on expenditures submitted
4 under this subsection readily available to interested
5 parties upon request, subject to such requirements
6 as the Secretary may specify under the procedures
7 established under this paragraph.”.

8 **SEC. 1415. STANDARDIZED COMPLAINT FORM.**

9 (a) SKILLED NURSING FACILITIES.—

10 (1) DEVELOPMENT BY THE SECRETARY.—Sec-
11 tion 1819(f) of the Social Security Act (42 U.S.C.
12 1395i–3(f)), as amended by section 1413(a)(3), is
13 amended by adding at the end the following new
14 paragraph:

15 “(9) STANDARDIZED COMPLAINT FORM.—The
16 Secretary shall develop a standardized complaint
17 form for use by a resident (or a person acting on the
18 resident’s behalf) in filing a complaint with a State
19 survey and certification agency and a State long-
20 term care ombudsman program with respect to a
21 skilled nursing facility.”.

22 (2) STATE REQUIREMENTS.—Section 1819(e)
23 of the Social Security Act (42 U.S.C. 1395i–3(e)) is
24 amended by adding at the end the following new
25 paragraph:

1 “(6) COMPLAINT PROCESSES AND WHISTLE-
2 BLOWER PROTECTION.—

3 “(A) COMPLAINT FORMS.—The State must
4 make the standardized complaint form devel-
5 oped under subsection (f)(9) available upon re-
6 quest to—

7 “(i) a resident of a skilled nursing fa-
8 cility;

9 “(ii) any person acting on the resi-
10 dent’s behalf; and

11 “(iii) any person who works at a
12 skilled nursing facility or is a representa-
13 tive of such a worker.

14 “(B) COMPLAINT RESOLUTION PROCESS.—

15 The State must establish a complaint resolution
16 process in order to ensure that a resident, the
17 legal representative of a resident of a skilled
18 nursing facility, or other responsible party is
19 not retaliated against if the resident, legal rep-
20 resentative, or responsible party has com-
21 plained, in good faith, about the quality of care
22 or other issues relating to the skilled nursing
23 facility, that the legal representative of a resi-
24 dent of a skilled nursing facility or other re-
25 sponsible party is not denied access to such

1 resident or otherwise retaliated against if such
2 representative party has complained, in good
3 faith, about the quality of care provided by the
4 facility or other issues relating to the facility,
5 and that a person who works at a skilled nurs-
6 ing facility is not retaliated against if the work-
7 er has complained, in good faith, about quality
8 of care or services or an issue relating to the
9 quality of care or services provided at the facil-
10 ity, whether the resident, legal representative,
11 other responsible party, or worker used the
12 form developed under subsection (f)(9) or some
13 other method for submitting the complaint.
14 Such complaint resolution process shall in-
15 clude—

16 “(i) procedures to assure accurate
17 tracking of complaints received, including
18 notification to the complainant that a com-
19 plaint has been received;

20 “(ii) procedures to determine the like-
21 ly severity of a complaint and for the in-
22 vestigation of the complaint;

23 “(iii) deadlines for responding to a
24 complaint and for notifying the complain-

1 ant of the outcome of the investigation;
2 and

3 “(iv) procedures to ensure that the
4 identity of the complainant will be kept
5 confidential.

6 “(C) WHISTLEBLOWER PROTECTION.—

7 “(i) PROHIBITION AGAINST RETALIA-
8 TION.—No person who works at a skilled
9 nursing facility may be penalized, discrimi-
10 nated, or retaliated against with respect to
11 any aspect of employment, including dis-
12 charge, promotion, compensation, terms,
13 conditions, or privileges of employment, or
14 have a contract for services terminated, be-
15 cause the person (or anyone acting at the
16 person’s request) complained, in good
17 faith, about the quality of care or services
18 provided by a nursing facility or about
19 other issues relating to quality of care or
20 services, whether using the form developed
21 under subsection (f)(9) or some other
22 method for submitting the complaint.

23 “(ii) RETALIATORY REPORTING.—A
24 skilled nursing facility may not file a com-
25 plaint or a report against a person who

1 works (or has worked at the facility with
2 the appropriate State professional discipli-
3 nary agency because the person (or anyone
4 acting at the person's request) complained
5 in good faith, as described in clause (i).

6 “(iii) COMMENCEMENT OF ACTION.—
7 Any person who believes the person has
8 been penalized, discriminated , or retali-
9 ated against or had a contract for services
10 terminated in violation of clause (i) or
11 against whom a complaint has been filed in
12 violation of clause (ii) may bring an action
13 at law or equity in the appropriate district
14 court of the United States, which shall
15 have jurisdiction over such action without
16 regard to the amount in controversy or the
17 citizenship of the parties, and which shall
18 have jurisdiction to grant complete relief,
19 including, but not limited to, injunctive re-
20 lief (such as reinstatement, compensatory
21 damages (which may include reimburse-
22 ment of lost wages, compensation, and
23 benefits), costs of litigation (including rea-
24 sonable attorney and expert witness fees),
25 exemplary damages where appropriate, and

1 such other relief as the court deems just
2 and proper.

3 “(iv) RIGHTS NOT WAIVABLE.—The
4 rights protected by this paragraph may not
5 be diminished by contract or other agree-
6 ment, and nothing in this paragraph shall
7 be construed to diminish any greater or
8 additional protection provided by Federal
9 or State law or by contract or other agree-
10 ment.

11 “(v) REQUIREMENT TO POST NOTICE
12 OF EMPLOYEE RIGHTS.—Each skilled
13 nursing facility shall post conspicuously in
14 an appropriate location a sign (in a form
15 specified by the Secretary) specifying the
16 rights of persons under this paragraph and
17 including a statement that an employee
18 may file a complaint with the Secretary
19 against a skilled nursing facility that vio-
20 lates the provisions of this paragraph and
21 information with respect to the manner of
22 filing such a complaint.

23 “(D) RULE OF CONSTRUCTION.—Nothing
24 in this paragraph shall be construed as pre-
25 venting a resident of a skilled nursing facility

1 (or a person acting on the resident's behalf)
2 from submitting a complaint in a manner or
3 format other than by using the standardized
4 complaint form developed under subsection
5 (f)(9) (including submitting a complaint orally).

6 “(E) GOOD FAITH DEFINED.—For pur-
7 poses of this paragraph, an individual shall be
8 deemed to be acting in good faith with respect
9 to the filing of a complaint if the individual rea-
10 sonably believes—

11 “(i) the information reported or dis-
12 closed in the complaint is true; and

13 “(ii) the violation of this title has oc-
14 curred or may occur in relation to such in-
15 formation”.

16 (b) NURSING FACILITIES.—

17 (1) DEVELOPMENT BY THE SECRETARY.—Sec-
18 tion 1919(f) of the Social Security Act (42 U.S.C.
19 1395i–3(f)) is amended by adding at the end the fol-
20 lowing new paragraph:

21 “(10) STANDARDIZED COMPLAINT FORM.—The
22 Secretary shall develop a standardized complaint
23 form for use by a resident (or a person acting on the
24 resident's behalf) in filing a complaint with a State
25 survey and certification agency and a State long-

1 term care ombudsman program with respect to a
2 nursing facility.”.

3 (2) STATE REQUIREMENTS.—Section 1919(e)
4 of the Social Security Act (42 U.S.C. 1395i–3(e)) is
5 amended by adding at the end the following new
6 paragraph:

7 “(8) COMPLAINT PROCESSES AND WHISTLE-
8 BLOWER PROTECTION.—

9 “(A) COMPLAINT FORMS.—The State must
10 make the standardized complaint form devel-
11 oped under subsection (f)(10) available upon re-
12 quest to—

13 “(i) a resident of a nursing facility;

14 “(ii) any person acting on the resi-
15 dent’s behalf; and

16 “(iii) any person who works at a nurs-
17 ing facility or a representative of such a
18 worker.

19 “(B) COMPLAINT RESOLUTION PROCESS.—
20 The State must establish a complaint resolution
21 process in order to ensure that a resident, the
22 legal representative of a resident of a nursing
23 facility, or other responsible party is not retali-
24 ated against if the resident, legal representa-
25 tive, or responsible party has complained, in

1 good faith, about the quality of care or other
2 issues relating to the nursing facility, that the
3 legal representative of a resident of a nursing
4 facility or other responsible party is not denied
5 access to such resident or otherwise retaliated
6 against if such representative party has com-
7 plained, in good faith, about the quality of care
8 provided by the facility or other issues relating
9 to the facility, and that a person who works at
10 a nursing facility is not retaliated against if the
11 worker has complained, in good faith, about
12 quality of care or services or an issue relating
13 to the quality of care or services provided at the
14 facility, whether the resident, legal representa-
15 tive, other responsible party, or worker used the
16 form developed under subsection (f)(10) or
17 some other method for submitting the com-
18 plaint. Such complaint resolution process shall
19 include—

20 “(i) procedures to assure accurate
21 tracking of complaints received, including
22 notification to the complainant that a com-
23 plaint has been received;

1 “(ii) procedures to determine the like-
2 ly severity of a complaint and for the in-
3 vestigation of the complaint;

4 “(iii) deadlines for responding to a
5 complaint and for notifying the complain-
6 ant of the outcome of the investigation;
7 and

8 “(iv) procedures to ensure that the
9 identity of the complainant will be kept
10 confidential.

11 “(C) WHISTLEBLOWER PROTECTION.—

12 “(i) PROHIBITION AGAINST RETALIA-
13 TION.—No person who works at a nursing
14 facility may be penalized, discriminated, or
15 retaliated against with respect to any as-
16 pect of employment, including discharge,
17 promotion, compensation, terms, condi-
18 tions, or privileges of employment, or have
19 a contract for services terminated, because
20 the person (or anyone acting at the per-
21 son’s request) complained, in good faith,
22 about the quality of care or services pro-
23 vided by a nursing facility or about other
24 issues relating to quality of care or serv-
25 ices, whether using the form developed

1 under subsection (f)(10) or some other
2 method for submitting the complaint.

3 “(ii) RETALIATORY REPORTING.—A
4 nursing facility may not file a complaint or
5 a report against a person who works (or
6 has worked at the facility with the appro-
7 priate State professional disciplinary agen-
8 cy because the person (or anyone acting at
9 the person’s request) complained in good
10 faith, as described in clause (i).

11 “(iii) COMMENCEMENT OF ACTION.—
12 Any person who believes the person has
13 been penalized, discriminated, or retaliated
14 against or had a contract for services ter-
15 minated in violation of clause (i) or against
16 whom a complaint has been filed in viola-
17 tion of clause (ii) may bring an action at
18 law or equity in the appropriate district
19 court of the United States, which shall
20 have jurisdiction over such action without
21 regard to the amount in controversy or the
22 citizenship of the parties, and which shall
23 have jurisdiction to grant complete relief,
24 including, but not limited to, injunctive re-
25 lief (such as reinstatement, compensatory

1 damages (which may include reimburse-
2 ment of lost wages, compensation, and
3 benefits), costs of litigation (including rea-
4 sonable attorney and expert witness fees),
5 exemplary damages where appropriate, and
6 such other relief as the court deems just
7 and proper.

8 “(iv) RIGHTS NOT WAIVABLE.—The
9 rights protected by this paragraph may not
10 be diminished by contract or other agree-
11 ment, and nothing in this paragraph shall
12 be construed to diminish any greater or
13 additional protection provided by Federal
14 or State law or by contract or other agree-
15 ment.

16 “(v) REQUIREMENT TO POST NOTICE
17 OF EMPLOYEE RIGHTS.—Each nursing fa-
18 cility shall post conspicuously in an appro-
19 priate location a sign (in a form specified
20 by the Secretary) specifying the rights of
21 persons under this paragraph and includ-
22 ing a statement that an employee may file
23 a complaint with the Secretary against a
24 nursing facility that violates the provisions
25 of this paragraph and information with re-

1 spect to the manner of filing such a com-
2 plaint.

3 “(D) RULE OF CONSTRUCTION.—Nothing
4 in this paragraph shall be construed as pre-
5 venting a resident of a nursing facility (or a
6 person acting on the resident’s behalf) from
7 submitting a complaint in a manner or format
8 other than by using the standardized complaint
9 form developed under subsection (f)(10) (in-
10 cluding submitting a complaint orally).

11 “(E) GOOD FAITH DEFINED.—For pur-
12 poses of this paragraph, an individual shall be
13 deemed to be acting in good faith with respect
14 to the filing of a complaint if the individual rea-
15 sonably believes—

16 “(i) the information reported or dis-
17 closed in the complaint is true; and

18 “(ii) the violation of this title has oc-
19 curred or may occur in relation to such in-
20 formation.”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect 1 year after the date of the
23 enactment of this Act.

1 **SEC. 1416. ENSURING STAFFING ACCOUNTABILITY.**

2 (a) SKILLED NURSING FACILITIES.—Section
3 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–
4 3(b)(8)) is amended by adding at the end the following
5 new subparagraph:

6 “(C) SUBMISSION OF STAFFING INFORMA-
7 TION BASED ON PAYROLL DATA IN A UNIFORM
8 FORMAT.—Beginning not later than 2 years
9 after the date of the enactment of this subpara-
10 graph, and after consulting with State long-
11 term care ombudsman programs, consumer ad-
12 vocacy groups, provider stakeholder groups, em-
13 ployees and their representatives, and other
14 parties the Secretary deems appropriate, the
15 Secretary shall require a skilled nursing facility
16 to electronically submit to the Secretary direct
17 care staffing information (including information
18 with respect to agency and contract staff) based
19 on payroll and other verifiable and auditable
20 data in a uniform format (according to speci-
21 fications established by the Secretary in con-
22 sultation with such programs, groups, and par-
23 ties). Such specifications shall require that the
24 information submitted under the preceding sen-
25 tence—

1 “(i) specify the category of work a
2 certified employee performs (such as
3 whether the employee is a registered nurse,
4 licensed practical nurse, licensed vocational
5 nurse, certified nursing assistant, thera-
6 pist, or other medical personnel);

7 “(ii) include resident census data and
8 information on resident case mix;

9 “(iii) include a regular reporting
10 schedule; and

11 “(iv) include information on employee
12 turnover and tenure and on the hours of
13 care provided by each category of certified
14 employees referenced in clause (i) per resi-
15 dent per day.

16 Nothing in this subparagraph shall be con-
17 strued as preventing the Secretary from requir-
18 ing submission of such information with respect
19 to specific categories, such as nursing staff, be-
20 fore other categories of certified employees. In-
21 formation under this subparagraph with respect
22 to agency and contract staff shall be kept sepa-
23 rate from information on employee staffing.”.

1 (b) NURSING FACILITIES.—Section 1919(b)(8) of the
2 Social Security Act (42 U.S.C. 1396r(b)(8)) is amended
3 by adding at the end the following new subparagraph:

4 “(C) SUBMISSION OF STAFFING INFORMA-
5 TION BASED ON PAYROLL DATA IN A UNIFORM
6 FORMAT.—Beginning not later than 2 years
7 after the date of the enactment of this subpara-
8 graph, and after consulting with State long-
9 term care ombudsman programs, consumer ad-
10 vocacy groups, provider stakeholder groups, em-
11 ployees and their representatives, and other
12 parties the Secretary deems appropriate, the
13 Secretary shall require a nursing facility to elec-
14 tronically submit to the Secretary direct care
15 staffing information (including information with
16 respect to agency and contract staff) based on
17 payroll and other verifiable and auditable data
18 in a uniform format (according to specifications
19 established by the Secretary in consultation
20 with such programs, groups, and parties). Such
21 specifications shall require that the information
22 submitted under the preceding sentence—

23 “(i) specify the category of work a
24 certified employee performs (such as
25 whether the employee is a registered nurse,

1 licensed practical nurse, licensed vocational
2 nurse, certified nursing assistant, thera-
3 pist, or other medical personnel);

4 “(ii) include resident census data and
5 information on resident case mix;

6 “(iii) include a regular reporting
7 schedule; and

8 “(iv) include information on employee
9 turnover and tenure and on the hours of
10 care provided by each category of certified
11 employees referenced in clause (i) per resi-
12 dent per day.

13 Nothing in this subparagraph shall be con-
14 strued as preventing the Secretary from requir-
15 ing submission of such information with respect
16 to specific categories, such as nursing staff, be-
17 fore other categories of certified employees. In-
18 formation under this subparagraph with respect
19 to agency and contract staff shall be kept sepa-
20 rate from information on employee staffing.”.

21 **PART 2—TARGETING ENFORCEMENT**

22 **SEC. 1421. CIVIL MONEY PENALTIES.**

23 (a) **SKILLED NURSING FACILITIES.—**

1 (1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of
2 the Social Security Act (42 U.S.C. 1395i–
3 3(h)(2)(B)(ii)) is amended to read as follows:

4 “(ii) AUTHORITY WITH RESPECT TO
5 CIVIL MONEY PENALTIES.—

6 “(I) AMOUNT.—The Secretary
7 may impose a civil money penalty in
8 the applicable per instance or per day
9 amount (as defined in subclause (II)
10 and (III)) for each day or instance,
11 respectively, of noncompliance (as de-
12 termined appropriate by the Sec-
13 retary).

14 “(II) APPLICABLE PER INSTANCE
15 AMOUNT.—In this clause, the term
16 ‘applicable per instance amount’
17 means—

18 “(aa) in the case where the
19 deficiency is found to be a direct
20 proximate cause of death of a
21 resident of the facility, an
22 amount not to exceed \$100,000.

23 “(bb) in each case of a defi-
24 ciency where the facility is cited
25 for actual harm or immediate

1 jeopardy, an amount not less
2 than \$3,050 and not more than
3 \$25,000; and

4 “(cc) in each case of any
5 other deficiency, an amount not
6 less than \$250 and not to exceed
7 \$3050.

8 “(III) APPLICABLE PER DAY
9 AMOUNT.—In this clause, the term
10 ‘applicable per day amount’ means—

11 “(aa) in each case of a defi-
12 ciency where the facility is cited
13 for actual harm or immediate
14 jeopardy, an amount not less
15 than \$3,050 and not more than
16 \$25,000 and

17 “(bb) in each case of any
18 other deficiency, an amount not
19 less than \$250 and not to exceed
20 \$3,050.

21 “(IV) REDUCTION OF CIVIL
22 MONEY PENALTIES IN CERTAIN CIR-
23 CUMSTANCES.—Subject to subclauses
24 (V) and (VI), in the case where a fa-
25 cility self-reports and promptly cor-

1 rects a deficiency for which a penalty
2 was imposed under this clause not
3 later than 10 calendar days after the
4 date of such imposition, the Secretary
5 may reduce the amount of the penalty
6 imposed by not more than 50 percent.

7 “(V) PROHIBITION ON REDUC-
8 TION FOR CERTAIN DEFICIENCIES.—

9 “(aa) REPEAT DEFI-
10 CIENCIES.—The Secretary may
11 not reduce under subclause (IV)
12 the amount of a penalty if the
13 deficiency is a repeat deficiency.

14 “(bb) CERTAIN OTHER DE-
15 FICIENCIES.—The Secretary may
16 not reduce under subclause (IV)
17 the amount of a penalty if the
18 penalty is imposed for a defi-
19 ciency described in subclause
20 (II)(aa) or (III)(aa) and the ac-
21 tual harm or widespread harm
22 immediately jeopardizes the
23 health or safety of a resident or
24 residents of the facility, or if the
25 penalty is imposed for a defi-

1 ency described in subclause
2 (II)(bb).

3 “(VI) LIMITATION ON AGGRE-
4 GATE REDUCTIONS.—The aggregate
5 reduction in a penalty under sub-
6 clause (IV) may not exceed 35 percent
7 on the basis of self-reporting, on the
8 basis of a waiver or an appeal (as pro-
9 vided for under regulations under sec-
10 tion 488.436 of title 42, Code of Fed-
11 eral Regulations), or on the basis of
12 both.

13 “(VII) COLLECTION OF CIVIL
14 MONEY PENALTIES.—In the case of a
15 civil money penalty imposed under
16 this clause, the Secretary—

17 “(aa) subject to item (cc),
18 shall, not later than 30 days
19 after the date of imposition of
20 the penalty, provide the oppor-
21 tunity for the facility to partici-
22 pate in an independent informal
23 dispute resolution process which
24 generates a written record prior
25 to the collection of such penalty;

1 “(bb) in the case where the
2 penalty is imposed for each day
3 of noncompliance, shall not im-
4 pose a penalty for any day during
5 the period beginning on the ini-
6 tial day of the imposition of the
7 penalty and ending on the day on
8 which the informal dispute reso-
9 lution process under item (aa) is
10 completed;

11 “(cc) may provide for the
12 collection of such civil money
13 penalty and the placement of
14 such amounts collected in an es-
15 crow account under the direction
16 of the Secretary on the earlier of
17 the date on which the informal
18 dispute resolution process under
19 item (aa) is completed or the
20 date that is 90 days after the
21 date of the imposition of the pen-
22 alty;

23 “(dd) may provide that such
24 amounts collected are kept in

1 such account pending the resolu-
2 tion of any subsequent appeals;
3 “(ee) in the case where the
4 facility successfully appeals the
5 penalty, may provide for the re-
6 turn of such amounts collected
7 (plus interest) to the facility; and
8 “(ff) in the case where all
9 such appeals are unsuccessful,
10 may provide that some portion of
11 such amounts collected may be
12 used to support activities that
13 benefit residents, including as-
14 sistance to support and protect
15 residents of a facility that closes
16 (voluntarily or involuntarily) or is
17 decertified (including offsetting
18 costs of relocating residents to
19 home and community-based set-
20 tings or another facility), projects
21 that support resident and family
22 councils and other consumer in-
23 volvement in assuring quality
24 care in facilities, and facility im-
25 provement initiatives approved by

1 the Secretary (including joint
2 training of facility staff and sur-
3 veyors, technical assistance for
4 facilities under quality assurance
5 programs, the appointment of
6 temporary management, and
7 other activities approved by the
8 Secretary).

9 “(VIII) PROCEDURE.—The pro-
10 visions of section 1128A (other than
11 subsections (a) and (b) and except to
12 the extent that such provisions require
13 a hearing prior to the imposition of a
14 civil money penalty) shall apply to a
15 civil money penalty under this clause
16 in the same manner as such provi-
17 sions apply to a penalty or proceeding
18 under section 1128A(a).”.

19 (2) CONFORMING AMENDMENT.—The second
20 sentence of section 1819(h)(5) of the Social Security
21 Act (42 U.S.C. 1395i–3(h)(5)) is amended by insert-
22 ing “(ii)(IV),” after “(i),”.

23 (b) NURSING FACILITIES.—

24 (1) PENALTIES IMPOSED BY THE STATE.—

1 (A) IN GENERAL.—Section 1919(h)(2) of
2 the Social Security Act (42 U.S.C. 1396r(h)(2))
3 is amended—

4 (i) in subparagraph (A)(ii), by strik-
5 ing the first sentence and inserting the fol-
6 lowing: “A civil money penalty in accord-
7 ance with subparagraph (G).”; and

8 (ii) by adding at the end the following
9 new subparagraph:

10 “(G) CIVIL MONEY PENALTIES.—

11 “(i) IN GENERAL.—The State may
12 impose a civil money penalty under sub-
13 paragraph (A)(ii) in the applicable per in-
14 stance or per day amount (as defined in
15 subclause (II) and (III)) for each day or
16 instance, respectively, of noncompliance (as
17 determined appropriate by the Secretary).

18 “(ii) APPLICABLE PER INSTANCE
19 AMOUNT.—In this subparagraph, the term
20 ‘applicable per instance amount’ means—

21 “(I) in the case where the defi-
22 ciency is found to be a direct proximi-
23 mate cause of death of a resident of
24 the facility, an amount not to exceed
25 \$100,000.

1 “(II) in each case of a deficiency
2 where the facility is cited for actual
3 harm or immediate jeopardy, an
4 amount not less than \$3,050 and not
5 more than \$25,000; and

6 “(III) in each case of any other
7 deficiency, an amount not less than
8 \$250 and not to exceed \$3050.

9 “(iii) APPLICABLE PER DAY
10 AMOUNT.—In this subparagraph, the term
11 ‘applicable per day amount’ means—

12 “(I) in each case of a deficiency
13 where the facility is cited for actual
14 harm or immediate jeopardy, an
15 amount not less than \$3,050 and not
16 more than \$25,000 and

17 “(II) in each case of any other
18 deficiency, an amount not less than
19 \$250 and not to exceed \$3,050.

20 “(iv) REDUCTION OF CIVIL MONEY
21 PENALTIES IN CERTAIN CIR-
22 CUMSTANCES.—Subject to clauses (v) and
23 (vi), in the case where a facility self-re-
24 ports and promptly corrects a deficiency
25 for which a penalty was imposed under

1 subparagraph (A)(ii) not later than 10 cal-
2 endar days after the date of such imposi-
3 tion, the State may reduce the amount of
4 the penalty imposed by not more than 50
5 percent.

6 “(v) PROHIBITION ON REDUCTION
7 FOR CERTAIN DEFICIENCIES.—

8 “(I) REPEAT DEFICIENCIES.—
9 The State may not reduce under
10 clause (iv) the amount of a penalty if
11 the State had reduced a penalty im-
12 posed on the facility in the preceding
13 year under such clause with respect to
14 a repeat deficiency.

15 “(II) CERTAIN OTHER DEFICI-
16 CIENCIES.—The State may not reduce
17 under clause (iv) the amount of a pen-
18 alty if the penalty is imposed for a de-
19 ficiency described in clause (ii)(II) or
20 (iii)(I) and the actual harm or wide-
21 spread harm that immediately jeop-
22 ardizes the health or safety of a resi-
23 dent or residents of the facility, or if
24 the penalty is imposed for a deficiency
25 described in clause (ii)(I).

1 “(III) LIMITATION ON AGGRE-
2 GATE REDUCTIONS.—The aggregate
3 reduction in a penalty under clause
4 (iv) may not exceed 35 percent on the
5 basis of self-reporting, on the basis of
6 a waiver or an appeal (as provided for
7 under regulations under section
8 488.436 of title 42, Code of Federal
9 Regulations), or on the basis of both.

10 “(iv) COLLECTION OF CIVIL MONEY
11 PENALTIES.—In the case of a civil money
12 penalty imposed under subparagraph
13 (A)(ii), the State—

14 “(I) subject to subclause (III),
15 shall, not later than 30 days after the
16 date of imposition of the penalty, pro-
17 vide the opportunity for the facility to
18 participate in an independent informal
19 dispute resolution process which gen-
20 erates a written record prior to the
21 collection of such penalty;

22 “(II) in the case where the pen-
23 alty is imposed for each day of non-
24 compliance, shall not impose a penalty
25 for any day during the period begin-

1 ning on the initial day of the imposi-
2 tion of the penalty and ending on the
3 day on which the informal dispute res-
4 olution process under subclause (I) is
5 completed;

6 “(III) may provide for the collec-
7 tion of such civil money penalty and
8 the placement of such amounts col-
9 lected in an escrow account under the
10 direction of the State on the earlier of
11 the date on which the informal dis-
12 pute resolution process under sub-
13 clause (I) is completed or the date
14 that is 90 days after the date of the
15 imposition of the penalty;

16 “(IV) may provide that such
17 amounts collected are kept in such ac-
18 count pending the resolution of any
19 subsequent appeals;

20 “(V) in the case where the facil-
21 ity successfully appeals the penalty,
22 may provide for the return of such
23 amounts collected (plus interest) to
24 the facility; and

1 “(VI) in the case where all such
2 appeals are unsuccessful, may provide
3 that such funds collected shall be used
4 for the purposes described in the sec-
5 ond sentence of subparagraph
6 (A)(ii).”.

7 (B) CONFORMING AMENDMENT.—The sec-
8 ond sentence of section 1919(h)(2)(A)(ii) of the
9 Social Security Act (42 U.S.C.
10 1396r(h)(2)(A)(ii)) is amended by inserting be-
11 fore the period at the end the following: “, and
12 some portion of such funds may be used to sup-
13 port activities that benefit residents, including
14 assistance to support and protect residents of a
15 facility that closes (voluntarily or involuntarily)
16 or is decertified (including offsetting costs of re-
17 locating residents to home and community-
18 based settings or another facility), projects that
19 support resident and family councils and other
20 consumer involvement in assuring quality care
21 in facilities, and facility improvement initiatives
22 approved by the Secretary (including joint
23 training of facility staff and surveyors, pro-
24 viding technical assistance to facilities under
25 quality assurance programs, the appointment of

1 temporary management, and other activities ap-
2 proved by the Secretary”.

3 (2) PENALTIES IMPOSED BY THE SEC-
4 RETARY.—

5 (A) IN GENERAL.—Section
6 1919(h)(3)(C)(ii) of the Social Security Act (42
7 U.S.C. 1396r(h)(3)(C)) is amended to read as
8 follows:

9 “(ii) AUTHORITY WITH RESPECT TO
10 CIVIL MONEY PENALTIES.—

11 “(I) AMOUNT.—Subject to sub-
12 clause (II), the Secretary may impose
13 a civil money penalty in an amount
14 not to exceed \$10,000 for each day or
15 each instance of noncompliance (as
16 determined appropriate by the Sec-
17 retary).

18 “(II) REDUCTION OF CIVIL
19 MONEY PENALTIES IN CERTAIN CIR-
20 CUMSTANCES.—Subject to subclause
21 (III), in the case where a facility self-
22 reports and promptly corrects a defi-
23 ciency for which a penalty was im-
24 posed under this clause not later than
25 10 calendar days after the date of

1 such imposition, the Secretary may
2 reduce the amount of the penalty im-
3 posed by not more than 50 percent.

4 “(III) PROHIBITION ON REDUC-
5 TION FOR REPEAT DEFICIENCIES.—
6 The Secretary may not reduce the
7 amount of a penalty under subclause
8 (II) if the Secretary had reduced a
9 penalty imposed on the facility in the
10 preceding year under such subclause
11 with respect to a repeat deficiency.

12 “(IV) COLLECTION OF CIVIL
13 MONEY PENALTIES.—In the case of a
14 civil money penalty imposed under
15 this clause, the Secretary—

16 “(aa) subject to item (bb),
17 shall, not later than 30 days
18 after the date of imposition of
19 the penalty, provide the oppor-
20 tunity for the facility to partici-
21 pate in an independent informal
22 dispute resolution process which
23 generates a written record prior
24 to the collection of such penalty;

1 “(bb) in the case where the
2 penalty is imposed for each day
3 of noncompliance, shall not im-
4 pose a penalty for any day during
5 the period beginning on the ini-
6 tial day of the imposition of the
7 penalty and ending on the day on
8 which the informal dispute reso-
9 lution process under item (aa) is
10 completed;

11 “(cc) may provide for the
12 collection of such civil money
13 penalty and the placement of
14 such amounts collected in an es-
15 crow account under the direction
16 of the Secretary on the earlier of
17 the date on which the informal
18 dispute resolution process under
19 item (aa) is completed or the
20 date that is 90 days after the
21 date of the imposition of the pen-
22 alty;

23 “(dd) may provide that such
24 amounts collected are kept in

1 such account pending the resolu-
2 tion of any subsequent appeals;
3 “(ee) in the case where the
4 facility successfully appeals the
5 penalty, may provide for the re-
6 turn of such amounts collected
7 (plus interest) to the facility; and
8 “(ff) in the case where all
9 such appeals are unsuccessful,
10 may provide that some portion of
11 such amounts collected may be
12 used to support activities that
13 benefit residents, including as-
14 sistance to support and protect
15 residents of a facility that closes
16 (voluntarily or involuntarily) or is
17 decertified (including offsetting
18 costs of relocating residents to
19 home and community-based set-
20 tings or another facility), projects
21 that support resident and family
22 councils and other consumer in-
23 volvement in assuring quality
24 care in facilities, and facility im-
25 provement initiatives approved by

1 the Secretary (including joint
2 training of facility staff and sur-
3 veyors, technical assistance for
4 facilities under quality assurance
5 programs, the appointment of
6 temporary management, and
7 other activities approved by the
8 Secretary).

9 “(V) PROCEDURE.—The provi-
10 sions of section 1128A (other than
11 subsections (a) and (b) and except to
12 the extent that such provisions require
13 a hearing prior to the imposition of a
14 civil money penalty) shall apply to a
15 civil money penalty under this clause
16 in the same manner as such provi-
17 sions apply to a penalty or proceeding
18 under section 1128A(a).”.

19 (B) CONFORMING AMENDMENT.—Section
20 1919(h)(5)(8) of the Social Security Act (42
21 U.S.C. 1396r(h)(5)(8)) is amended by inserting
22 “(ii)(IV),” after “(i),”.

23 (c) EFFECTIVE DATE.—The amendments made by
24 this section shall take effect 1 year after the date of the
25 enactment of this Act.

1 **SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PRO-**
2 **GRAM.**

3 (a) ESTABLISHMENT.—

4 (1) IN GENERAL.—The Secretary, in consulta-
5 tion with the Inspector General of the Department
6 of Health and Human Services, shall establish a
7 pilot program (in this section referred to as the
8 “pilot program”) to develop, test, and implement use
9 of an independent monitor to oversee interstate and
10 large intrastate chains of skilled nursing facilities
11 and nursing facilities.

12 (2) SELECTION.—The Secretary shall select
13 chains of skilled nursing facilities and nursing facili-
14 ties described in paragraph (1) to participate in the
15 pilot program from among those chains that submit
16 an application to the Secretary at such time, in such
17 manner, and containing such information as the Sec-
18 retary may require.

19 (3) DURATION.—The Secretary shall conduct
20 the pilot program for a two-year period.

21 (4) IMPLEMENTATION.—The Secretary shall
22 implement the pilot program not later than one year
23 after the date of the enactment of this Act.

24 (b) REQUIREMENTS.—The Secretary shall evaluate
25 chains selected to participate in the pilot program based
26 on criteria selected by the Secretary, including where evi-

1 dence suggests that one or more facilities of the chain are
2 experiencing serious safety and quality of care problems.
3 Such criteria may include the evaluation of a chain that
4 includes one or more facilities participating in the “Special
5 Focus Facility” program (or a successor program) or one
6 or more facilities with a record of repeated serious safety
7 and quality of care deficiencies.

8 (c) RESPONSIBILITIES OF THE INDEPENDENT MON-
9 ITOR.—An independent monitor that enters into a con-
10 tract with the Secretary to participate in the conduct of
11 such program shall—

12 (1) conduct periodic reviews and prepare root-
13 cause quality and deficiency analyses of a chain to
14 assess if facilities of the chain are in compliance
15 with State and Federal laws and regulations applica-
16 ble to the facilities;

17 (2) undertake sustained oversight of the chain,
18 whether publicly or privately held, to involve the
19 owners of the chain and the principal business part-
20 ners of such owners in facilitating compliance by fa-
21 cilities of the chain with State and Federal laws and
22 regulations applicable to the facilities;

23 (3) analyze the management structure, distribu-
24 tion of expenditures, and nurse staffing levels of fa-

1 cilities of the chain in relation to resident census,
2 staff turnover rates, and tenure;

3 (4) report findings and recommendations with
4 respect to such reviews, analyses, and oversight to
5 the chain and facilities of the chain, to the Secretary
6 and to relevant States; and

7 (5) publish the results of such reviews, anal-
8 yses, and oversight.

9 (d) IMPLEMENTATION OF RECOMMENDATIONS.—

10 (1) RECEIPT OF FINDING BY CHAIN.—Not later
11 than 10 days after receipt of a finding of an inde-
12 pendent monitor under subsection (c)(4), a chain
13 participating in the pilot program shall submit to
14 the independent monitor a report—

15 (A) outlining corrective actions the chain
16 will take to implement the recommendations in
17 such report; or

18 (B) indicating that the chain will not im-
19 plement such recommendations and why it will
20 not do so.

21 (2) RECEIPT OF REPORT BY INDEPENDENT
22 MONITOR.—Not later than 10 days after the date of
23 receipt of a report submitted by a chain under para-
24 graph (1), an independent monitor shall finalize its
25 recommendations and submit a report to the chain

1 and facilities of the chain, the Secretary, and the
2 State (or States) involved, as appropriate, containing
3 such final recommendations.

4 (e) COST OF APPOINTMENT.—A chain shall be re-
5 sponsible for a portion of the costs associated with the
6 appointment of independent monitors under the pilot pro-
7 gram. The chain shall pay such portion to the Secretary
8 (in an amount and in accordance with procedures estab-
9 lished by the Secretary).

10 (f) WAIVER AUTHORITY.—The Secretary may waive
11 such requirements of titles XVIII and XIX of the Social
12 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as
13 may be necessary for the purpose of carrying out the pilot
14 program.

15 (g) AUTHORIZATION OF APPROPRIATIONS.—There
16 are authorized to be appropriated such sums as may be
17 necessary to carry out this section.

18 (h) DEFINITIONS.—In this section:

19 (1) FACILITY.—The term “facility” means a
20 skilled nursing facility or a nursing facility.

21 (2) NURSING FACILITY.—The term “nursing
22 facility” has the meaning given such term in section
23 1919(a) of the Social Security Act (42 U.S.C.
24 1396r(a)).

1 (3) SECRETARY.—The term “Secretary” means
2 the Secretary of Health and Human Services, acting
3 through the Assistant Secretary for Planning and
4 Evaluation.

5 (4) SKILLED NURSING FACILITY.—The term
6 “skilled nursing facility” has the meaning given such
7 term in section 1819(a) of the Social Security Act
8 (42 U.S.C. 1395(a)).

9 (i) EVALUATION AND REPORT.—

10 (1) EVALUATION.—The Inspector General of
11 the Department of Health and Human Services shall
12 evaluate the pilot program. Such evaluation shall—

13 (A) determine whether the independent
14 monitor program should be established on a
15 permanent basis; and

16 (B) if the Inspector General determines
17 that the independent monitor program should
18 be established on a permanent basis, rec-
19 ommend appropriate procedures and mecha-
20 nisms for such establishment.

21 (2) REPORT.—Not later than 180 days after
22 the completion of the pilot program, the Inspector
23 General shall submit to Congress and the Secretary
24 a report containing the results of the evaluation con-
25 ducted under paragraph (1), together with rec-

1 ommendations for such legislation and administra-
2 tive action as the Inspector General determines ap-
3 propriate.

4 **SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.**

5 (a) SKILLED NURSING FACILITIES.—

6 (1) IN GENERAL.—Section 1819(c) of the So-
7 cial Security Act (42 U.S.C. 1395i–3(c)) is amended
8 by adding at the end the following new paragraph:

9 “(7) NOTIFICATION OF FACILITY CLOSURE.—

10 “(A) IN GENERAL.—Any individual who is
11 the administrator of a skilled nursing facility
12 must—

13 “(i) submit to the Secretary, the State
14 long-term care ombudsman, residents of
15 the facility, and the legal representatives of
16 such residents or other responsible parties,
17 written notification of an impending clo-
18 sure—

19 “(I) subject to subclause (II), not
20 later than the date that is 60 days
21 prior to the date of such closure; and

22 “(II) in the case of a facility
23 where the Secretary terminates the fa-
24 cility’s participation under this title,

1 not later than the date that the Sec-
2 retary determines appropriate;

3 “(ii) ensure that the facility does not
4 admit any new residents on or after the
5 date on which such written notification is
6 submitted; and

7 “(iii) include in the notice a plan for
8 the transfer and adequate relocation of the
9 residents of the facility by a specified date
10 prior to closure that has been approved by
11 the State, including assurances that the
12 residents will be transferred to the most
13 appropriate facility or other setting in
14 terms of quality, services, and location,
15 taking into consideration the needs and
16 best interests of each resident.

17 “(B) RELOCATION.—

18 “(i) IN GENERAL.—The State shall
19 ensure that, before a facility closes, all
20 residents of the facility have been success-
21 fully relocated to another facility or an al-
22 ternative home and community-based set-
23 ting.

24 “(ii) CONTINUATION OF PAYMENTS
25 UNTIL RESIDENTS RELOCATED.—The Sec-

1 retary may, as the Secretary determines
2 appropriate, continue to make payments
3 under this title with respect to residents of
4 a facility that has submitted a notification
5 under subparagraph (A) during the period
6 beginning on the date such notification is
7 submitted and ending on the date on which
8 the resident is successfully relocated.”.

9 (2) CONFORMING AMENDMENTS.—Section
10 1819(h)(4) of the Social Security Act (42 U.S.C.
11 1395i–3(h)(4)) is amended—

12 (A) in the first sentence, by striking “the
13 Secretary shall terminate” and inserting “the
14 Secretary, subject to subsection (c)(7), shall
15 terminate”; and

16 (B) in the second sentence, by striking
17 “subsection (c)(2)” and inserting “paragraphs
18 (2) and (7) of subsection (c)”.

19 (b) NURSING FACILITIES.—

20 (1) IN GENERAL.—Section 1919(c) of the So-
21 cial Security Act (42 U.S.C. 1396r(c)) is amended
22 by adding at the end the following new paragraph:

23 “(9) NOTIFICATION OF FACILITY CLOSURE.—

24 “(A) IN GENERAL.—Any individual who is
25 an administrator of a nursing facility must—

1 “(i) submit to the Secretary, the State
2 long-term care ombudsman, residents of
3 the facility, and the legal representatives of
4 such residents or other responsible parties,
5 written notification of an impending clo-
6 sure—

7 “(I) subject to subclause (II), not
8 later than the date that is 60 days
9 prior to the date of such closure; and

10 “(II) in the case of a facility
11 where the Secretary terminates the fa-
12 cility’s participation under this title,
13 not later than the date that the Sec-
14 retary determines appropriate;

15 “(ii) ensure that the facility does not
16 admit any new residents on or after the
17 date on which such written notification is
18 submitted; and

19 “(iii) include in the notice a plan for
20 the transfer and adequate relocation of the
21 residents of the facility by a specified date
22 prior to closure that has been approved by
23 the State, including assurances that the
24 residents will be transferred to the most
25 appropriate facility or other setting in

1 terms of quality, services, and location,
2 taking into consideration the needs and
3 best interests of each resident.

4 “(B) RELOCATION.—

5 “(i) IN GENERAL.—The State shall
6 ensure that, before a facility closes, all
7 residents of the facility have been success-
8 fully relocated to another facility or an al-
9 ternative home and community-based set-
10 ting.

11 “(ii) CONTINUATION OF PAYMENTS
12 UNTIL RESIDENTS RELOCATED.—The Sec-
13 retary may, as the Secretary determines
14 appropriate, continue to make payments
15 under this title with respect to residents of
16 a facility that has submitted a notification
17 under subparagraph (A) during the period
18 beginning on the date such notification is
19 submitted and ending on the date on which
20 the resident is successfully relocated.”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect 1 year after the date of the
23 enactment of this Act.

1 **PART 3—IMPROVING STAFF TRAINING**

2 **SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING.**

3 (a) **SKILLED NURSING FACILITIES.**—Section
4 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.
5 1395i–3(f)(2)(A)(i)(I)) is amended by inserting “(includ-
6 ing, in the case of initial training and, if the Secretary
7 determines appropriate, in the case of ongoing training,
8 dementia management training, and resident abuse pre-
9 vention training” before “, (II)”.

10 (b) **NURSING FACILITIES.**—Section
11 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C.
12 1396r(f)(2)(A)(i)(I)) is amended by inserting “(including,
13 in the case of initial training and, if the Secretary deter-
14 mines appropriate, in the case of ongoing training, demen-
15 tia management training, and resident abuse prevention
16 training” before “, (II)”.

17 (c) **EFFECTIVE DATE.**—The amendments made by
18 this section shall take effect 1 year after the date of the
19 enactment of this Act.

20 **SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED**
21 **FOR CERTIFIED NURSE AIDES AND SUPER-**
22 **VISORY STAFF.**

23 (a) **STUDY.**—

24 (1) **IN GENERAL.**—The Secretary shall conduct
25 a study on the content of training for certified nurse
26 aides and supervisory staff of skilled nursing facili-

1 ties and nursing facilities. The study shall include an
2 analysis of the following:

3 (A) Whether the number of initial training
4 hours for certified nurse aides required under
5 sections 1819(f)(2)(a)(i)(ii) and
6 1919(f)(2)(a)(i)(ii) of the Social Security Act
7 (42 U.S.C. 1395i-3(f)(2)(A)(i)(II);
8 1396r(f)(2)(A)(i)(II)) should be increased from
9 75 and, if so, what the required number of ini-
10 tial training hours should be, including any rec-
11 ommendations for the content of such training
12 (including training related to dementia).

13 (B) Whether requirements for ongoing
14 training under such sections
15 1819(f)(2)(A)(i)(II) and 1919(f)(2)(A)(i)(II)
16 should be increased from 12 hours per year, in-
17 cluding any recommendations for the content of
18 such training.

19 (2) CONSULTATION.—In conducting the anal-
20 ysis under paragraph (1)(A), the Secretary shall
21 consult with States that, as of the date of the enact-
22 ment of this Act, require more than 75 hours of
23 training for certified nurse aides.

24 (3) DEFINITIONS.—In this section:

1 (A) NURSING FACILITY.—The term “nurs-
2 ing facility” has the meaning given such term
3 in section 1919(a) of the Social Security Act
4 (42 U.S.C. 1396r(a)).

5 (B) SECRETARY.—The term “Secretary”
6 means the Secretary of Health and Human
7 Services, acting through the Assistant Secretary
8 for Planning and Evaluation.

9 (C) SKILLED NURSING FACILITY.—The
10 term “skilled nursing facility” has the meaning
11 given such term in section 1819(a) of the Social
12 Security Act (42 U.S.C. 1395(a)).

13 (b) REPORT.—Not later than 2 years after the date
14 of the enactment of this Act, the Secretary shall submit
15 to Congress a report containing the results of the study
16 conducted under subsection (a), together with rec-
17 ommendations for such legislation and administrative ac-
18 tion as the Secretary determines appropriate.

19 **Subtitle C—Quality Measurements**

20 **SEC. 1441. ESTABLISHMENT OF NATIONAL PRIORITIES AND** 21 **PERFORMANCE MEASURES FOR QUALITY IM-** 22 **PROVEMENT.**

23 Title XI of the Social Security Act, as amended by
24 section 1401(a), is further amended by adding at the end
25 the following new part:

1 “PART E—QUALITY IMPROVEMENT

2 “ESTABLISHMENT OF NATIONAL PRIORITIES FOR
3 PERFORMANCE IMPROVEMENT

4 “SEC. 1191. (a) ESTABLISHMENT OF NATIONAL PRI-
5 ORITIES BY THE SECRETARY.—The Secretary shall estab-
6 lish and periodically update, not less frequently than tri-
7 ennially, national priorities for performance improvement.

8 “(b) RECOMMENDATIONS FOR NATIONAL PRIOR-
9 ITIES.—In establishing and updating national priorities
10 under subsection (a), the Secretary shall solicit and con-
11 sider recommendations from outside entities, including a
12 consensus-based entity described in section 1890(a), pro-
13 viders, payors, government agencies, nonprofit organiza-
14 tions, and other public and private entities.

15 “(c) CONSIDERATIONS IN SETTING NATIONAL PRI-
16 ORITIES.—With respect to such priorities, the Secretary
17 shall ensure that priority is given to areas in the delivery
18 of health care services in the United States that—

19 “(1) contribute to a large burden of disease, in-
20 cluding those that address the health care provided
21 to patients with prevalent, high-cost chronic dis-
22 eases;

23 “(2) have the greatest potential to decrease
24 morbidity and mortality in this country, including

1 those that are designed to eliminate harm to pa-
2 tients;

3 “(3) have the greatest potential for improving
4 the performance, affordability, and patient-
5 centeredness of health care, including those due to
6 variations in care;

7 “(4) address health disparities across groups
8 and areas; and

9 “(5) have the potential for rapid improvement
10 due to existing evidence, standards of care or other
11 reasons.

12 “(d) DEFINITIONS.—In this part:

13 “(1) CONSENSUS-BASED ENTITY.—The term
14 ‘consensus-based entity’ means an entity with a con-
15 tract with the Secretary under section 1890.

16 “(2) QUALITY MEASURE.—The term ‘quality
17 measure’ means a national consensus standard for
18 measuring the performance and improvement of pop-
19 ulation health, or of institutional providers of serv-
20 ices, physicians, and other health care practitioners
21 in the delivery of health care services.

22 “(3) MULTI-STAKEHOLDER GROUP.—The term
23 ‘multi-stakeholder group’ means, with respect to a
24 quality measure, a voluntary collaborative of organi-
25 zations representing persons interested in or affected

1 by the use of such quality measure, such as the fol-
2 lowing:

3 “(A) Hospitals and other health care set-
4 tings.

5 “(B) Physicians.

6 “(C) Health care quality alliances.

7 “(D) Nurses and other health care practi-
8 tioners.

9 “(E) Health plans.

10 “(F) Patient advocates and consumer
11 groups.

12 “(G) Employers.

13 “(H) Public and private purchasers of
14 health care items and services.

15 “(I) Labor organizations.

16 “(J) Relevant departments or agencies of
17 the United States.

18 “(K) Biopharmaceutical companies and
19 manufacturers of medical devices.

20 “(L) Licensing, credentialing, and accred-
21 iting bodies.

22 “(e) FUNDING.—The Secretary shall provide for the
23 transfer, from the Federal Hospital Insurance Trust Fund
24 under section 1817 and the Federal Supplementary Med-
25 ical Insurance Trust Fund under section 1841 (in such

1 proportion as the Secretary determines appropriate), of
2 \$7,000,000, for the activities under this section for each
3 of the fiscal years 2010 through 2014.

4 “DEVELOPMENT OF NEW QUALITY MEASURES

5 “SEC. 1192. (a) AGREEMENTS WITH QUALIFIED EN-
6 TITIES.—

7 “(1) IN GENERAL.—The Secretary shall,
8 through the Director of Agency for Healthcare Re-
9 search and Quality (in this section referred to as the
10 ‘Director of AHRQ’), enter into agreements with
11 qualified entities to develop quality measures for the
12 delivery of health care services in the United States.

13 “(2) FORM OF AGREEMENTS.—The Secretary
14 may carry out paragraph (1) by contract, grant, or
15 otherwise.

16 “(3) RECOMMENDATIONS OF CONSENSUS-
17 BASED ENTITY.—In carrying out this section, the
18 Secretary shall—

19 “(A) seek public input; and

20 “(B) take into consideration recommenda-
21 tions of the consensus-based entity with a con-
22 tract with the Secretary under section 1890(a).

23 “(b) DETERMINATION OF AREAS WHERE QUALITY
24 MEASURES ARE REQUIRED.—The Secretary, acting
25 through the Director of AHRQ and consistent with the
26 national priorities established under this part, and in con-

1 sultation with the Administrator of the Centers for Medi-
2 care & Medicaid Services and other relevant Federal agen-
3 cies, shall determine areas in which quality measures for
4 assessing health care services in the United States are
5 needed.

6 “(c) DEVELOPMENT OF QUALITY MEASURES.—

7 “(1) PATIENT-CENTERED AND POPULATION-
8 BASED MEASURES.—Quality measures developed
9 under agreements under subsection (a) shall be de-
10 signed—

11 “(A) to assess outcomes and functional
12 status of patients;

13 “(B) to assess the continuity and coordina-
14 tion of care and care transitions, including epi-
15 sodes of care, for patients across providers and
16 health care settings;

17 “(C) to assess patient experience and pa-
18 tient engagement;

19 “(D) to assess the safety, effectiveness,
20 and timeliness of care;

21 “(E) to assess health disparities including
22 those associated with individual race, ethnicity,
23 age, gender, place of residence or language;

24 “(F) to assess the efficiency and resource
25 use in the provision of care;

1 “(G) to the extent feasible, to be collected
2 as part of health information technologies sup-
3 porting better delivery of health care services;

4 “(H) to be available free of charge to users
5 for the use of such measures; and

6 “(I) to access delivery of health care serv-
7 ices to individuals regardless of age.

8 “(2) REVIEW OF PROPOSED MEASURES.—The
9 Secretary shall make proposed quality measures
10 available for public review and comment.

11 “(3) TESTING OF PROPOSED MEASURES.—The
12 Secretary may use amounts made available under
13 subsection (f) to fund the testing of proposed quality
14 measures by qualified entities. Testing funded under
15 this paragraph shall include testing of the feasibility
16 and usability of proposed measures.

17 “(4) UPDATING OF ENDORSED MEASURES.—
18 The Secretary may use amounts made available
19 under subsection (f) to fund the updating (and test-
20 ing, if applicable) by consensus-based entities of
21 quality measures that have been previously endorsed
22 by such an entity as new evidence is developed, in
23 a manner consistent with section 1890(b)(3).

24 “(d) QUALIFIED ENTITIES.—Before entering into
25 agreements with a qualified entity, the Secretary shall en-

1 sure that the entity is a public, nonprofit or academic in-
2 stitution with technical expertise in the area of health
3 quality measurement.

4 “(e) APPLICATION FOR GRANT.—A grant may be
5 made under this section only if an application for the
6 grant is submitted to the Secretary and the application
7 is in such form, is made in such manner, and contains
8 such agreements, assurances, and information as the Sec-
9 retary determines to be necessary to carry out this section.

10 “(f) FUNDING.—The Secretary shall provide for the
11 transfer, from the Federal Hospital Insurance Trust Fund
12 under section 1817 and the Federal Supplementary Med-
13 ical Insurance Trust Fund (in such proportion as the Sec-
14 retary determines appropriate), of \$35,000,000, to the
15 Secretary for purposes of carrying out this section for each
16 of the fiscal years 2010 through 2014.

17 “GAO EVALUATION OF DATA COLLECTION PROCESS FOR
18 QUALITY MEASUREMENT

19 “SEC. 1193. (a) GAO EVALUATIONS.—The Comp-
20 troller General of the United States shall conduct periodic
21 evaluations of the implementation of the data collection
22 processes for quality measures used by the Secretary.

23 “(b) CONSIDERATIONS.—In carrying out the evalua-
24 tion under subsection (a), the Comptroller General shall
25 determine—

1 “(1) whether the system for the collection of
2 data for quality measures provides for validation of
3 data as relevant and scientifically credible;

4 “(2) whether data collection efforts under the
5 system use the most efficient and cost-effective
6 means in a manner that minimizes administrative
7 burden on persons required to collect data and that
8 adequately protects the privacy of patients’ personal
9 health information and provides data security;

10 “(3) whether standards under the system pro-
11 vide for an opportunity for physicians and other cli-
12 nicians and institutional providers of services to re-
13 view and correct findings; and

14 “(4) the extent to which quality measures are
15 consistent with section 1193(c)(1) or result in direct
16 or indirect costs to users of such measures.

17 “(c) REPORT.—The Comptroller General shall sub-
18 mit reports to Congress and to the Secretary containing
19 a description of the findings and conclusions of the results
20 of each such evaluation.”.

1 **Subtitle D—Physician Payments**
2 **Sunshine Provisions**

3 **SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BE-**
4 **TWEEN MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES,**
5 **BIOLOGICALS, OR MEDICAL SUPPLIES**
6 **UNDER MEDICARE, MEDICAID, OR CHIP AND**
7 **PHYSICIANS AND OTHER HEALTH CARE ENTITIES AND BETWEEN PHYSICIANS AND OTHER**
8 **HEALTH CARE ENTITIES.**

9 **HEALTH CARE ENTITIES.**
11 (a) IN GENERAL.—Part A of title XI of the Social
12 Security Act (42 U.S.C. 1301 et seq.), as amended by sec-
13 tion 1631(a), is further amended by inserting after section
14 1128G the following new section:

15 **“SEC. 1128H. FINANCIAL REPORTS ON PHYSICIANS’ FINAN-**
16 **CIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED**
17 **DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL**
18 **SUPPLIES UNDER MEDICARE, MEDICAID, OR**
19 **CHIP AND WITH ENTITIES THAT BILL FOR**
20 **SERVICES UNDER MEDICARE.**

21 **SERVICES UNDER MEDICARE.**
22 “(a) REPORTING OF PAYMENTS OR OTHER TRANS-
23 FERS OF VALUE.—

24 “(1) IN GENERAL.—Except as provided in this
25 subsection, not later than March 31 of each year

1 (beginning with 2011), each applicable manufacturer
2 or distributor that provides a payment or other
3 transfer of value, directly, indirectly, or through an
4 agent, subsidiary, or other third party, to a covered
5 recipient (or to an entity or individual at the request
6 of or designated on behalf of a covered recipient)
7 shall submit to the Secretary, acting through the Of-
8 fice of the Inspector General of the Department of
9 Health and Human Services, in such electronic form
10 as the Secretary shall require, the following informa-
11 tion with respect to the preceding calendar year:

12 “(A) With respect to the covered recipient,
13 the recipient’s name, business address, physi-
14 cian specialty, and national provider identifier.

15 “(B) With respect to the payment or other
16 transfer of value, other than a drug sample—

17 “(I) its value and date;

18 “(ii) the name of the related drug, de-
19 vice, or supply, if available;

20 “(iii) a description of its form, indi-
21 cated (as appropriate for all that apply)

22 as—

23 “(I) cash or a cash equivalent;

24 “(II) in-kind items or services;

1 “(III) stock, a stock option, or
2 any other ownership interest, divi-
3 dend, profit, or other return on invest-
4 ment; or

5 “(IV) any other form (as defined
6 by the Secretary); and

7 “(iv) a description of its nature, indi-
8 cated (as appropriate for all that apply) by
9 the category described in a clause of sub-
10 section (g)(10)(A).

11 “(C) With respect to a drug sample, the
12 name, number, date, and dosage units of the
13 sample.

14 “(2) AGGREGATE REPORTING.—Information
15 submitted by an applicable manufacturer or dis-
16 tributor under paragraph (1) shall include the ag-
17 gregate amount of all payments or other transfers of
18 value provided by the manufacturer or distributor to
19 covered recipients (and to entities or individuals at
20 the request of or designated on behalf of a covered
21 recipient) during the year involved, including all pay-
22 ments and transfers of value regardless of whether
23 such payments or transfer of value were individually
24 disclosed.

1 “(3) SPECIAL RULE FOR CERTAIN PAYMENTS
2 OR OTHER TRANSFERS OF VALUE.—In the case
3 where an applicable manufacturer or distributor pro-
4 vides a payment or other transfer of value to an en-
5 tity or individual at the request of or designated on
6 behalf of a covered recipient, the manufacturer or
7 distributor shall disclose that payment or other
8 transfer of value under the name of the covered re-
9 cipient.

10 “(4) DELAYED REPORTING FOR PAYMENTS
11 MADE PURSUANT TO PRODUCT DEVELOPMENT
12 AGREEMENTS.—In the case of a payment or other
13 transfer of value made to a covered recipient by an
14 applicable manufacturer or distributor pursuant to a
15 product development agreement for services fur-
16 nished in connection with the development of a new
17 drug, device, biological, or medical supply, the appli-
18 cable manufacturer or distributor may report the
19 value and recipient of such payment or other trans-
20 fer of value in the first reporting period under this
21 subsection in the next reporting deadline after the
22 earlier of the following:

23 “(A) The date of the approval or clearance
24 of the covered drug, device, biological, or med-

1 ical supply by the Food and Drug Administra-
2 tion.

3 “(B) Two calendar years after the date
4 such payment or other transfer of value was
5 made.

6 “(b) REPORTING OF OWNERSHIP INTEREST BY PHY-
7 SICIANS IN HOSPITALS AND OTHER ENTITIES THAT BILL
8 MEDICARE.—Not later than March 31 of each year (be-
9 ginning with 2011), each hospital or other health care en-
10 tity (not including a Medicare Advantage organization)
11 that bills the Secretary under part A or part B of title
12 XVIII for services shall report on the ownership shares
13 (other than ownership shares described in section 1877(e))
14 of each physician who, directly or indirectly, owns an in-
15 terest in the entity. In this subsection, the term ‘physician’
16 includes a physician’s immediate family members (as de-
17 fined for purposes of section 1877(a)).

18 “(c) PUBLIC AVAILABILITY.—The Secretary shall es-
19 tablish procedures to ensure that, not later than Sep-
20 tember 30, 2011, and on June 30 of each year beginning
21 thereafter, the information submitted under subsections
22 (a) and (b), other than information regard drug samples,
23 with respect to the preceding calendar year is made avail-
24 able through an Internet website that—

1 “(1) is searchable and is in a format that is
2 clear and understandable;

3 “(2) contains information that is presented by
4 the name of the applicable manufacturer or dis-
5 tributor, the name of the covered recipient, the busi-
6 ness address of the covered recipient, the specialty
7 (if applicable) of the covered recipient, the value of
8 the payment or other transfer of value, the date on
9 which the payment or other transfer of value was
10 provided to the covered recipient, the form of the
11 payment or other transfer of value, indicated (as ap-
12 propriate) under subsection (a)(1)(B)(ii), the nature
13 of the payment or other transfer of value, indicated
14 (as appropriate) under subsection (a)(1)(B)(iii), and
15 the name of the covered drug, device, biological, or
16 medical supply, as applicable;

17 “(3) contains information that is able to be eas-
18 ily aggregated and downloaded;

19 “(4) contains a description of any enforcement
20 actions taken to carry out this section, including any
21 penalties imposed under subsection (b), during the
22 preceding year;

23 “(5) contains background information on indus-
24 try-physician relationships;

1 “(6) in the case of information submitted with
2 respect to a payment or other transfer of value de-
3 scribed in subsection (e), lists such information sep-
4 arately from the other information submitted under
5 subsection (a) and designates such separately listed
6 information as funding for clinical research;

7 “(7) contains any other information the Sec-
8 retary determines would be helpful to the average
9 consumer; and

10 “(8) provides the covered recipient an oppor-
11 tunity to submit corrections to the information made
12 available to the public with respect to the covered re-
13 cipient.

14 Information relating to drug samples provided under sub-
15 section (a) shall not be made available to the public but
16 may be made available outside the Department of Health
17 and Human Services by the Secretary for research or le-
18 gitimate business purposes pursuant to data use agree-
19 ments.

20 “(d) PENALTIES FOR NONCOMPLIANCE.—

21 “(1) FAILURE TO REPORT.—

22 “(A) IN GENERAL.—Subject to subpara-
23 graph (B), except as provided in paragraph (2),
24 any applicable manufacturer or distributor that
25 fails to submit information required under sub-

1 section (a) in a timely manner in accordance
2 with regulations promulgated to carry out such
3 subsection, and any hospital or other entity that
4 fails to submit information required under sub-
5 section (b) in a timely manner in accordance
6 with regulations promulgated to carry out such
7 subsection shall be subject to a civil money pen-
8 alty of not less than \$1,000, but not more than
9 \$10,000, for each payment or other transfer of
10 value or ownership or investment interest not
11 reported as required under such subsection.
12 Such penalty shall be imposed and collected in
13 the same manner as civil money penalties under
14 subsection (a) of section 1128A are imposed
15 and collected under that section.

16 “(B) LIMITATION.—The total amount of
17 civil money penalties imposed under subpara-
18 graph (A) with respect to each annual submis-
19 sion of information under subsection (a) by an
20 applicable manufacturer or distributor or other
21 entity shall not exceed \$150,000.

22 “(2) KNOWING FAILURE TO REPORT.—

23 “(A) IN GENERAL.—Subject to subpara-
24 graph (B), any applicable manufacturer or dis-
25 tributor that knowingly fails to submit informa-

1 tion required under subsection (a) in a timely
2 manner in accordance with regulations promul-
3 gated to carry out such subsection and any hos-
4 pital or other entity that fails to submit infor-
5 mation required under subsection (b) in a time-
6 ly manner in accordance with regulations pro-
7 mulgated to carry out such subsection, shall be
8 subject to a civil money penalty of not less than
9 \$10,000, but not more than \$100,000, for each
10 payment or other transfer of value or ownership
11 or investment interest not reported as required
12 under such subsection. Such penalty shall be
13 imposed and collected in the same manner as
14 civil money penalties under subsection (a) of
15 section 1128A are imposed and collected under
16 that section.

17 “(B) LIMITATION.—The total amount of
18 civil money penalties imposed under subpara-
19 graph (A) with respect to each annual submis-
20 sion of information under subsection (a) by an
21 applicable manufacturer, distributor, or entity
22 described in subsection (c) shall not exceed
23 \$1,000,000, or, if greater, 0.1 percentage of the
24 total annual revenues of the manufacturer, dis-
25 tributor, or entity.

1 “(3) USE OF FUNDS.—Funds collected by the
2 Secretary as a result of the imposition of a civil
3 money penalty under this subsection shall be used to
4 carry out this section.

5 “(4) ENFORCEMENT THROUGH STATE ATTOR-
6 NEYS GENERAL.—The attorney general of a State,
7 after providing notice to the Secretary of an intent
8 to proceed under this paragraph in a specific case
9 and providing the Secretary with an opportunity to
10 bring an action under this subsection and the Sec-
11 retary declining such opportunity, may proceed
12 under this subsection against a manufacturer or dis-
13 tributor in the State.

14 “(e) ANNUAL REPORT TO CONGRESS.—Not later
15 than April 1 of each year beginning with 2011, the Sec-
16 retary shall submit to Congress a report that includes the
17 following:

18 “(1) The information submitted under this sec-
19 tion during the preceding year, aggregated for each
20 applicable manufacturer or distributor of a covered
21 drug, device, biological, or medical supply that sub-
22 mitted such information during such year.

23 “(2) A description of any enforcement actions
24 taken to carry out this section, including any pen-

1 alties imposed under subsection (d), during the pre-
2 ceding year.

3 “(3) A description, based on the disclosure of
4 financial relationships report provided under section
5 1877(f), of the types and prevalence of financial ar-
6 rangements between hospitals and physicians.

7 “(f) DEFINITIONS.—In this section:

8 “(1) APPLICABLE MANUFACTURER; APPLICA-
9 BLE DISTRIBUTOR.—The term ‘applicable manufac-
10 turer’ means a manufacturer of a covered drug, de-
11 vice, biological, or medical supply, and the term ‘ap-
12 plicable distributor’ means a distributor of a covered
13 drug, device, or medical supply.

14 “(2) COVERED DRUG, DEVICE, BIOLOGICAL, OR
15 MEDICAL SUPPLY.—The term ‘covered’ means, with
16 respect to a drug, device, biological, or medical sup-
17 ply, such a drug, device, biological, or medical supply
18 for which payment is available under title XVIII or
19 a State plan under title XIX or XXI (or a waiver
20 of such a plan).

21 “(3) COVERED RECIPIENT.—The term ‘covered
22 recipient’ means the following:

23 “(A) A physician.

24 “(B) A physician group practice.

1 “(C) An other prescriber of a covered
2 drug, device, biological, or medical supply.

3 “(D) A pharmacy or pharmacist.

4 “(E) A health insurance issuer, group
5 health plan, or other entity offering a health
6 benefits plan, including any employee of such
7 an issuer, plan, or entity.

8 “(F) A pharmacy benefit manager, includ-
9 ing any employee of such a manager.

10 “(G) A hospital.

11 “(H) A medical school.

12 “(I) A sponsor of a continuing medical
13 education program.

14 “(J) A patient advocacy or disease specific
15 group.

16 “(K) A organization of health care profes-
17 sionals.

18 “(L) A biomedical researcher

19 “(4) DISTRIBUTOR OF A COVERED DRUG, DE-
20 VICE, OR MEDICAL SUPPLY.—The term ‘distributor
21 of a covered drug, device, or medical supply’ means
22 any entity which is engaged in the marketing or dis-
23 tribution of a covered drug, device, or medical sup-
24 ply (or any subsidiary of or entity affiliated with
25 such entity).

1 “(5) EMPLOYEE.—The term ‘employee’ has the
2 meaning given such term in section 1877(h)(2).

3 “(6) KNOWINGLY.—The term ‘knowingly’ has
4 the meaning given such term in section 3729(b) of
5 title 31, United States Code.

6 “(7) MANUFACTURER OF A COVERED DRUG,
7 DEVICE, BIOLOGICAL, OR MEDICAL SUPPLY.—The
8 term ‘manufacturer of a covered drug, device, bio-
9 logical, or medical supply’ means any entity which is
10 engaged in the production, preparation, propagation,
11 compounding, conversion, processing, marketing, or
12 distribution of a covered drug, device, biological, or
13 medical supply (or any subsidiary of or entity affili-
14 ated with such entity).

15 “(8) PAYMENT OR OTHER TRANSFER OF
16 VALUE.—

17 “(A) IN GENERAL.—The term ‘payment or
18 other transfer of value’ means a transfer of
19 anything of value for or of any of the following:

20 “(i) Gift, food, or entertainment.

21 “(ii) Travel or trip.

22 “(iii) Honoraria.

23 “(iv) Research funding or grant.

24 “(v) Education or conference funding.

25 “(vi) Consulting fees.

1 “(vii) Ownership or Investment inter-
2 est and royalties or license fee.

3 “(viii) any includes any compensation,
4 gift, honorarium, speaking fee, consulting
5 fee, travel, discount, cash rebate, services,
6 or dividend, profit distribution, stock or
7 stock option grant, or any ownership or in-
8 vestment interest held by a physician in a
9 manufacturer (excluding a dividend or
10 other profit distribution from, or ownership
11 or investment interest in, a publicly traded
12 security or mutual fund (as described in
13 section 1877(c)).

14 “(B) EXCLUSIONS.—Such term does not
15 include the following:

16 “(i) Any payment or other transfer of
17 value provided by an applicable manufac-
18 turer or distributor to a covered recipient
19 where the amount transferred to, requested
20 by, or designated on behalf of the covered
21 recipient does not exceed \$5.

22 “(ii) The loan of a covered device for
23 a short-term trial period, not to exceed 90
24 days, to permit evaluation of the covered
25 device by the covered recipient.

1 “(iii) Items or services provided under
2 a contractual warranty, including the re-
3 placement of a covered device, where the
4 terms of the warranty are set forth in the
5 purchase or lease agreement for the cov-
6 ered device.

7 “(iv) A transfer of anything of value
8 to a covered recipient when the covered re-
9 cipient is a patient and not acting in the
10 professional capacity of a covered recipient.

11 “(v) In-kind items used for the provi-
12 sion of charity care.

13 “(vi) A dividend or other profit dis-
14 tribution from, or ownership or investment
15 interest in, a publicly traded security and
16 mutual fund (as described in section
17 1877(c)).

18 “(vii) Compensation paid by a manu-
19 facturer or distributor of a covered drug,
20 device, biological, or medical supply to a
21 covered recipient who is directly employed
22 by and works solely for such manufacturer
23 or distributor.

24 “(9) PHYSICIAN.—The term ‘physician’ has the
25 meaning given that term in section 1861(r). For

1 purposes of this section, such term does not include
2 a physician who is an employee of the applicable
3 manufacturer that is required to submit information
4 under subsection (a).

5 “(g) ANNUAL REPORTS TO STATES.—Not later than
6 April 1 of each year beginning with 2011, the Secretary
7 shall submit to States a report that includes a summary
8 of the information submitted under subsections (a) and
9 (d) during the preceding year with respect to covered re-
10 cipients or other hospitals and entities in the State.”.

11 (b) AVAILABILITY OF INFORMATION FROM THE DIS-
12 CLOSURE OF FINANCIAL RELATIONSHIP REPORT
13 (DFRR).—Pursuant to section 5006 of the Deficit Reduc-
14 tion Act of 2005 (Public Law 109–171), the Secretary of
15 Health and Human Services—

16 (1) may conduct surveys of hospitals with re-
17 spect to the financial relationship (through owner-
18 ship, investment, or otherwise) physicians in such
19 hospitals; and

20 (2) shall make the full results of such surveys
21 available to the Congress and shall make a sum-
22 mary, and such details as the Secretary may specify,
23 of such surveys available to public through an Inter-
24 net website of the Department of Health and
25 Human Services.

1 **SEC. 1452. LIMITATION ON TAX DEDUCTIONS FOR ADVER-**
2 **TISING BY CERTAIN MANUFACTURERS OF**
3 **DRUGS, DEVICES, OR MEDICAL SUPPLIES.**

4 (a) In General- Part IX of subchapter B of chapter
5 1 of subtitle A of the Internal Revenue Code of 1986 (re-
6 lating to items not deductible) is amended by adding at
7 the end the following:

8 **“SEC. 280I. LIMITATION ON TAX DEDUCTIONS FOR ADVER-**
9 **TISING BY CERTAIN MANUFACTURERS OF**
10 **DRUGS, DEVICES, OR MEDICAL SUPPLIES.**

11 “(a) IN GENERAL.—No deduction shall be allowed
12 under this chapter for any taxable year for any expendi-
13 ture relating to the advertising, promoting, or marketing
14 (in any medium) of any covered drug, device, or medical
15 supply manufactured by the taxpayer if, during the tax-
16 able year, a penalty is imposed on the taxpayer under sec-
17 tion 1128G(d) of the Social Security Act (relating to quar-
18 terly transparency reports from manufacturers of covered
19 drugs, devices, or medical supplies under Medicare, Med-
20icaid, or CHIP).

21 “(b) DEFINITIONS AND SPECIAL RULES.—For pur-
22 poses of this section—

23 “(1) COVERED DRUG, DEVICE, OR MEDICAL
24 SUPPLY.—The term ‘Covered drug, device, or med-
25 ical supply’ has the meaning given such term by sec-
26 tion 1128G(g) of the Social Security Act.

1 “(2) AGGREGATION RULES.—All members of
2 the same controlled group of corporations (within
3 the meaning of section 52(a)) and all persons under
4 common control (within the meaning of section
5 52(b)) shall be treated as 1 person.”.

6 (b) CONFORMING AMENDMENT.—The table of sec-
7 tions for such part IX is amended by adding after the
8 item relating to section 280H the following:

9 **“SEC. 280I. Limitation on tax deductions for advertising by cer-
10 tain manufacturers of drugs, devices, or medical
11 supplies.”.**

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to taxable years beginning ending
14 after the date of the enactment of this Act.

15 **TITLE V—MEDICARE GRADUATE** 16 **MEDICAL EDUCATION**

17 **SEC. 1501. DISTRIBUTION OF UNUSED RESIDENCY POSI-** 18 **TIONS.**

19 (a) IN GENERAL.—Section 1886(h) of the Social Se-
20 curity Act (42 U.S.C. 1395ww(h)) is amended—

21 (1) in paragraph (4)(F)(i), by striking “para-
22 graph (7)” and inserting “paragraphs (7) and (8)”;

23 (2) in paragraph (4)(H)(i), by striking “para-
24 graph (7)” and inserting “paragraphs (7) and (8)”;

1 (3) in paragraph (7)(E), by inserting “and
2 paragraph (8)” after “this paragraph”; and

3 (4) by adding at the end the following new
4 paragraph:

5 “(8) ADDITIONAL REDISTRIBUTION OF UNUSED
6 RESIDENCY POSITIONS.—

7 “(A) REDUCTIONS IN LIMIT BASED ON UN-
8 USED POSITIONS.—

9 “(i) PROGRAMS SUBJECT TO REDUC-
10 TION.—If a hospital’s reference resident
11 level (specified in clause (ii)) is less than
12 the otherwise applicable resident limit (as
13 defined in paragraph (7)(C)(ii)), effective
14 for portions of cost reporting periods oc-
15 ccurring on or after July 1, 2011, the oth-
16 erwise applicable resident limit shall be re-
17 duced by 90 percent of the difference be-
18 tween such otherwise applicable resident
19 limit and such reference resident level.

20 “(ii) REFERENCE RESIDENT LEVEL.—

21 “(I) IN GENERAL.—Except as
22 otherwise provided in a subsequent
23 subclause, the reference resident level
24 specified in this clause for a hospital
25 is the highest resident level for any of

1 the 3 most recent cost reporting peri-
2 ods (ending before the date of the en-
3 actment of this paragraph) of the hos-
4 pital for which a cost report has been
5 settled (or, if not, submitted (subject
6 to audit)), as determined by the Sec-
7 retary.

8 “(II) USE OF MOST RECENT AC-
9 COUNTING PERIOD TO RECOGNIZE EX-
10 PANSION OF EXISTING PROGRAMS.—If
11 a hospital submits a timely request to
12 increase its resident level due to an
13 expansion of an existing residency
14 training program that is not reflected
15 on the most recent settled or sub-
16 mitted cost report, after audit and
17 subject to the discretion of the Sec-
18 retary, subject to subclause (IV), the
19 reference resident level for such hos-
20 pital is the resident level that includes
21 the additional residents attributable to
22 such expansion or establishment, as
23 determined by the Secretary. The Sec-
24 retary is authorized to determine an
25 alternative resident reference level for

1 hospitals that submitted a timely re-
2 quest to the Secretary before the start
3 of the 2009 to 2010 academic year.

4 “(III) SPECIAL PROVIDER
5 AGREEMENT.—In the case of a hos-
6 pital described in paragraph
7 (4)(H)(v), the reference resident level
8 specified in this clause is limitation
9 applicable under sub clause (I) of
10 such paragraph.

11 “(IV) PREVIOUS REDISTRIBU-
12 TION.—The reference resident level
13 specified in this clause for a hospital
14 shall be increased to the extent re-
15 quired to take into account an in-
16 crease in resident positions made
17 available to the hospital under para-
18 graph (7)(B) that are not otherwise
19 taken into account under a previous
20 subclause.

21 “(iii) AFFILIATION.—The provisions
22 of clause (i) shall be applied to hospitals
23 which are members of the same affiliated
24 group (as defined by the Secretary under
25 paragraph (4)(H)(ii)) or which the Sec-

1 retary otherwise has permitted (under sec-
2 tion 402 of the Social Security Amend-
3 ments of 1967) to be aggregated for pur-
4 poses of applying the resident position lim-
5 itations under this subsection.

6 “(B) REDISTRIBUTION.—

7 “(i) IN GENERAL.—The Secretary
8 shall increase the otherwise applicable resi-
9 dent limit for each qualifying hospital that
10 submits an application under this subpara-
11 graph by such number as the Secretary
12 may approve for portions of cost reporting
13 periods occurring on or after July 1, 2011.
14 The estimated aggregate number of in-
15 creases in the otherwise applicable resident
16 limit under this subparagraph may not ex-
17 ceed the Secretary’s estimate of the aggre-
18 gate reduction in such limits attributable
19 to subparagraph (A).

20 “(ii) REQUIREMENTS FOR QUALI-
21 FYING HOSPITALS.—A hospital is not a
22 qualifying hospital for purposes of this
23 paragraph unless the following require-
24 ments are met:

1 “(I) MAINTENANCE OF PRIMARY
2 CARE RESIDENT LEVEL.—The hos-
3 pital maintains the number of primary
4 care residents at a level that is not
5 less than the base level of primary
6 care residents increased by the num-
7 ber of additional primary care resi-
8 dent positions provided to the hospital
9 under this subparagraph. For pur-
10 poses of this subparagraph, the ‘base
11 level of primary care residents’ for a
12 hospital is the level of such residents
13 as of a base period (specified by the
14 Secretary), determined without regard
15 to whether such positions were in ex-
16 cess of the otherwise applicable resi-
17 dent limit for such period but taking
18 into account the application of sub-
19 clauses (II) and (III) of subparagraph
20 (A)(ii).

21 “(II) DEDICATED ASSIGNMENT
22 OF ADDITIONAL RESIDENT POSITIONS
23 TO PRIMARY CARE.—The hospital as-
24 signs all such additional resident posi-
25 tions for primary care residents..

1 “(III) ACCREDITATION.—The
2 hospital’s residency programs in pri-
3 mary care are fully accredited or, in
4 the case of a residency training pro-
5 gram not in operation as of the base
6 year, the hospital is actively applying
7 for such accreditation for the program
8 for such additional resident positions
9 (as determined by the Secretary).

10 “(iii) CONSIDERATIONS IN REDIS-
11 TRIBUTION.—In determining for which
12 qualifying hospitals the increase in the oth-
13 erwise applicable resident limit is provided
14 under this subparagraph, the Secretary
15 shall take into account the demonstrated
16 likelihood of the hospital filling the posi-
17 tions within the first 3 cost reporting peri-
18 ods beginning on or after July 1, 2011,
19 made available under this subparagraph,
20 as determined by the Secretary.

21 “(iv) PRIORITY FOR CERTAIN HOS-
22 PITALS.—In determining for which quali-
23 fying hospitals the increase in the other-
24 wise applicable resident limit is provided
25 under this subparagraph, the Secretary

1 shall distribute the increase to qualifying
2 hospitals based on the following criteria:

3 “(I) The Secretary shall give
4 preference to hospitals that had a re-
5 duction in resident training positions
6 under subparagraph (A).

7 “(II) The Secretary shall give
8 preference to hospitals with 3-year
9 primary care residency training pro-
10 grams, such as family practice and
11 general internal medicine.

12 “(III) The Secretary shall give
13 preference to hospitals insofar as they
14 have in effect formal arrangements
15 that place greater emphasis upon
16 training in Federally qualified health
17 centers, rural health clinics, off-cam-
18 pus provider-based outpatient depart-
19 ments, and other non-provider set-
20 tings.

21 “(IV) The Secretary shall give
22 preference to hospitals insofar as they
23 have in effect formal arrangements
24 that place greater emphasis upon
25 training in a health professional

1 shortage area (designated under sec-
2 tion 332 of the Public Health Service
3 Act) or a health profession needs area
4 (designated under section 111 of such
5 Act).

6 “(V) The Secretary shall give
7 preference to hospitals in States have
8 low resident-to-population ratios (in-
9 cluding a greater preference for those
10 States with lower resident-to-popu-
11 lation ratios).

12 “(v) LIMITATION.—In no case shall
13 more than 20 full-time equivalent addi-
14 tional residency positions be made available
15 under this subparagraph with respect to
16 any hospital.

17 “(vi) APPLICATION OF PER RESIDENT
18 AMOUNTS FOR PRIMARY CARE.—With re-
19 spect to additional residency positions in a
20 hospital attributable to the increase pro-
21 vided under this subparagraph, the ap-
22 proved FTE resident amounts are deemed
23 to be equal to the hospital per resident
24 amounts for primary care and nonprimary

1 care computed under paragraph (2)(D) for
2 that hospital.

3 “(vi) DISTRIBUTION.—The Secretary
4 shall distribute the increase in resident
5 training positions to qualifying hospitals
6 under this subparagraph not later than
7 July 1, 2011.

8 “(C) RESIDENT LEVEL AND LIMIT DE-
9 FINED.—In this paragraph:

10 “(i) The term ‘resident level’ has the
11 meaning given such term in paragraph
12 (7)(C)(i).

13 “(ii) The term ‘otherwise applicable
14 resident limit’ means, with respect to a
15 hospital, the limit otherwise applicable
16 under subparagraphs (F)(i) and (H) of
17 paragraph (4) on the resident level for the
18 hospital determined without regard to this
19 paragraph but taking into account para-
20 graph (7)(A).

21 “(D) MAINTENANCE OF PRIMARY CARE
22 RESIDENT LEVEL.—In carrying out this para-
23 graph, the Secretary shall require hospitals that
24 receive additional resident positions under sub-
25 paragraph (B)—

1 “(i) to maintain records, and periodi-
2 cally report to the Secretary, on the num-
3 ber of primary care residents in its resi-
4 dency training programs; and

5 “(ii) as a condition of continuing pay-
6 ment under this subsection for such posi-
7 tions, to maintain the level of such posi-
8 tions at not less than the sum of—

9 “(I) the level of primary care
10 resident positions before receiving
11 such additional positions; and

12 “(II) the number of such addi-
13 tional positions.”.

14 (b) IME.—

15 (1) IN GENERAL.—Section 1886(d)(5)(B)(v) of
16 the Social Security Act (42 U.S.C.
17 1395ww(d)(5)(B)(v)), in the second sentence, is
18 amended—

19 (A) by striking “subsection (h)(7)” and in-
20 serting “subsections (h)(7) and (h)(8)”; and

21 (B) by striking “it applies” and inserting
22 “they apply”.

23 (2) CONFORMING PROVISION.—Section
24 1886(d)(5)(B) of the Social Security Act (42 U.S.C.

1 1395ww(d)(5)(B)) is amended by adding at the end
2 the following clause:

3 “(x) For discharges occurring on or after July 1,
4 2011, insofar as an additional payment amount under this
5 subparagraph is attributable to resident positions distrib-
6 uted to a hospital under subsection (h)(8)(B), the indirect
7 teaching adjustment factor shall be computed in the same
8 manner as provided under clause (ii) with respect to such
9 resident positions.”.

10 (c) CONFORMING AMENDMENT.—Section 422(e)(2)
11 of the Medicare Prescription Drug, Improvement, and
12 Modernization Act of 2003 (Public Law 108-173) is
13 amended by striking “section 1886(h)(7)” and all that fol-
14 lows and inserting “paragraphs (7) and (8) of subsection
15 (h) of section 1886(h) of the Social Security Act”.

16 **SEC. 1502. INCREASING TRAINING IN NON-PROVIDER SET-**
17 **TINGS.**

18 (a) DIRECT GME.—Section 1886(h)(4)(E) of the So-
19 cial Security Act (42 U.S.C. 1395ww(h)) is amended—

20 (1) by striking “shall be counted and that all
21 the time” and inserting “shall be counted and
22 that—

23 “(i) effective for cost reporting peri-
24 ods beginning before July 1, 2009, all the
25 time”;

1 (2) in clause (i), as inserted by paragraph (1),
2 by striking the period at the end and inserting “;
3 and”; and

4 (3) by inserting after clause (i), as so inserted,
5 the following:

6 “(ii) effective for cost reporting peri-
7 ods beginning on or after July 1, 2009, all
8 the time so spent by a resident shall be
9 counted towards the determination of full-
10 time equivalency, without regard to the
11 setting in which the activities are per-
12 formed, if the hospital incurs the costs of
13 the stipends and fringe benefits of the resi-
14 dent during the time the resident spends in
15 that setting.

16 Any hospital claiming under this subparagraph
17 for time spent in a non-provider setting shall
18 maintain and make available to the Secretary
19 records regarding the amount of such time and
20 such amount in comparison with amounts of
21 such time in such base year as the Secretary
22 shall specify.”.

23 (b) IME.—Section 1886(d)(5)(B)(iv) of the Social
24 Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amend-
25 ed—

1 (1) by striking “(iv) Effective for discharges oc-
2 curring on or after October 1, 1997” and inserting
3 “(iv)(A) Effective for discharges occurring on or
4 after October 1, 1997, and before July 1, 2009”;
5 and

6 (2) by inserting after subparagraph (A), as in-
7 serted by paragraph (1), the following new subpara-
8 graph:

9 “(B) Effective for discharges occur-
10 ring on or after July 1, 2009, all the time
11 spent by an intern or resident in patient
12 care activities at an entity in a non-pro-
13 vider setting shall be counted towards the
14 determination of full-time equivalency if
15 the hospital incurs the costs of the sti-
16 pends and fringe benefits of the intern or
17 resident during the time the intern or resi-
18 dent spends in that setting.”.

19 (c) **OIG STUDY ON IMPACT ON TRAINING.**—The In-
20 specter General of the Department of Health and Human
21 Services shall analyze the data collected by the Secretary
22 of Health and Human Services from the records made
23 available to the Secretary under section 1886(h)(4)(E) of
24 the Social Security Act, as amended by subsection (a), in
25 order to assess the extent to which there is an increase

1 in time spent by medical residents in training in non-pro-
2 vider settings.

3 (d) DEMONSTRATION PROJECT FOR APPROVED
4 TEACHING HEALTH CENTERS.—

5 (1) IN GENERAL.—The Secretary of Health and
6 Human Services may conduct a demonstration
7 project under which an approved teaching health
8 center (as defined in paragraph (3)) would be eligi-
9 ble for payment under subsections (h) and (k) of
10 section 1886 of the Social Security Act (42 U.S.C.
11 1395ww) of amounts for its own direct costs of
12 graduate medical education activities for primary
13 care residents, as well as for the direct costs of grad-
14 uate medical education activities of its contracting
15 hospital for such residents, in a manner similar to
16 the manner in which such payments would be made
17 to a hospital if the hospital were to operate such a
18 program.

19 (2) CONDITIONS.—Under the demonstration
20 project—

21 (A) an approved teaching health center
22 shall contract with an accredited teaching hos-
23 pital to carry out the inpatient responsibilities
24 of the primary care residency program to the
25 hospital involved and is responsible for payment

1 of the hospital for the hospital's costs of the
2 salary and fringe benefits for residents in the
3 program;

4 (B) the hospital's full-time equivalent resi-
5 dent amount does not affect the contracting
6 hospital's resident limit; and

7 (C) the contracting hospital agrees and
8 does not diminish the number of residents in its
9 primary care residency training program.

10 (3) APPROVED TEACHING HEALTH CENTER DE-
11 FINED.—In this subsection, the term “approved
12 teaching health center” means a non-provider set-
13 ting, such as a Federally qualified health center or
14 rural health center (as defined in section 1861(aa)
15 of the Social Security Act), that develops and oper-
16 ates an accredited primary care residency program
17 for which funding would be available if it were oper-
18 ated by a hospital in connection with a hospital.

19 **SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DI-**
20 **DACTIC AND SCHOLARLY ACTIVITIES AND**
21 **OTHER ACTIVITIES.**

22 (a) DIRECT GME.—Section 1886(h) of the Social Se-
23 curity Act (42 U.S.C. 1395ww(h)), as amended by section
24 1502, is amended—

25 (1) in paragraph (4)(E)—

1 (A) by designating the first sentence as a
2 clause (i) with the heading “IN GENERAL” and
3 appropriate indentation and by striking “Such
4 rules” and inserting “Subject to clause (ii),
5 such rules”; and

6 (B) by adding at the end the following new
7 clause:

8 “(ii) TREATMENT OF CERTAIN NON-
9 PROVIDER AND DIDACTIC ACTIVITIES.—
10 Such rules shall provide that all time spent
11 by an intern or resident in an approved
12 medical residency training program in a
13 non-provider setting that is primarily en-
14 gaged in furnishing patient care (as de-
15 fined in paragraph (5)(K)) in non-patient
16 care activities, such as didactic conferences
17 and seminars, but not including research
18 not associated with the treatment or diag-
19 nosis of a particular patient, as such time
20 and activities are defined by the Secretary,
21 shall be counted toward the determination
22 of full-time equivalency.”;

23 (2) in paragraph (4), by adding at the end the
24 following new subparagraph:

1 “(I) In determining the hospital’s number
2 of full-time equivalent residents for purposes of
3 this subsection, all the time that is spent by an
4 intern or resident in an approved medical resi-
5 dency training program on vacation, sick leave,
6 or other approved leave, as such time is defined
7 by the Secretary, and that does not prolong the
8 total time the resident is participating in the
9 approved program beyond the normal duration
10 of the program shall be counted toward the de-
11 termination of full-time equivalency.”; and

12 (3) in paragraph (5), by adding at the end the
13 following new subparagraph:

14 “(K) NON-PROVIDER SETTING THAT IS
15 PRIMARILY ENGAGED IN FURNISHING PATIENT
16 CARE.—The term ‘non-provider setting that is
17 primarily engaged in furnishing patient care’
18 means a non-provider setting in which the pri-
19 mary activity is the care and treatment of pa-
20 tients, as defined by the Secretary.”.

21 (b) IME DETERMINATIONS.—Section 1886(d)(5)(B)
22 of such Act (42 U.S.C. 1395ww(d)(5)(B)), as amended by
23 section 1501(b), is amended by adding at the end the fol-
24 lowing new clause:

1 “(xi)(I) The provisions of subparagraph (I) of sub-
2 section (h)(4) shall apply under this subparagraph in the
3 same manner as they apply under such subsection.

4 “(II) In determining the hospital’s number of full-
5 time equivalent residents for purposes of this subpara-
6 graph, all the time spent by an intern or resident in an
7 approved medical residency training program in non-pa-
8 tient care activities, such as didactic conferences and semi-
9 nars, as such time and activities are defined by the Sec-
10 retary, that occurs in the hospital shall be counted toward
11 the determination of full-time equivalency if the hospital—

12 “(aa) is recognized as a subsection (d) hospital;

13 “(bb) is recognized as a subsection (d) Puerto
14 Rico hospital;

15 “(cc) is reimbursed under a reimbursement sys-
16 tem authorized under section 1814(b)(3); or

17 “(dd) is a provider-based hospital outpatient de-
18 partment.

19 “(III) In determining the hospital’s number of full-
20 time equivalent residents for purposes of this subpara-
21 graph, all the time spent by an intern or resident in an
22 approved medical residency training program in research
23 activities that are not associated with the treatment or di-
24 agnosis of a particular patient, as such time and activities

1 are defined by the Secretary, shall not be counted toward
2 the determination of full-time equivalency.”.

3 (c) EFFECTIVE DATES; APPLICATION.—

4 (1) IN GENERAL.—Except as otherwise pro-
5 vided, the Secretary of Health and Human Services
6 shall implement the amendments made by this sec-
7 tion in a manner so as to apply to cost reporting pe-
8 riods beginning on or after January 1, 1983.

9 (2) DIRECT GME.—Section 1886(h)(4)(E)(ii) of
10 the Social Security Act, as added by subsection
11 (a)(1)(B), shall apply to cost reporting periods be-
12 ginning on or after July 1, 2008.

13 (3) IME.—Section 1886(d)(5)(B)(x)(III) of the
14 Social Security Act, as added by subsection (b), shall
15 apply to cost reporting periods beginning on or after
16 October 1, 2001. Such section, as so added, shall
17 not give rise to any inference on how the law in ef-
18 fect prior to such date should be interpreted.

19 (4) APPLICATION.—The amendments made by
20 this section shall not be applied in a manner that re-
21 quires reopening of any settled hospital cost reports
22 as to which there is not a jurisdictionally proper ap-
23 peal pending as of the date of the enactment of this
24 Act on the issue of payment for indirect costs of
25 medical education under section 1886(d)(5)(B) of

1 the Social Security Act or for direct graduate med-
2 ical education costs under section 1886(h) of such
3 Act.

4 **SEC. 1504. PRESERVATION OF RESIDENT CAP POSITIONS**
5 **FROM CLOSED HOSPITALS.**

6 (a) DIRECT GME.—Section 1886(h)(4)(H) of the So-
7 cial Security Act (42 U.S.C. Section 1395ww(h)(4)(H))
8 is amended by adding at the end the following new clause:

9 “(vi) REDISTRIBUTION OF RESIDENCY
10 SLOTS AFTER A HOSPITAL CLOSES.—

11 “(I) IN GENERAL.—Subject to
12 the succeeding provisions of this
13 clause, the Secretary shall, by regula-
14 tion, establish a process under which,
15 in the case where a hospital with an
16 approved medical residency program
17 in a State closes on or after the date
18 that is 2 years before the date of the
19 enactment of this clause, the Sec-
20 retary shall increase the otherwise ap-
21 plicable resident limit under this para-
22 graph for other hospitals in the State
23 in accordance with this clause.

24 “(II) PROCESS FOR HOSPITALS
25 IN CERTAIN AREAS.—Subject to the

1 succeeding provisions of this clause, in
2 determining for which hospitals the
3 increase in the otherwise applicable
4 resident limit is provided under such
5 process, the Secretary shall distribute
6 the increase to hospitals located in a
7 State in a manner specified by the
8 Secretary, which shall be consistent
9 with any recommendations submitted
10 to the Secretary by the Secretary of
11 Health for the State if such rec-
12 ommendations are submitted not later
13 than 180 days after the date of the
14 hospital closure involved (or, in the
15 case of a hospital that closed before
16 the date of the enactment of this
17 clause, 180 days after such date).

18 “(III) LIMITATION.—The esti-
19 mated aggregate number of increases
20 in the otherwise applicable resident
21 limits for hospitals under this clause
22 shall be equal to the estimated num-
23 ber of resident positions in the ap-
24 proved medical residency programs

1 that closed on or after the date de-
2 scribed in subclause (I).”.

3 (b) NO EFFECT ON TEMPORARY FTE CAP ADJUST-
4 MENTS.—The amendments made by this section shall not
5 effect any temporary adjustment to a hospital’s FTE cap
6 under section 413.79(h) of title 42, Code of Federal Regu-
7 lations (as in effect on the date of enactment of this Act).

8 (c) CONFORMING AMENDMENT.—Section 422(c)(2)
9 of the Medicare Prescription Drug, Improvement, and
10 Modernization Act of 2003 (Public Law 108-173), as
11 amended by section 1501(c), is amended by striking “(7)
12 and” and inserting “(4)(H)(vi), (7), and”.

13 **SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED**
14 **MEDICAL RESIDENCY TRAINING.**

15 (a) SPECIFICATION OF GOALS FOR APPROVED MED-
16 ICAL RESIDENCY TRAINING PROGRAMS.—Section
17 1886(h)(1) of the Social Security Act (42 U.S.C.
18 1395ww(h)(1)) is amended—

19 (1) by designating the matter beginning with
20 “Notwithstanding” as a subparagraph (A) with the
21 heading “IN GENERAL.—” and with appropriate in-
22 dentation; and

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

1 “(B) GOALS FOR APPROVED MEDICAL
2 RESIDENCY TRAINING PROGRAMS.—The goals
3 of medical residency training programs are to
4 foster a physician workforce so that physicians
5 are trained to be able to do the following:

6 “(i) Work effectively in various health
7 care delivery settings, such as non-provider
8 settings.

9 “(ii) Coordinate patient care within
10 and across settings relevant to their spe-
11 cialties.

12 “(iii) Understand the relevant cost
13 and value of various diagnostic and treat-
14 ment options.

15 “(iv) Work in inter-professional teams
16 and multi-disciplinary team-based models
17 in provider and non-provider settings to
18 enhance safety and improve quality of pa-
19 tient care.

20 “(v) Be knowledgeable in methods of
21 identifying systematic errors in health care
22 delivery and in implementing systematic
23 solutions in case of such errors, including
24 experience and participation in continuous
25 quality improvement projects to improve

1 health outcomes of the population the phy-
2 sician serve.

3 “(vi) Be meaningful EHR users (as
4 determined under section 1848(o)(2)) in
5 the delivery of care and in improving the
6 quality of the health of the community and
7 the individuals that the hospital serves.”

8 (b) GAO STUDY ON EVALUATION OF TRAINING PRO-
9 GRAMS.—

10 (1) IN GENERAL.—The Comptroller General of
11 the United States shall conduct a study to evaluate
12 the extent to which medical residency training pro-
13 grams—

14 (A) are meeting the goals described in sec-
15 tion 1886(h)(1)(B) of the Social Security Act,
16 as added by subsection (a), in a range of resi-
17 dency programs, including primary care and
18 specialties; and

19 (B) have the appropriate faculty expertise
20 to teach the topics required to achieve such
21 goals.

22 (2) REPORT.—Not later than 18 months after
23 the date of the enactment of this Act, the Comp-
24 troller General shall submit to Congress a report on
25 such study and shall include in such report rec-

1 ommendations as to how medical residency training
2 programs could be further encouraged to meet such
3 goals through means such as—

4 (A) development of curriculum require-
5 ments; and

6 (B) assessment of the accreditation proc-
7 esses of the Accreditation Council for Graduate
8 Medical Education and the American Osteo-
9 pathic Association and effectiveness of those
10 processes in accrediting medical residency pro-
11 grams that meet the goals referred to in sub-
12 paragraph (A)(i).

13 **TITLE VI—PROGRAM INTEGRITY**
14 **Subtitle A—Increased Funding to**
15 **Fight Waste, Fraud, and Abuse**

16 **SEC. 1601. INCREASED FUNDING FOR HCFAC FUND.**

17 The amounts appropriated to the Health Care Fraud
18 and Abuse Control Account under section 1817(k) shall
19 be increased as specified by Congress.

1 **Subtitle B—Enhanced Penalties for**
2 **Fraud and Abuse**

3 **SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS**
4 **ON PROVIDER OR SUPPLIER ENROLLMENT**
5 **APPLICATIONS.**

6 (a) IN GENERAL.—Section 1128A(a) of the Social
7 Security Act (42 U.S.C. 1320a–7a(a)) is amended—

8 (1) in paragraph (1)(D), by striking all that fol-
9 lows “in which the person was excluded” and insert-
10 ing “under Federal law from the Federal health care
11 program under which the claim was made, or”;

12 (2) by striking “or” at the end of paragraph
13 (6);

14 (3) in paragraph (7), by inserting at the end
15 “or”;

16 (4) by inserting after paragraph (7) the fol-
17 lowing new paragraph:

18 “(8) knowingly makes or causes to be made any
19 false statement or misrepresentation of a material
20 fact in any application to participate or enroll as a
21 provider or supplier of items or services under a
22 Federal health care program, including managed
23 care organizations under title XIX, MA organiza-
24 tions and Medicare Advantage plans under part C of
25 title XVIII, PDP sponsors and prescription drug

1 plans under part D of such title, and entities that
2 apply to participate as providers or suppliers in such
3 managed care organizations and such plans;”;

4 (5) in the matter following paragraph (8), as
5 inserted by paragraph (4), by striking “or in cases
6 under paragraph (7), \$ 50,000 for each such act)”
7 and inserting “in cases under paragraph (7),
8 \$50,000 for each such act, or in cases under para-
9 graph (8), \$50,000 for each false statement or mis-
10 representation of a material fact)”;

11 (6) in the second sentence, by striking “for a
12 lawful purpose)” and inserting “for a lawful pur-
13 pose), or in cases under paragraph (8), an assess-
14 ment of not more than 3 times the amount claimed
15 as the result of the false statement or misrepresenta-
16 tion of material fact claimed by a provider or sup-
17 plier whose application to participate contained such
18 false statement or misrepresentation)”.

19 (b) **EFFECTIVE DATE.**—The amendments made by
20 subsection (a) shall apply to violations committed on or
21 after January 1, 2010.

1 **SEC. 1612. ENHANCED PENALTIES FOR SUBMISSION OF**
2 **FALSE MEDICARE, MEDICAID, OR CHIP**
3 **CLAIMS DATA.**

4 (a) **IN GENERAL.**—Section 1128A(a) of the Social
5 Security Act (42 U.S.C. 1320a–7a(a)), as amended by sec-
6 tion 1611, is further amended—

7 (1) in paragraph (7), by striking “or” at the
8 end;

9 (2) in paragraph (8), by inserting “or” at the
10 end; and

11 (3) by inserting after paragraph (8), the fol-
12 lowing new paragraph:

13 “(9) knowingly makes or causes to be made any
14 false statement or misrepresentation of a material
15 fact in any data or information submitted to support
16 a claim for payment for items and services furnished
17 under a program under title XVIII, XIX, or XXI;”;
18 and

19 (4) in the matter following paragraph (10), as
20 inserted by paragraph (3), by striking “under para-
21 graph (8)” and inserting “under paragraph (8) or
22 (9)”.

23 (b) **EFFECTIVE DATE.**—The amendments made by
24 subsection (a) shall apply to violations committed on or
25 after January 1, 2010.

1 **SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPEC-**
2 **TOR GENERAL INVESTIGATIONS.**

3 (a) IN GENERAL.—Section 1128A(a) of the Social
4 Security Act (42 U.S.C. 1320a–7a(a)), as amended by sec-
5 tions 1611 and 1612, is further amended—

6 (1) in paragraph (8), by striking “or” at the
7 end;

8 (2) in paragraph (9), by inserting “or” at the
9 end;

10 (3) by inserting after paragraph (9) the fol-
11 lowing new paragraph:

12 “(10) fails to grant timely access, upon reason-
13 able request (as defined by the Secretary in regula-
14 tions), to the Inspector General of the Department
15 of Health and Human Services, for the purpose of
16 audits, investigations, evaluations, or other statutory
17 functions of the Inspector General;” and

18 (4) in the matter following paragraph (10), as
19 inserted by paragraph (3), by striking “in cases
20 under paragraph (7), \$50,000 for each such act”
21 and inserting “in cases under paragraph (7),
22 \$50,000 for each such act, in cases under paragraph
23 (10), \$15,000 for each day of the failure described
24 in such paragraph”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to violations committed on or
3 after January 1, 2010.

4 **SEC. 1614. ENHANCED HOSPICE PROGRAM SAFEGUARDS.**

5 Part A of title XVIII of the Social Security Act is
6 amended by inserting after section 1819 the following new
7 section:

8 **“SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE**
9 **CARE.**

10 “(a) IN GENERAL.—If the Secretary determines on
11 the basis of a survey or otherwise, that a hospice program
12 that is certified for participation under this title has dem-
13 onstrated a substandard quality of care and failed to meet
14 such other requirements as the Secretary may find nec-
15 essary in the interest of the health and safety of the indi-
16 viduals who are provided care and services by the agency
17 or organization involved and determines—

18 “(1) that the deficiencies involved immediately
19 jeopardize the health and safety of the individuals to
20 whom the program furnishes items and services, the
21 Secretary shall take immediate action to remove the
22 jeopardy and correct the deficiencies through the
23 remedy specified in subsection (b)(2)(A)(iii) or ter-
24minate the certification of the program, and may

1 provide, in addition, for 1 or more of the other rem-
2 edies described in subsection (b)(2)(A); or

3 “(2) that the deficiencies involved do not imme-
4 diately jeopardize the health and safety of the indi-
5 viduals to whom the program furnishes items and
6 services, the Secretary may—

7 “(A) (for a period not to exceed 6 months)
8 impose intermediate sanctions developed pursu-
9 ant to subsection (b), in lieu of terminating the
10 certification of the program; and

11 “(B) if, after such a period of intermediate
12 sanctions, the program is still not in compliance
13 with such requirements, the Secretary shall ter-
14minate the certification of the program.

15 If the Secretary determines that a hospice program
16 that is certified for participation under this title is
17 in compliance with such requirements but, as of a
18 previous period, was not in compliance with such re-
19 quirements, the Secretary may provide for a civil
20 money penalty under subsection (b)(2)(A)(i) for the
21 days in which it finds that the program was not in
22 compliance with such requirements.

23 “(b) INTERMEDIATE SANCTIONS.—

1 “(1) DEVELOPMENT AND IMPLEMENTATION.—

2 The Secretary shall develop and implement, by not
3 later than January 1, 2011—

4 “(A) a range of intermediate sanctions to
5 apply to hospice programs under the conditions
6 described in subsection (a), and

7 “(B) appropriate procedures for appealing
8 determinations relating to the imposition of
9 such sanctions.

10 “(2) SPECIFIED SANCTIONS.—

11 “(A) IN GENERAL.—The intermediate
12 sanctions developed under paragraph (1) may
13 include—

14 “(i) civil money penalties in an
15 amount not to exceed \$10,000 for each day
16 of noncompliance,

17 “(ii) suspension of all or part of the
18 payments to which a hospice program
19 would otherwise be entitled under this title
20 with respect to items and services fur-
21 nished by a hospice program on or after
22 the date on which the Secretary determines
23 that intermediate sanctions should be im-
24 posed pursuant to subsection (a)(2),

1 “(iii) the appointment of temporary
2 management to oversee the operation of
3 the hospice program and to protect and as-
4 sure the health and safety of the individ-
5 uals under the care of the program while
6 improvements are made,

7 “(iv) directed plans of correction, and

8 “(v) in-service training for staff.

9 The provisions of section 1128A (other than
10 subsections (a) and (b)) shall apply to a civil
11 money penalty under clause (i) in the same
12 manner as such provisions apply to a penalty or
13 proceeding under section 1128A(a). The tem-
14 porary management under clause (iii) shall not
15 be terminated until the Secretary has deter-
16 mined that the program has the management
17 capability to ensure continued compliance with
18 all requirements referred to in that clause.

19 “(B) CLARIFICATION.—The sanctions
20 specified in subparagraph (A) are in addition to
21 sanctions otherwise available under State or
22 Federal law and shall not be construed as lim-
23 iting other remedies, including any remedy
24 available to an individual at common law.

1 “(C) A finding to suspend payment under
2 subparagraph (A)(ii) shall terminate when the
3 Secretary finds that the hospice program no
4 longer demonstrates a substandard quality of
5 care and meets such other requirements as the
6 Secretary may find necessary in the interest of
7 the health and safety of the individuals who are
8 provided care and services by the agency or or-
9 ganization involved.

10 “(3) SECRETARIAL AUTHORITY.—The Secretary
11 shall develop and implement, by not later than Janu-
12 ary 1, 2011, specific procedures with respect to the
13 conditions under which each of the intermediate
14 sanctions developed under paragraph (1) is to be ap-
15 plied, including the amount of any fines and the se-
16 verity of each of these sanctions. Such procedures
17 shall be designed so as to minimize the time between
18 identification of deficiencies and imposition of these
19 sanctions and shall provide for the imposition of in-
20 crementally more severe fines for repeated or uncor-
21 rected deficiencies.”.

1 **SEC. 1615. ENHANCED PENALTIES FOR INDIVIDUALS EX-**
2 **CLUDED FROM PROGRAM PARTICIPATION.**

3 (a) **IN GENERAL.**—Section 1128A(a) of the Social
4 Security Act (42 U.S.C. 1320a–7a(a)), as amended by the
5 previous sections, is further amended—

6 (1) by striking “or” at the end of paragraph
7 (9);

8 (2) by inserting after paragraph (10) the fol-
9 lowing new paragraph:

10 “(11) orders or prescribes an item or service
11 during a period when the person has been excluded
12 from participation in a Federal health care program,
13 and the person knows or should know that a claim
14 for such item or service will be presented to such a
15 program;” and

16 (3) in the matter following paragraph (11), as
17 inserted by paragraph (2), by striking “\$15,000 for
18 each day of the failure described in such paragraph”
19 and inserting “\$15,000 for each day of the failure
20 described in such paragraph, in cases under para-
21 graph (11), \$50,000 for each such violation”.

22 (b) **EFFECTIVE DATE.**—The amendments made by
23 subsection (a) shall apply to violations committed on or
24 after January 1, 2010.

1 **SEC. 1616. ENHANCED PENALTIES FOR PROVISION OF**
2 **FALSE INFORMATION BY MEDICARE ADVAN-**
3 **TAGE AND PART D PLANS.**

4 (a) **IN GENERAL.**—Section 1857(g)(2)(A) of the So-
5 cial Security Act (42 U.S.C. 1395w—27(g)(2)(A)) is
6 amended by inserting “except with respect to a determina-
7 tion under subparagraph (E), an assessment of not more
8 than 3 times the amount paid to such plan or plan sponsor
9 based upon the misrepresentation or falsified information
10 involved,” after “for each such determination,”.

11 (b) **EFFECTIVE DATE.**—The amendment made by
12 subsection (a) shall apply to violations committed on or
13 after January 1, 2010.

14 **SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVAN-**
15 **TAGE AND PART D MARKETING VIOLATIONS.**

16 (a) **IN GENERAL.**—Section 1857(g)(1) of the Social
17 Security Act (42 U.S.C. 1395w—27(g)(1)), as amended
18 by section 1221(b)(3), is amended—

19 (1) in subparagraph (G), by striking “or” at
20 the end;

21 (2) by inserting after subparagraph (H) the fol-
22 lowing new subparagraphs:

23 “(I) except as provided under section sub-
24 paragraph (C) or (D) of section 1860D-
25 1(b)(1), enrolls an individual in any plan under

1 this part without the prior consent of the indi-
2 vidual or the designee of the individual;

3 “(J) transfers an individual enrolled under
4 this part from one plan to another without the
5 prior consent of the individual or the designee
6 of the individual or solely for the purpose of
7 earning a commission;

8 “(K) fails to comply with marketing re-
9 strictions described in subsections (h)(6),
10 (h)(7), and (j) of section 1851 or applicable im-
11 plementing regulations; or

12 “(L) employs or contracts with any indi-
13 vidual or entity who engages in the conduct de-
14 scribed in subparagraphs (A) through (K) of
15 this paragraph;” and

16 (3) by adding at the end the following new sen-
17 tence: “The Secretary may provide, in addition to
18 any other remedies authorized by law, for any of the
19 remedies described in paragraph (2), if the Secretary
20 determines that any employee or agent of such orga-
21 nization, or any provider or supplier who contracts
22 with such organization, has engaged in any conduct
23 described in subparagraphs (A) through (L) of this
24 paragraph.”

1 (b) AUTHORITY FOR OIG TO IMPOSE PENALTIES.—
2 Section 1857(g)(3) of such Act (42 U.S.C. 1395w-
3 27(g)(3)) is amended by striking “Secretary may apply”
4 and inserting “Secretary or the Administrator of the Cen-
5 ters for Medicare & Medicaid Services may apply”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 subsections (a) and (b) shall apply to violations committed
8 on or after January 1, 2010.

9 **SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF**
10 **PROGRAM AUDITS.**

11 (a) IN GENERAL.—Section 1128(b)(2) of the Social
12 Security Act (42 U.S.C. 1320a-7(b)(2)) is amended—

13 (1) in the heading, by inserting “OR AUDIT”
14 after “INVESTIGATION”; and

15 (2) by striking “investigation into” and all that
16 follows through the period and inserting “investiga-
17 tion or audit related to—”

18 “(i) any offense described in para-
19 graph (1) or in subsection (a); or

20 “(ii) the use of funds received, directly
21 or indirectly, from any Federal health care
22 program (as defined in section
23 1128B(f)).”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to violations committed on or
3 after January 1, 2010.

4 **Subtitle C—Enhanced Program**
5 **and Provider Protections**

6 **SEC. 1631. ENHANCED CMS PROGRAM PROTECTION AU-**
7 **THORITY.**

8 (a) IN GENERAL.—Title XI of the Social Security Act
9 (42 U.S.C. 1301 et seq.) is amended by inserting after
10 section 1128F the following new section:

11 **“SEC. 1128G. ENHANCED PROGRAM AND PROVIDER PRO-**
12 **TECTIONS IN THE MEDICARE, MEDICAID, AND**
13 **CHIP PROGRAMS.**

14 **“(a) CERTAIN AUTHORIZED SCREENING, ENHANCED**
15 **OVERSIGHT PERIODS, AND ENROLLMENT MORATORIA.—**

16 **“(1) IN GENERAL.—**For periods beginning after
17 January 1, 2010, in the case that the Secretary de-
18 termines there is a significant risk (as determined by
19 the Secretary based on relevant complaints, reports,
20 referrals, data analysis of historical data, trending
21 information, and claims submissions by providers
22 and suppliers) of fraudulent activity with respect to
23 a category of provider or supplier, including a cat-
24 egory within a geographic area, under title XVIII,
25 XIX, or XXI, the Secretary may impose any of the

1 following requirements with respect to a provider of
2 services or a supplier (whether such provider or sup-
3 plier is first enrolling in the program or is renewing
4 such enrollment) for purposes of such applicable cat-
5 egory:

6 “(A) Screening under paragraph (2).

7 “(B) Enhanced oversight periods under
8 paragraph (3).

9 “(C) Enrollment moratoria under para-
10 graph (4).

11 In applying this subsection for purposes of title XIX
12 and XXI the Secretary may require a State to carry
13 out the provisions of this subsection as a require-
14 ment of the State plan under title XIX or the child
15 health plan under title XXI.

16 “(2) SCREENING.—For purposes of paragraph
17 (1), the Secretary shall establish procedures under
18 which screening is conducted with respect to pro-
19 viders of services and suppliers described in such
20 paragraph. Such screening may include—

21 “(A) licensing board checks;

22 “(B) screening against the list of individ-
23 uals and entities excluded from the program
24 under title XVIII, XIX, or XXI;

25 “(C) the excluded provider list system;

1 “(D) background checks; and

2 “(E) unannounced pre-enrollment or other
3 site visits.

4 “(3) ENHANCED OVERSIGHT PERIOD.—For
5 purposes of paragraph (1), the Secretary shall estab-
6 lish procedures to provide for a period of not less
7 than 30 days and not more than 365 during which
8 providers of services and suppliers described in such
9 paragraph, as the Secretary determines appropriate,
10 would be subject to enhanced oversight(such as site
11 visits, prepayment review, enhanced review of claims,
12 and such other actions as specified by the Secretary)
13 under the programs under titles XVIII, XIX, and
14 XXI.

15 “(4) MORATORIUM ON ENROLLMENT OF NEW
16 PROVIDERS.—For purposes of paragraph (1), the
17 Secretary, based upon a finding of serious ongoing
18 fraud within a program under title XVIII, XIX, or
19 XXI, may impose a moratorium on the enrollment of
20 providers of services and suppliers within a category
21 of providers of services and suppliers (including a
22 category within a specific geographic area) under
23 such title. Such a moratorium may only be imposed
24 if the Secretary makes a determination that the
25 moratorium would not adversely impact access of in-

1 individuals to care under such program. There shall be
2 no administrative review with respect to any morato-
3 rium imposed under this paragraph.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) MEDICAID.—Section 1902(a) of the Social
6 Security Act (42 U.S.C. 42 U.S.C. 1396a(a)) is
7 amended—

8 (A) in paragraph (23), by inserting before
9 the semicolon at the end the following: “or by
10 a person to whom or entity to which a morato-
11 rium under section 1128G(a)(4) is applied dur-
12 ing the period of such moratorium”; and

13 (B) in paragraph (72); by striking at the
14 end “and”;

15 (C) in paragraph (73), by striking the pe-
16 riod at the end and inserting “and”; and

17 (D) by adding after paragraph (73) the
18 following new paragraph:

19 “(74) provide that the State will enforce any
20 determination made by the Secretary under sub-
21 section (a) of section 1128G (relating to a signifi-
22 cant risk of fraudulent activity with respect to a cat-
23 egory of provider or supplier described in such sub-
24 section (a) through use of the appropriate proce-
25 dures described in such subsection (a)), and that the

1 State will carry out any activities as required by the
2 Secretary for purposes of such subsection (a).”.

3 (2) CHIP.—Section 2102 of such Act (42
4 U.S.C. 1397bb) is amended by adding at the end the
5 following new subsection:

6 “(d) PROGRAM INTEGRITY.—A State child health
7 plan shall include a description of the procedures to be
8 used by the State—

9 “(1) to enforce any determination made by the
10 Secretary under subsection (a) of section 1128G (re-
11 lating to a significant risk of fraudulent activity with
12 respect to a category of provider or supplier de-
13 scribed in such subsection through use of the appro-
14 priate procedures described in such subsection); and

15 “(2) to carry out any activities as required by
16 the Secretary for purposes of such subsection.”.

17 **SEC. 1632. ENHANCED MEDICARE, MEDICAID, AND CHIP**
18 **PROGRAM DISCLOSURE REQUIREMENTS RE-**
19 **LATING TO PREVIOUS AFFILIATIONS.**

20 (a) IN GENERAL.—Section 1128G of the Social Secu-
21 rity Act, as inserted by section 1631, is amended by add-
22 ing at the end the following new subsection:

23 “(b) ENHANCED PROGRAM DISCLOSURE REQUIRE-
24 MENTS.—

1 “(1) DISCLOSURE.—A provider of services or
2 supplier who submits on or after January 1, 2010,
3 an application for enrollment and renewing enroll-
4 ment in a program under title XVIII, XIX, or XXI
5 shall disclose (in a form and manner determined by
6 the Secretary) any current affiliation or affiliation
7 within the previous 7-year period with a provider of
8 services or supplier that has uncollected debt or with
9 a person or entity that has been suspended or ex-
10 cluded under such program.

11 “(2) ENHANCED SAFEGUARDS.—If the Sec-
12 retary determines that such previous affiliation of
13 such provider or supplier poses an undue risk of
14 fraud, waste, or abuse, the Secretary may apply
15 such enhanced safeguards as the Secretary deter-
16 mines necessary to reduce such risk associated with
17 such provider or supplier enrolling or participating
18 in the program under title XVIII, XIX, or XXI.
19 Such safeguards may include enhanced oversight
20 (such as enhanced screening of claims, required site
21 visits or inspections, additional information report-
22 ing requirements, and conditioning such participa-
23 tion on the provision of a surety bond.

24 “(3) AUTHORITY TO DENY PARTICIPATION.—If
25 the Secretary determines that there has been more

1 than one such affiliation and that such affiliations of
2 such provider or supplier pose a serious risk of
3 fraud, waste, or abuse, the Secretary may deny the
4 application of such provider or such supplier. Such
5 a denial shall be subject to appeal, with such appeal
6 to be heard by the Secretary not later than 30 days
7 after such appeal is filed.”.

8 (b) CONFORMING AMENDMENTS.—

9 (1) MEDICAID.—Paragraph (74) of section
10 1902(a) of such Act (42 U.S.C. 1396a(a)), as added
11 by section 1631(b)(1), is amended—

12 (A) by inserting “or subsection (b) of such
13 section (relating to disclosure requirements)”
14 before “, and that the State”; and

15 (B) by inserting before the period the fol-
16 lowing: “and apply any enhanced safeguards,
17 with respect to a provider or supplier described
18 in such subsection (b), as the Secretary deter-
19 mines necessary under such subsection (b)”.

20 (2) CHIP.—Subsection (d) of section 2102 of
21 such Act (42 U.S.C. 1397bb), as added by section
22 1631(b)(2), is amended—

23 (A) in paragraph (1), by striking at the
24 end “and”;

1 (B) in paragraph (2) by striking the period
2 at the end and inserting “; and’ ” and

3 (C) by adding at the end the following new
4 paragraph:

5 “(3) to enforce any determination made by the
6 Secretary under subsection (b) of section 1128G (re-
7 lating to disclosure requirements) and to apply any
8 enhanced safeguards, with respect to a provider or
9 supplier described in such subsection, as the Sec-
10 retary determines necessary under such subsection.”.

11 **SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER**
12 **FOR CERTAIN EVALUATION AND MANAGE-**
13 **MENT SERVICES.**

14 Section 1848 of the Social Security Act (42 U.S.C.
15 1395w-4), as amended by section 4101 of the HITECH
16 Act (Public Law 111-5), is amended by adding at the end
17 the following new subsection:

18 “(p) **PAYMENT MODIFIER FOR CERTAIN EVALUA-**
19 **TION AND MANAGEMENT SERVICES.**—The Secretary shall
20 establish a payment modifier under the fee schedule under
21 this section for evaluation and management services (as
22 specified in section 1842(b)(16)(B)(ii)) that result in the
23 ordering of additional services (such as lab tests), the pre-
24 scription of drugs, or the furnishing or ordering of durable
25 medical equipment in order to enable better monitoring

1 of claims for payment for such additional services under
2 this title.”.

3 **SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER**
4 **MEDICARE INTEGRITY PROGRAM.**

5 (a) IN GENERAL.—Section 1893(c) of the Social Se-
6 curity Act (42 U.S.C. 1395ddd(c)) is amended—

7 (1) in paragraph (3), by striking at the end
8 “and”;

9 (2) by redesignating paragraph (4) as para-
10 graph (5); and

11 (3) by inserting after paragraph (3) the fol-
12 lowing new paragraph:

13 “(4) for the contract year beginning in 2011
14 and each subsequent contract year, the entity pro-
15 vides assurances to the satisfaction of the Secretary
16 that the entity will conduct periodic evaluations of
17 the effectiveness of the activities carried out by such
18 entity under the Program and will submit to the
19 Secretary an annual report on such activities; and”.

20 (b) REFERENCE TO MEDICAID INTEGRITY PRO-
21 GRAM.—For a similar provision with respect to the Med-
22 icaid Integrity Program, see section 1852.

1 **SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO**
2 **ADOPT PROGRAMS TO REDUCE WASTE,**
3 **FRAUD, AND ABUSE.**

4 (a) IN GENERAL.—

5 (1) PROVIDERS OF SERVICES.—Section 1866 of
6 the Social Security Act (42 U.S.C. 1395cc) is
7 amended—

8 (A) in subsection (a)(1)—

9 (i) in subparagraph (U), by striking
10 at the end “and”;

11 (ii) in subparagraph (V), by striking
12 at the end the period and inserting “,
13 and”;

14 (iii) by adding after subparagraph (V)
15 the following new subparagraph:

16 “(W) subject to paragraph (5) of sub-
17 section (k), to establish a compliance program
18 described in paragraph (1) of such subsection
19 in accordance with such subsection.”; and

20 (B) by adding at the end the following new
21 subsection:

22 “(k) COMPLIANCE PROGRAMS.—

23 “(1) IN GENERAL.—The compliance program
24 described in this paragraph is a program that con-
25 tains the core elements established under paragraph
26 (2).

1 “(2) ESTABLISHMENT OF CORE ELEMENTS.—

2 The Secretary, in consultation with the Inspector
3 General of the Department of Health and Human
4 Services, shall establish core elements for a compli-
5 ance program under paragraph (1). Such elements
6 may include written policies, procedures, and stand-
7 ards of conduct, a designated compliance officer and
8 a compliance committee; effective training and edu-
9 cation pertaining to fraud, waste, and abuse for the
10 organization’s employees and contractors; a con-
11 fidential or anonymous mechanism, such as a hot-
12 line, to receive compliance questions and reports of
13 fraud, waste, or abuse; disciplinary guidelines for en-
14 forcement of standards; internal monitoring and au-
15 diting procedures, including monitoring and auditing
16 of contractors; and procedures for ensuring prompt
17 responses to detected offenses and development of
18 corrective action initiatives, including responses to
19 potential offenses.

20 “(3) TIMELINE FOR IMPLEMENTATION.—The
21 Secretary, in consultation with the Inspector General
22 of the Department of Health and Human Services,
23 shall determine a timeline for the establishment of
24 the core elements under paragraph (2) and the date
25 on which a provider of services and suppliers (other

1 than physicians) shall be required to have estab-
2 lished such a program for purposes of subsection
3 (a)(1)(W).

4 “(4) CMS ENFORCEMENT AUTHORITY.—The
5 Administrator for the Centers of Medicare & Med-
6 icaid Services shall have the authority to determine
7 whether a provider of services or supplier described
8 in subparagraph (3) has met the requirement of this
9 subsection and to impose a civil monetary penalty
10 not to exceed \$50,000 for each violation. The Sec-
11 retary may also impose other intermediate sanctions,
12 including corrective plans of actions and additional
13 monitoring in the case of a violation of this sub-
14 section.

15 “(5) PILOT PROGRAM.—The Secretary may
16 conduct a pilot program on the application of this
17 subsection with respect to a category of providers of
18 services or suppliers (other than physicians) that the
19 Secretary determines to be a category which is at
20 high risk for waste, fraud, and abuse before imple-
21 menting the requirements of this subsection and
22 subsection (a)(1)(W) to all providers of services and
23 suppliers described in paragraph (3).”.

1 (b) REDUCING MAXIMUM PERIOD FOR SUBMIS-
2 SION.—

3 (1) PART A.—Section 1814(a)(1) of the Social
4 Security Act (42 U.S.C. 1395f(a)(1)) is amended—

5 (A) by striking “period of 3 calendar
6 years” and inserting “1 calendar year period”;
7 and

8 (B) by striking “except that” and all that
9 follows through “calendar year”.

10 (2) PART B.—Section 1835(a)(1) of such Act
11 (42 U.S.C. 1395n(a)(1)) is amended—

12 (A) by striking “period of 3 calendar
13 years” and inserting “1 calendar year period”;
14 and

15 (B) by striking “except that” and all that
16 follows through “calendar year”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 subsection (a) shall apply to services furnished on or after
19 January 1, 2010.

20 **SEC. 1637. PHYSICIANS WHO ORDER DURABLE MEDICAL**
21 **EQUIPMENT OR HOME HEALTH SERVICES RE-**
22 **QUIRED TO BE MEDICARE PARTICIPATING**
23 **PHYSICIANS.**

24 (a) DME.—Section 1834(a)(11)(B) of the Social Se-
25 curity Act (42 U.S.C. 1395m(a)(11)(B)) is amended by

1 striking “physician” and inserting “participating physi-
2 cian”.

3 (b) HOME HEALTH SERVICES.—

4 (1) PART A.—Section 1814(a)(2) of such Act
5 (42 U.S.C. 1395(a)(2)) is amended in the matter
6 preceding subparagraph (A) by inserting “in the
7 case of services described in subparagraph (C), a
8 participating physician,” before “or, in the case of
9 services”.

10 (2) PART B.—Section 1835(a)(2) of such Act
11 (42 U.S.C. 1395n(a)(2)) is amended in the matter
12 preceding subparagraph (A) by inserting “, or in the
13 case of services described in subparagraph (A), a
14 participating physician,” after “a physician”.

15 (c) DISCRETION TO EXPAND APPLICATION.—The
16 Secretary may extend the requirement applied by the
17 amendments made by subsections (a) and (b) to durable
18 medical equipment and home health services (relating to
19 requiring certifications and written orders to be made by
20 participating physicians and health professions) to other
21 categories of items or services if the Secretary determines
22 that such application would help to reduce waste, fraud,
23 and abuse with respect to such other categories under title
24 XVIII of the Social Security Act.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to written orders and certifications
3 made on or after January 1, 2010.

4 **SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE**
5 **DOCUMENTATION ON REFERRALS TO PRO-**
6 **GRAMS AT HIGH RISK OF WASTE AND ABUSE.**

7 (a) PHYSICIANS AND OTHER SUPPLIERS.—Section
8 1842(h) of the Social Security Act, as amended by section
9 1635, is further amended by adding at the end the fol-
10 lowing new paragraph

11 “(10) The Secretary may disenroll a physician or
12 supplier under this subsection if such physician or supplier
13 fails to maintain and, upon request of the Secretary (or
14 designee of the Secretary), provide access to documenta-
15 tion relating to written orders or requests for payment for
16 durable medical equipment, certifications for home health
17 services, or referrals for other items or services written
18 or ordered by such physician or supplier under this title,
19 as specified by the Secretary.”.

20 (b) PROVIDERS OF SERVICES.—Section 1866(a)(1)
21 of such Act (42 U.S.C. 1395cc), as amended by section
22 1635, is further amended—

23 (1) in subparagraph (V), by striking at the end
24 “and”;

1 (2) in subparagraph (W), by striking the period
2 at the end and adding “; and”; and

3 (3) by adding at the end the following new sub-
4 paragraph:

5 “(X) maintain and, upon request of the
6 Secretary (or designee of the Secretary), pro-
7 vide access to documentation relating to written
8 orders or requests for payment for durable
9 medical equipment, certifications for home
10 health services, or referrals for other items or
11 services written or ordered by the provider
12 under this title, as specified by the Secretary.”.

13 (c) **OIG PERMISSIVE EXCLUSION AUTHORITY.**—Sec-
14 tion 1128(b)(11) of the Social Security Act (42 U.S.C.
15 1320a–7(b)(11)) is amended by inserting “, ordering, re-
16 ferring for furnishing, or certifying the need for” after
17 “furnishing”.

18 (d) **EFFECTIVE DATE.**—The amendments made by
19 this section shall apply to orders, certifications, and refer-
20 rals made on or after January 1, 2010.

1 **SEC. 1639. FACE TO FACE ENCOUNTER WITH PATIENT RE-**
2 **QUIRED BEFORE PHYSICIANS MAY CERTIFY**
3 **ELIGIBILITY FOR HOME HEALTH SERVICES**
4 **UNDER MEDICARE.**

5 (a) CONDITION OF PAYMENT FOR SERVICE UNDER
6 PART A.—Section 1814(a)(2)(C) of such Act is amend-
7 ed—

8 (1) by striking “and such services” and insert-
9 ing “such services”; and

10 (2) by inserting after “care of a physician” the
11 following: “, and, in the case of a certification or re-
12 certification made by a physician after January 1,
13 2010, prior to making such certification the physi-
14 cian had a face-to-face encounter (including through
15 use of telehealth) with the individual”.

16 (b) CONDITION OF PAYMENT FOR SERVICE UNDER
17 PART B.—Section 1835(a)(2)(A) of the Social Security
18 Act is amended—

19 (1) by striking “and” before “(iii)”; and

20 (2) by inserting after “care of a physician” the
21 following: “, and (iv) in the case of a certification or
22 recertification after January 1, 2010, prior to mak-
23 ing such certification the physician must document
24 that the physician has had a face-to-face encounter
25 (including through use of telehealth) with the indi-
26 vidual”.

1 (c) APPLICATION TO MEDICAID AND CHIP.—The re-
2 quirements pursuant to the amendments made by sub-
3 sections (a) and (b) shall apply in the case of physicians
4 making certifications for home health services under title
5 XIX or XXI of the Social Security Act, in the same man-
6 ner and to the same extent as such requirements apply
7 in the case of physicians making such certifications under
8 title XVIII of such Act.

9 **SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AU-**
10 **THORITY TO PROGRAM EXCLUSION INVES-**
11 **TIGATIONS.**

12 (a) IN GENERAL.—Section 1128(f) of the Social Se-
13 curity Act (42 U.S.C. 1320a-7(f)) is amended by adding
14 at the end the following new paragraph:

15 “(4) The provisions of subsections (d) and (e) of sec-
16 tion 205 shall apply with respect to this section to the
17 same extent as they are applicable with respect to title
18 II. The Secretary may delegate the authority granted by
19 section 205(d) (as made applicable to this section) to the
20 Inspector General of the Department of Health and
21 Human Services for purposes of any investigation under
22 this section.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall apply to investigations beginning on
25 or after January 1, 2010.

1 **SEC. 1641. REQUIRED REPAYMENTS OF MEDICARE AND**
2 **MEDICAID OVERPAYMENTS.**

3 Section 1128G of the Social Security Act, as inserted
4 by section 1631 and amended by the previous provisions
5 of this title, is further amended by adding at the end the
6 following new subsection:

7 “(c) REPORTS ON AND REPAYMENT OF OVERPAY-
8 MENTS IDENTIFIED THROUGH INTERNAL AUDITS AND
9 REVIEWS.—

10 “(1) REPORTING AND RETURNING OVERPAY-
11 MENTS.—If a person knows of an overpayment, the
12 person must—

13 “(A) report and return the overpayment to
14 the Secretary, the State, an intermediary, a
15 carrier, or a contractor, as appropriate, at the
16 correct address, and

17 “(B) notify the Secretary, the State, inter-
18 mediary, carrier, or contractor to whom the
19 overpayment was returned in writing of the rea-
20 son for the overpayment.

21 “(2) TIMING.—An overpayment must be re-
22 ported and returned under paragraph (1)(A) by not
23 later than the later of the following dates:

24 “(A) The date that is 60 days from the
25 date the overpayment is identified; or

1 “(B) The date on which payment is re-
2 quired by the applicable claims appeal or rec-
3 onciliation process provided by law, regulation,
4 or program procedures.

5 Any known overpayment retained later than the ap-
6 plicable date specified in this paragraph creates an
7 obligation as defined in section 3729(b)(3) of title
8 31 of the United States Code.

9 “(3) DEFINITIONS.—In this subsection:

10 “(A) OVERPAYMENT.—The term “overpay-
11 ment” means any funds that a person receives
12 under title XVIII or XIX in excess of amounts
13 payable to the person under such title.

14 “(B) PERSON.—The term ‘person’ means
15 any person (including a provider of services,
16 supplier, medicaid managed care organization
17 (as defined in section 1903(m)(1)(A)), Medicare
18 Advantage organization (as defined in section
19 1859(a)(1)), or PDP sponsor (as defined in sec-
20 tion 1860D–41(a)(13)), but excluding a bene-
21 ficiary).”.

1 **SEC. 1642. EXPANDED APPLICATION OF HARDSHIP WAIV-**
2 **ERS FOR OIG EXCLUSIONS TO BENE-**
3 **FICIARIES OF ANY FEDERAL HEALTH CARE**
4 **PROGRAM.**

5 Section 1128(c)(3)(B) of the Social Security Act (42
6 U.S.C. 1320a-7(c)(3)(B)) is amended by striking “indi-
7 viduals entitled to benefits under part A of title XVIII
8 or enrolled under part B of such title, or both” and insert-
9 ing “beneficiaries (as defined in section 1128A(i)(5)) of
10 that program”.

11 **SEC. 1643. OIG ACCESS TO CERTAIN INFORMATION ON**
12 **RENAL DIALYSIS FACILITIES.**

13 For purposes of evaluating or auditing payments
14 made to renal dialysis facilities for items and services
15 under section 1881 of the Social Security Act (42 U.S.C.
16 1395rr), as a requirement under subsection (b)(1) of such
17 section, each such renal dialysis facility, upon the request
18 of the Inspector General of the Department of Health and
19 Human Services, shall provide to the Inspector General
20 access to information relating to any ownership or com-
21 pensation arrangement between such facility and the med-
22 ical director of such facility or between such facility and
23 any physician.

1 **Subtitle D—Access to Information**
2 **Needed to Prevent Fraud and**
3 **Abuse**

4 **SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY WASTE AND ABUSE.**
5

6 (a) IN GENERAL.—Section 1128G of the Social Security Act, as added by section 1631 and amended by the
7 previous provisions of this title, is further amended by
8 adding at the end the following new subsection;

9
10 “(d) ACCESS TO INFORMATION NECESSARY TO IDENTIFY WASTE AND ABUSE.—
11

12 “(1) IN GENERAL.—Subject to paragraph (4),
13 notwithstanding any other provision of this title,
14 title XVIII, or title XIX, nothing shall be construed
15 as limiting access facilitated for the Attorney General by the Office of the Inspector General of the
16 Department of Health and Human Services, in consultation with the Centers for Medicare & Medicaid
17 Services or the owner of such database to all claims
18 and payment databases for purposes of the programs under title XVIII and XIX.
19
20
21

22 “(2) HHS PAYEE OR RELATED PARTY DEFINED.—For purposes of this subsection, the term
23 ‘HHS payee or related party’ means someone who
24 receives payment directly or indirectly under title
25

1 XVIII or XIX, including providers of services, sup-
2 pliers, grantees, contractors, subcontractors, and
3 prescribing parties.

4 “(3) COMPLIANCE WITH PRIVACY AND SECUR-
5 RITY LAWS.—The provisions of this subsection shall
6 be carried out in a manner consistent with applica-
7 ble privacy and security laws, including standards
8 promulgated by the Secretary pursuant to sections
9 262(a) and 264 of the Health Insurance Portability
10 and Accountability Act of 1996.”

11 (b) ACCESS TO PART C AND PART D CONTRACT IN-
12 FORMATION.—

13 (1) IN GENERAL.—Section 1860D—15(f)(2) of
14 the Social Security Act (42 U.S.C. 1395w—
15 101(f)(2)) is amended by striking “only for the pur-
16 poses of” and all that follows through the period at
17 the end and insert the following: “, the Department
18 of Justice, and the United States Government Ac-
19 countability Office for the purposes of, and to the
20 extent necessary in, carrying out this section, and
21 for audit, evaluation, and enforcement activities.”

22 (2) APPLICATION TO PART C.—The amendment
23 under paragraph (1) shall apply to part C of title
24 XVIII in the same manner and to the same extent
25 as such amendment applies to part D of such title.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to claims submitted on or after
3 January 1, 2010.

4 **SEC. 1652. ELIMINATION OF DUPLICATION BETWEEN THE**
5 **HEALTHCARE INTEGRITY AND PROTECTION**
6 **DATA BANK AND THE NATIONAL PRACTI-**
7 **TIONER DATA BANK.**

8 (a) IN GENERAL.—To eliminate duplication between
9 the Healthcare Integrity and Protection Data Bank
10 (HIPDB) established under section 1128E of the Social
11 Security Act and the National Practitioner Data Bank
12 (NPBD) established under the Health Care Quality Im-
13 provement Act of 1986, section 1128E of the Social Secu-
14 rity Act (42 U.S.C. 1320a-7e) is amended—

15 (1) in subsection (a), by striking “Not later
16 than” and inserting “Subject to subsection (h), not
17 later than”;

18 (2) in the first sentence of subsection (d)(2), by
19 striking “(other than with respect to requests by
20 Federal agencies)”; and

21 (3) by adding at the end the following new sub-
22 section:

23 “(h) SUNSET OF THE HEALTHCARE INTEGRITY AND
24 PROTECTION DATA BANK; TRANSITION PROCESS.—Ef-
25 fective upon the enactment of this subsection, the Sec-

1 retary shall implement a process to eliminate duplication
2 between the Healthcare Integrity and Protection Data
3 Bank (in this subsection referred to as the ‘HIPDB’ es-
4 tablished pursuant to subsection (a) and the National
5 Practitioner Data Bank (in this subsection referred to as
6 the ‘NPDB’) as implemented under the Health Care Qual-
7 ity Improvement Act of 1986 and section 1921 of this Act,
8 including systems testing necessary to ensure that infor-
9 mation formerly collected in the HIPDB will be accessible
10 through the NPDB, and other activities necessary to
11 eliminate duplication between the two data banks. Upon
12 the completion of such process, notwithstanding any other
13 provision of law, the Secretary shall cease the operation
14 of the HIPDB and shall collect information required to
15 be reported under the preceding provisions of this section
16 in the NPDB. Except as otherwise provided in this sub-
17 section, the provisions of subsections (a) through (g) shall
18 continue to apply with respect to the reporting of (or fail-
19 ure to report), access to, and other treatment of the infor-
20 mation specified in this section..”.

21 (b) ELIMINATION OF THE RESPONSIBILITY OF THE
22 HHS OFFICE OF THE INSPECTOR GENERAL.—Section
23 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-
24 7c(a)(1)) is amended—

1 (1) in subparagraph (C), by adding at the end
2 “and”;

3 (2) in subparagraph (D), by striking at the end
4 “, and” and inserting a period; and

5 (3) by striking subparagraph (E).

6 (c) SPECIAL PROVISION FOR ACCESS TO THE NA-
7 TIONAL PRACTITIONER DATA BANK BY THE DEPART-
8 MENT OF VETERANS AFFAIRS.—

9 (1) IN GENERAL.—Notwithstanding any other
10 provision of law, during the one year period that be-
11 gins on the effective date specified in subsection
12 (e)(1), the information described in paragraph (2)
13 shall be available from the National Practitioner
14 Data Bank (described in section 1921 of the Social
15 Security Act) to the Secretary of Veterans Affairs
16 without charge.

17 (2) INFORMATION DESCRIBED.—For purposes
18 of paragraph (1), the information described in this
19 paragraph is the information that would, but for the
20 amendments made by this section, have been avail-
21 able to the Secretary of Veterans Affairs from the
22 National Practitioner Data Bank.

23 (d) FUNDING.—Notwithstanding any provisions of
24 this Act, sections 1128E(d)(2) and 1817(k)(3) of the So-
25 cial Security Act, or any other provision of law, there shall

1 be available for carrying out the transition process under
2 section 1128E(h) of the Social Security Act over the pe-
3 riod required to complete such process, and for operation
4 of the National Practitioner Data Bank until such process
5 is completed, without fiscal year limitation—

6 (1) any fees collected pursuant to section
7 1128E(d)(2) of such Act; and

8 (2) such additional amounts as necessary, from
9 appropriations available to the Secretary and to the
10 Office of the Inspector General of the Department of
11 Health and Human Services under clauses (i) and
12 (ii), respectively, of section 1817(k)(3)(A) of such
13 Act, for costs of such activities during the first 12
14 months following the date of the enactment of this
15 Act.

16 (e) EFFECTIVE DATE.—The amendments made—

17 (1) by subsection (a)(2) shall take effect on the
18 first day after the Secretary of Health and Human
19 Services certifies that the process implemented pur-
20 suant to section 1128E(h) of the Social Security Act
21 (as added by subsection (a)(3)) is complete; and

22 (2) by subsection (b) shall take effect on the
23 earlier of the date specified in paragraph (1) or the
24 first day of the second succeeding fiscal year after
25 the fiscal year during which this Act is enacted.

1 **SEC. 1653. COMPLIANCE WITH HIPAA PRIVACY AND SECUR-**
2 **RITY STANDARDS.**

3 The provisions of (and standards promulgated pursu-
4 ant to) sections 262(a) and 264 of the Health Insurance
5 Portability and Accountability Act of 1996 shall apply
6 with respect to the provisions of this subtitle and amend-
7 ments made by this subtitle.

8 **TITLE VII—MISCELLANEOUS**
9 **PROVISIONS**

10 **SEC. 1701. REPEAL OF TRIGGER PROVISION.**

11 Subtitle A of title VIII of the Medicare Prescription
12 Drug, Improvement, and Modernization Act of 2003 (Pub-
13 lic Law 108–173) is repealed and the provisions of law
14 amended by such subtitle are restored as if such subtitle
15 had never been enacted.

16 **SEC. 1702. REPEAL OF COMPARATIVE COST ADJUSTMENT**
17 **(CCA) PROGRAM.**

18 Section 1860C–1 of the Social Security Act (42
19 U.S.C. 1395w–29), as added by section 241(a) of the
20 Medicare Prescription Drug, Improvement, and Mod-
21 ernization Act of 2003 (Public Law 108–173), is repealed.

22 **SEC. 1703. EXTENSION OF GAINSHARING DEMONSTRATION.**

23 (a) IN GENERAL.—Subsection (d)(3) of section
24 5007(d)(3) of the Deficit Reduction Act of 2005 (Public
25 Law 109-171) is amended by striking “December 31,
26 2009” and inserting “September 30, 2011”.

1 (b) FUNDING.—

2 (1) IN GENERAL.—Subsection (f)(1) of such
3 section is amended by inserting “and for fiscal year
4 2010, \$1,600,000,” after “\$6,000,000,”.

5 (2) AVAILABILITY.—Subsection (f)(2) of such
6 section is amended by striking “2010” and inserting
7 “2014 or until expended”.

8 (c) REPORTS.—

9 (1) QUALITY IMPROVEMENT AND SAVINGS.—
10 Subsection (e)(3) of such section is amended by
11 striking “December 1, 2008” and inserting “March
12 31, 2011”.

13 (2) FINAL REPORT.—Subsection (e)(4) of such
14 section is amended by striking “May 1, 2010” and
15 inserting “March 31, 2013”.

16 **SEC. 1704. GRANTS TO STATES FOR QUALITY HOME VISITA-**
17 **TION PROGRAMS FOR FAMILIES WITH YOUNG**
18 **CHILDREN AND FAMILIES EXPECTING CHIL-**
19 **DREN.**

20 Part B of title IV of the Social Security Act (42
21 U.S.C. 621–629i) is amended by adding at the end the
22 following:

1 “(A) the number, quality, and capacity of
2 home visitation programs for families with
3 young children and families expecting children
4 in the State;

5 “(B) the number and types of families who
6 are receiving services under the programs;

7 “(C) the sources and amount of funding
8 provided to the programs;

9 “(D) the gaps in home visitation in the
10 State, including identification of communities
11 that are in high need of the services; and

12 “(E) training and technical assistance ac-
13 tivities designed to achieve or support the goals
14 of the programs.

15 “(3) ASSURANCES.—Assurances from the State
16 that—

17 “(A) in supporting home visitation pro-
18 grams using funds provided under this section,
19 the State shall identify and prioritize serving
20 communities that are in high need of such serv-
21 ices, especially communities with a high propor-
22 tion of low-income families or a high incidence
23 of child maltreatment;

24 “(B) the State will reserve 5 percent of the
25 grant funds for training and technical assist-

1 ance to the home visitation programs using
2 such funds;

3 “(C) in supporting home visitation pro-
4 grams using funds provided under this section,
5 the State will promote coordination and collabo-
6 ration with other home visitation programs (in-
7 cluding programs funded under title XIX) and
8 with other child and family services, health
9 services, income supports, and other related as-
10 sistance;

11 “(D) home visitation programs supported
12 using such funds will, when appropriate, pro-
13 vide referrals to other programs serving chil-
14 dren and families; and

15 “(E) the State will comply with subsection
16 (i), and cooperate with any evaluation con-
17 ducted under subsection (j).

18 “(4) OTHER INFORMATION.—Such other infor-
19 mation as the Secretary may require.

20 “(c) ALLOTMENTS.—

21 “(1) INDIAN TRIBES.—From the amount re-
22 served under subsection (l)(2) for a fiscal year, the
23 Secretary shall allot to each Indian tribe that meets
24 the requirement of subsection (d), if applicable, for
25 the fiscal year the amount that bears the same ratio

1 to the amount so reserved as the number of children
2 in the Indian tribe whose families have income that
3 does not exceed 200 percent of the poverty line bears
4 to the total number of children in such Indian tribes
5 whose families have income that does not exceed 200
6 percent of the poverty line.

7 “(2) STATES AND TERRITORIES.—From the
8 amount appropriated under subsection (m) for a fis-
9 cal year that remains after making the reservations
10 required by subsection (l), the Secretary shall allot
11 to each State that is not an Indian tribe and that
12 meets the requirement of subsection (d), if applica-
13 ble, for the fiscal year the amount that bears the
14 same ratio to the remainder of the amount so appro-
15 priated as the number of children in the State whose
16 families have income that does not exceed 200 per-
17 cent of the poverty line bears to the total number of
18 children in such States whose families have income
19 that does not exceed 200 percent of the poverty line.

20 “(3) REALLOTMENTS.—The amount of any al-
21 lotment to a State under a paragraph of this sub-
22 section for any fiscal year that the State certifies to
23 the Secretary will not be expended by the State pur-
24 suant to this section shall be available for reallocot-
25 ment using the allotment methodology specified in

1 that paragraph. Any amount so reallocated to a State
2 is deemed part of the allotment of the State under
3 this subsection.

4 “(d) MAINTENANCE OF EFFORT.—Beginning with
5 fiscal year 2011, a State meets the requirement of this
6 subsection for a fiscal year if the Secretary finds that the
7 aggregate expenditures by the State for programs of home
8 visitation for families with young children and families ex-
9 pecting children for the then preceding fiscal year was not
10 less than 100 percent of such aggregate expenditures for
11 the then 2nd preceding fiscal year.

12 “(e) PAYMENT OF GRANT.—

13 “(1) IN GENERAL.—The Secretary shall make a
14 grant to each State that meets the requirements of
15 subsections (b) and (d), if applicable, for a fiscal
16 year for which funds are appropriated under sub-
17 section (m), in an amount equal to the reimbursable
18 percentage of the eligible expenditures of the State
19 for the fiscal year, but not more than the amount
20 allotted to the State under subsection (c) for the fis-
21 cal year.

22 “(2) REIMBURSABLE PERCENTAGE DEFINED.—

23 In paragraph (1), the term ‘reimbursable percent-
24 age’ means, with respect to a fiscal year—

1 “(A) 85 percent, in the case of fiscal year
2 2010;

3 “(B) 80 percent, in the case of fiscal year
4 2011; or

5 “(C) 75 percent, in the case of fiscal year
6 2012 and any succeeding fiscal year.

7 “(f) ELIGIBLE EXPENDITURES.—

8 “(1) IN GENERAL.—In this section, the term
9 ‘eligible expenditures’—

10 “(A) means expenditures to provide vol-
11 untary home visitation for as many families
12 with young children (under the age of school
13 entry) and families expecting children as prac-
14 ticable, through the implementation or expan-
15 sion of high quality home visitation programs
16 that—

17 “(i) adhere to clear evidence-based
18 models of home visitation that have dem-
19 onstrated positive effects on important pro-
20 gram-determined child and parenting out-
21 comes, such as reducing abuse and neglect
22 and improving child health and develop-
23 ment;

24 “(ii) employ well-trained and com-
25 petent staff, maintain high quality super-

1 vision, provide for ongoing training and
2 professional development, and show strong
3 organizational capacity to implement such
4 a program;

5 “(iii) establish appropriate linkages
6 and referrals to other community resources
7 and supports;

8 “(iv) monitor fidelity of program im-
9 plementation to ensure that services are
10 delivered according to the specified model;
11 and

12 “(v) provide parents with—

13 “(I) knowledge of age-appro-
14 priate child development in cognitive,
15 language, social, emotional, and motor
16 domains (including knowledge of sec-
17 ond language acquisition, in the case
18 of English language learners);

19 “(II) knowledge of realistic ex-
20 pectations of age-appropriate child be-
21 haviors;

22 “(III) knowledge of health and
23 wellness issues for children and par-
24 ents;

1 “(IV) modeling, consulting, and
2 coaching on parenting practices;

3 “(V) skills to interact with their
4 child to enhance age-appropriate de-
5 velopment;

6 “(VI) skills to recognize and seek
7 help for issues related to health, devel-
8 opmental delays, and social, emo-
9 tional, and behavioral skills; and

10 “(VII) activities designed to help
11 parents become full partners in the
12 education of their children;

13 “(B) includes expenditures for training,
14 technical assistance, and evaluations related to
15 the programs; and

16 “(C) does not include any expenditure with
17 respect to which a State has submitted a claim
18 for payment under any other provision of Fed-
19 eral law.

20 “(2) PRIORITY FUNDING FOR PROGRAMS WITH
21 STRONGEST EVIDENCE.—

22 “(A) IN GENERAL.—The expenditures, de-
23 scribed in paragraph (1), of a State for a fiscal
24 year that are attributable to the cost of pro-
25 grams that do not adhere to a model of home

1 visitation with the strongest evidence of effec-
2 tiveness shall not be considered eligible expendi-
3 tures for the fiscal year to the extent that the
4 total of the expenditures exceeds the applicable
5 percentage for the fiscal year of the allotment
6 of the State under subsection (c) for the fiscal
7 year.

8 “(B) APPLICABLE PERCENTAGE DE-
9 FINED.—In subparagraph (A), the term ‘appli-
10 cable percentage’ means, with respect to a fiscal
11 year—

12 “(i) 60 percent for fiscal year 2010;

13 “(ii) 55 percent for fiscal year 2011;

14 “(iii) 50 percent for fiscal year 2012;

15 “(iv) 45 percent for fiscal year 2013;

16 or

17 “(v) 40 percent for fiscal year 2014.

18 “(g) NO USE OF OTHER FEDERAL FUNDS FOR
19 STATE MATCH.—A State to which a grant is made under
20 this section may not expend any Federal funds to meet
21 the State share of the cost of an eligible expenditure for
22 which the State receives a payment under this section.

23 “(h) WAIVER AUTHORITY.—

24 “(1) IN GENERAL.—The Secretary may waive
25 or modify the application of any provision of this

1 section, other than subsection (b) or (f), to an In-
2 dian tribe if the failure to do so would impose an
3 undue burden on the Indian tribe.

4 “(2) SPECIAL RULE.—An Indian tribe is
5 deemed to meet the requirement of subsection (d)
6 for purposes of subsections (c) and (e) if—

7 “(A) the Secretary waives the requirement;

8 or

9 “(B) the Secretary modifies the require-
10 ment, and the Indian tribe meets the modified
11 requirement.

12 “(i) STATE REPORTS.—Each State to which a grant
13 is made under this section shall submit to the Secretary
14 an annual report on the progress made by the State in
15 addressing the purposes of this section. Each such report
16 shall include a description of—

17 “(1) the services delivered by the programs that
18 received funds from the grant;

19 “(2) the characteristics of each such program,
20 including information on the service model used by
21 the program and the performance of the program;

22 “(3) the characteristics of the providers of serv-
23 ices through the program, including staff qualifica-
24 tions, work experience, and demographic characteris-
25 tics;

1 “(4) the characteristics of the recipients of serv-
2 ices provided through the program, including the
3 number of the recipients, the demographic charac-
4 teristics of the recipients, and family retention;

5 “(5) the annual cost of implementing the pro-
6 gram, including the cost per family served under the
7 program;

8 “(6) the outcomes experienced by recipients of
9 services through the program;

10 “(7) the training and technical assistance pro-
11 vided to aid implementation of the program, and
12 how the training and technical assistance contrib-
13 uted to the outcomes achieved through the program;

14 “(8) the indicators and methods used to mon-
15 itor whether the program is being implemented as
16 designed; and

17 “(9) other information as determined necessary
18 by the Secretary.

19 “(j) EVALUATION.—

20 “(1) IN GENERAL.—The Secretary shall, by
21 grant or contract, provide for the conduct of an
22 independent evaluation of the effectiveness of home
23 visitation programs receiving funds provided under
24 this section, which shall examine the following:

1 “(A) The effect of home visitation pro-
2 grams on child and parent outcomes, including
3 child maltreatment, child health and develop-
4 ment, school readiness, and links to community
5 services.

6 “(B) The effectiveness of home visitation
7 programs on different populations, including
8 the extent to which the ability of programs to
9 improve outcomes varies across programs and
10 populations.

11 “(2) REPORTS TO THE CONGRESS.—

12 “(A) INTERIM REPORT.—Within 3 years
13 after the date of the enactment of this section,
14 the Secretary shall submit to the Congress an
15 interim report on the evaluation conducted pur-
16 suant to paragraph (1).

17 “(B) FINAL REPORT.—Within 5 years
18 after the date of the enactment of this section,
19 the Secretary shall submit to the Congress a
20 final report on the evaluation conducted pursu-
21 ant to paragraph (1).

22 “(k) ANNUAL REPORTS TO THE CONGRESS.—The
23 Secretary shall submit annually to the Congress a report
24 on the activities carried out using funds made available

1 under this section, which shall include a description of the
2 following:

3 “(1) The high need communities targeted by
4 States for programs carried out under this section.

5 “(2) The service delivery models used in the
6 programs receiving funds provided under this sec-
7 tion.

8 “(3) The characteristics of the programs, in-
9 cluding—

10 “(A) the qualifications and demographic
11 characteristics of program staff; and

12 “(B) recipient characteristics including the
13 number of families served, the demographic
14 characteristics of the families served, and fam-
15 ily retention and duration of services.

16 “(4) The outcomes reported by the programs.

17 “(5) The research-based instruction, materials,
18 and activities being used in the activities funded
19 under the grant.

20 “(6) The training and technical activities, in-
21 cluding on-going professional development, provided
22 to the programs.

23 “(7) The annual costs of implementing the pro-
24 grams, including the cost per family served under
25 the programs.

1 “(8) The indicators and methods used by States
2 to monitor whether the programs are being been im-
3 plemented as designed.

4 “(1) RESERVATIONS OF FUNDS.—From the amounts
5 appropriated for a fiscal year under subsection (m), the
6 Secretary shall reserve—

7 “(1) an amount equal to 5 percent of the
8 amounts to pay the cost of the evaluation provided
9 for in subsection (j), and the provision to States of
10 training and technical assistance, including the dis-
11 semination of best practices in early childhood home
12 visitation; and

13 “(2) after making the reservation required by
14 paragraph (1), an amount equal to 3 percent of the
15 amount so appropriated, to pay for grants to Indian
16 tribes under this section.

17 “(m) APPROPRIATIONS.—Out of any money in the
18 Treasury of the United States not otherwise appropriated,
19 there is appropriated to the Secretary to carry out this
20 section—

21 “(1) \$150,000,000 for fiscal year 2010;

22 “(2) \$250,000,000 for fiscal year 2011;

23 “(3) \$350,000,000 for fiscal year 2012;

24 “(4) \$450,000,000 for fiscal year 2013; and

25 “(5) \$550,000,000 for fiscal year 2014.

1 “(n) INDIAN TRIBES TREATED AS STATES.—In this
2 section, paragraphs (4), (5), and (6) of section 431(a)
3 shall apply.”.

4 **TITLE VIII—MEDICAID AND CHIP**

5 **PART 1—MEDICAID AND HEALTH REFORM**

6 **SEC. 1801. ELIGIBILITY FOR INDIVIDUALS WITH INCOME** 7 **BELOW 133- $\frac{1}{3}$ PERCENT OF THE FEDERAL** 8 **POVERTY LEVEL.**

9 (a) ELIGIBILITY FOR NON-TRADITIONAL INDIVID-
10 UALS WITH INCOME BELOW 133 PERCENT OF THE FED-
11 ERAL POVERTY LEVEL.—

12 (1) IN GENERAL.—Section 1902(a)(10)(A)(i) of
13 the Social Security Act (42 U.S.C.
14 1396b(a)(10)(A)(i)) is amended—

15 (A) by striking “or” at the end of sub-
16 clause (VI);

17 (B) by adding “or” at the end of subclause
18 (VII); and

19 (C) by adding at the end the following new
20 subclause:

21 “(VIII) who are under 65 years
22 of age, who are not described in a pre-
23 vious subclause of this clause, and
24 who are in families whose income does
25 not exceed 133 $\frac{1}{3}$ percent of the

1 income official poverty line (as defined
2 by the Office of Management and
3 Budget, and revised annually in ac-
4 cordance with section 673(2) of the
5 Omnibus Budget Reconciliation Act of
6 1981) applicable to a family of the
7 size involved;”.

8 (2) 100% FMAP FOR NON-TRADITIONAL MED-
9 ICAID ELIGIBLE INDIVIDUALS.—The third sentence
10 of section 1905(b) of such Act (42 U.S.C. 1396d(b))
11 is amended by inserting before the period at the end
12 the following: “and as amounts expended for medical
13 assistance for individuals described in subclause
14 (VIII) of section 1902(a)(10)(A)(i)”.

15 (3) CONSTRUCTION.—Nothing in this sub-
16 section shall be construed as not providing for cov-
17 erage under subclause (VIII) of section
18 1902(a)(10)(A)(i) of the Social Security Act, as
19 added by paragraph (1) of, and an increased FMAP
20 under the amendment made by paragraph (2) for,
21 an individual who has been provided medical assist-
22 ance under title XIX of the Act under a waiver ap-
23 proved under section 1115 of such Act or otherwise.

1 (b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELI-
2 GIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 133-
3 $\frac{1}{3}$ PERCENT OF THE FEDERAL POVERTY LEVEL.—

4 (1) IN GENERAL.—Section 1902(a)(10)(A) of
5 the Social Security Act (42 U.S.C.
6 1396b(a)(10)(A)), as amended by subsection (a), is
7 amended—

8 (A) by striking “or” at the end of sub-
9 clause (VII);

10 (B) by adding “or” at the end of subclause
11 (VIII); and

12 (C) by adding at the end the following new
13 subclause:

14 “(IX) who are under 65 years of
15 age, who would be eligible for medical
16 assistance under the State plan under
17 a previous subclause of this clause
18 (based on the income standards in ef-
19 fect as of June 16, 2009) but for in-
20 come and who are in families whose
21 income does not exceed $133\frac{1}{3}$ percent
22 of the income official poverty line (as
23 defined by the Office of Management
24 and Budget, and revised annually in
25 accordance with section 673(2) of the

1 Omnibus Budget Reconciliation Act of
2 1981) applicable to a family of the
3 size involved;”.

4 (2) 100% FMAP FOR CERTAIN TRADITIONAL
5 MEDICAID ELIGIBLE INDIVIDUALS.—The third sen-
6 tence of section 1905(b) of such Act (42 U.S.C.
7 1396d(b)) is amended by inserting “or (IX)” after
8 “(VIII)”.

9 (3) CONSTRUCTION.—Nothing in this sub-
10 section shall be construed as not providing for cov-
11 erage under subclause (IX) of section
12 1902(a)(10)(A)(i) of the Social Security Act, as
13 added by paragraph (1) of, and an increased FMAP
14 under the amendment made by paragraph (2) for,
15 an individual who has been provided medical assist-
16 ance under title XIX of the Act under a waiver ap-
17 proved under section 1115 of such Act or otherwise.

18 (c) CLARIFICATION OF TREATMENT OF CERTAIN
19 NEWBORNS.—

20 (1) COVERAGE AT BIRTH IN UNITED STATES.—

21 The first sentence of section 1902(e)(4) of the Social
22 Security Act (42 U.S.C. 1396a(e)(4)) is amended by
23 inserting “(or a child described in section
24 203(b)(3)(C) of the [short title])” after “date of
25 the child’s birth”.

1 (2) 100% MATCHING RATE.—The third sen-
2 tence of section 1905(b) of such Act is amended by
3 inserting before the period the following: “or a child
4 described in section 203(b)(3)(C) of the [short
5 title]”.

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section shall take effect on the first day of Y1, and
8 shall apply with respect to items and services furnished
9 on or after such date.

10 **SEC. 1802. REQUIREMENTS AND SPECIAL RULES FOR CER-**
11 **TAIN MEDICAID ENROLLEES AND FOR MED-**
12 **ICAID ELIGIBLE INDIVIDUALS ENROLLED IN**
13 **A NON-MEDICAID EXCHANGE-PARTICIPATING**
14 **HEALTH BENEFITS PLAN.**

15 (a) IN GENERAL.—Title XIX of the Social Security
16 Act is amended by adding at the end the following new
17 section:

18 “REQUIREMENTS AND SPECIAL RULES FOR CERTAIN
19 MEDICAID ENROLLEES AND MEDICAID ELIGIBLE IN-
20 DIVIDUALS ENROLLED IN A EXCHANGE-PARTICI-
21 PATING HEALTH BENEFITS PLAN

22 “SEC. 1943. (a) COORDINATION WITH NHI EX-
23 CHANGE THROUGH MEMORANDUM OF UNDER-
24 STANDING.—

25 “(1) IN GENERAL.—The State shall enter into
26 a Medicaid memorandum of understanding described

1 in section 204(c)(4) of the [short title] with the
2 Health Choices Commissioner with respect to coordi-
3 nating enrollment of individuals in Exchange-partici-
4 pating health benefits plans and otherwise coordi-
5 nating the implementation of the provisions of divi-
6 sion A of such Act with respect to the State plan
7 under this title.

8 “(2) ENROLLMENT OF EXCHANGE-REFERRED
9 INDIVIDUALS.—

10 “(A) NON-TRADITIONAL INDIVIDUALS.—

11 Pursuant to such memorandum the State shall
12 accept without further determination the enroll-
13 ment under this title of an individual deter-
14 mined by the Commissioner to be a non-tradi-
15 tional Medicaid eligible individual. The State
16 shall not do any redeterminations of eligibility
17 for such individuals unless the periodicity of
18 such redeterminations is consistent with the pe-
19 riodicity for redeterminations by the Commis-
20 sioner of eligibility for affordability credits
21 under subtitle C of title II, as specified under
22 such memorandum.

23 “(B) TRADITIONAL INDIVIDUALS.—

24 “(i) REGULAR ENROLLMENT OP-
25 TION.—Pursuant to such memorandum,

1 insofar as the memorandum has selected
2 the option described in section
3 203(e)(3)(A) the State shall accept without
4 further determination the enrollment under
5 this title of an individual determined by
6 the Commissioner to be a traditional Med-
7 icaid eligible individual. The State may do
8 redeterminations of eligibility of such indi-
9 vidual consistent with such section and the
10 memorandum.

11 “(ii) PRESUMPTION ELIGIBILITY OP-
12 TION.—Pursuant to such memorandum,
13 insofar as the memorandum has selected
14 the option described in section
15 203(e)(3)(B) the State shall provide for
16 making medical assistance available during
17 the presumptive eligibility period and shall,
18 upon application of the individual for med-
19 ical assistance under this title, promptly
20 make a determination (and subsequent re-
21 determinations) of eligibility in the same
22 manner as if the individual had applied di-
23 rectly to the State for such assistance ex-
24 cept that the State shall use the income-re-
25 lated information used by the Commis-

1 sioner and provided to the State under the
2 memorandum in making the presumptive
3 eligibility determination to the maximum
4 extent feasible.

5 “(3) DETERMINATIONS OF ELIGIBILITY FOR
6 AFFORDABILITY CREDITS.—If the Commissioner de-
7 termines that a State has the capacity to make de-
8 termination of eligibility for affordability credits
9 under subtitle C of title II of the [short title],
10 under such memorandum—

11 “(A) the State shall conduct such deter-
12 minations for any Exchange-eligible individual
13 who requests such a determination; and

14 “(B) the Commissioner shall reimburse the
15 State for the costs of conducting such deter-
16 minations.

17 “(b) TREATMENT OF TRADITIONAL MEDICAID ELIGI-
18 BLES ENROLLING IN AN EXCHANGE-PARTICIPATING
19 HEALTH BENEFITS PLAN.—In the case of a traditional
20 Medicaid eligible individual who is enrolled in an Ex-
21 change-participating health benefits plan beginning with
22 Y5, the following rules apply:

23 “(1) CONTINUED ENTITLEMENT TO WRAP
24 AROUND BENEFITS.—The individual remains eligible
25 for medical assistance under this title for items and

1 services for which benefits are not available under
2 such Exchange-participating health benefits plan.

3 “(2) STATE RESPONSIBILITY FOR STATE SHARE
4 OF COSTS.—

5 “(A) IN GENERAL.—The State shall pro-
6 vide for payment to the Secretary of the prod-
7 uct of—

8 “(i) the amount of the affordability
9 credits furnished with respect to such indi-
10 vidual under subtitle C of title II with re-
11 spect to coverage under such plan; and

12 “(ii) the State matching percentage
13 specified in subparagraph (B).

14 “(B) STATE MATCHING PERCENTAGE.—

15 “(i) IN GENERAL.—Subject to clause
16 (ii), the State matching percentage speci-
17 fied in this subparagraph for a State shall
18 be a percentage , based upon a percentage
19 equal to 100 percent minus the Federal
20 medical assistance percentage otherwise
21 applicable, that the Secretary estimates is
22 the aggregate percentage, of the medical
23 assistance under this title that would be
24 made with respect to an individual of the

1 type involved, for which a Federal payment
2 is not payable under section 1903(a).

3 “(ii) REDUCTION FOR STATES DEM-
4 ONSTRATING ABOVE-AVERAGE REDUCTIONS
5 IN UNINSURED.—In the case of a State
6 that is in the upper 50th percentile of
7 States in reducing the percentage of people
8 without health insurance (as measured by
9 the Current Population Survey) in the
10 State beginning with 2009 and ending with
11 Y1, the State matching percentage applied
12 under subparagraph (A)(ii) shall be one-
13 half the State matching percentage speci-
14 fied in clause (i).

15 “(C) FORM AND MANNER OF PAYMENT.—
16 Payment under subparagraph (A) shall be made
17 in a manner specified by the Secretary that is
18 similar to the manner in which State payments
19 are made under an agreement entered into
20 under section 1843, except that all such pay-
21 ments shall be deposited into the Health Insur-
22 ance Exchange Trust Fund established under
23 section 207(a) of the [short title].

24 “(D) COMPLIANCE.—The provisions of
25 subparagraph (C) of section 1935(c)(1) shall

1 apply to a failure to payment an amount under
2 subparagraph (A) in the same manner as such
3 provisions apply to a failure to payment an
4 amount under subparagraph (A) of such sec-
5 tion.

6 “(c) DEFINITIONS.—In this section:

7 “(1) MEDICAID ELIGIBLE INDIVIDUALS.—In
8 this section, the terms ‘Medicaid eligible individual’,
9 ‘traditional Medicaid eligible individual’, and ‘non-
10 traditional Medicaid eligible individual’ have the
11 meanings given such terms in section 203(c)(5) of
12 the [short title].

13 “(2) MEMORANDUM.—The term ‘memorandum’
14 means a Medicaid memorandum of understanding
15 under section 203(c)(4) of the [short title].

16 “(3) Y1.—The term ‘Y1’ has the meaning given
17 such term in section 100(b) of the [short title].”.

18 (b) CONFORMING AMENDMENT TO ERROR RATE.—
19 Section 1903(u)(1)(D) of the Social Security Act (42
20 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end
21 the following new clause:

22 “(vi) In determining the amount of erroneous excess
23 payments, there shall not be included any erroneous pay-
24 ments made that are attributable to an error in an eligi-

1 bility determination under subtitle C of title II of [short
2 title].”.

3 **SEC. 1803. CHIP MAINTENANCE OF EFFORT.**

4 (a) IN GENERAL.—Section 1902 of the Social Secu-
5 rity Act (42 U.S.C. 1396a) is amended—

6 (1) in subsection (a), as amended by section
7 1631(b)(1)(D)—

8 (A) by striking “and” at the end of para-
9 graph (72);

10 (B) by striking the period at the end of
11 paragraph (73) and inserting “; and”; and

12 (C) by inserting after paragraph (74) the
13 following new paragraph:

14 “(75) provide for maintenance of effort under
15 the State child health plan under title XXI in ac-
16 cordance with subsection (gg).”; and

17 (2) by adding at the end the following new sub-
18 section:

19 “(gg) CHIP MAINTENANCE OF EFFORT REQUIRE-
20 MENT.—

21 “(1) IN GENERAL.—Subject to paragraph (2),
22 as a condition of its State plan under this title under
23 subsection (a)(75) and receipt of any Federal finan-
24 cial assistance under section 1903(a) for calendar
25 quarters beginning after the date of the enactment

1 of this subsection and before the first day of Y1 (as
2 defined in section 100(c) of the **[short title]**), a
3 State shall not have in effect eligibility standards,
4 methodologies, or procedures under its State child
5 health plan under title XXI (including any waiver
6 under such title or under section 1115 that is per-
7 mitted to continue effect) that are more restrictive
8 than the eligibility standards, methodologies, or pro-
9 cedures, respectively, under such plan (or waiver) as
10 in effect on June 16, 2009.

11 “(2) **LIMITATION.**—Paragraph (1) shall not be
12 construed as preventing a State from imposing a
13 limitation described in section 2110(b)(5)(C)(i)(II)
14 for a fiscal year in order to limit expenditures under
15 its State child health plan under title XXI to those
16 for which Federal financial participation is available
17 under section 2105 for the fiscal year.”

18 (b) **MEDICAID MAINTENANCE OF EFFORT.**—Section
19 1903 of such Act (42 U.S.C. 1396b) is amended by adding
20 at the end the following new subsection:

21 “(aa) **MAINTENANCE OF MEDICAID EFFORT.**—A
22 State is not eligible for payment under subsection (a) for
23 a calendar quarter beginning after the date of the enact-
24 ment of this subsection if eligibility standards, methodolo-
25 gies, or procedures under its plan under this title (includ-

1 ing any waiver under this title or under section 1115 that
2 is permitted to continue effect) that are more restrictive
3 than the eligibility standards, methodologies, or proce-
4 dures, respectively, under such plan (or waiver) as in ef-
5 fect on June 16, 2009.”.

6 **SEC. 1804. MEDICAID DSH REPORT.**

7 (a) IN GENERAL.—Not later than July 1, 2016, the
8 Secretary of Health and Human Services (in this title re-
9 ferred to as the “Secretary”) shall submit to Congress a
10 report concerning the extent to which, based upon the im-
11 pact of the health care reforms carried out under division
12 A in reducing the number of uninsured individuals, there
13 is a continued role for Medicaid DSH. The report shall
14 include recommendations relating to the following:

15 (1) The appropriate targeting of Medicaid DSH
16 within States.

17 (2) The distribution of Medicaid DSH among
18 the States.

19 (b) MEDICAID DSH.—In this section, the term
20 “Medicaid DSH” means adjustments in payments under
21 section 1923 of the Social Security Act for inpatient hos-
22 pital services furnished by disproportionate share hos-
23 pitals.

24 (c) COORDINATION WITH MEDICARE DSH RE-
25 PORT.—The Secretary shall coordinate the report under

1 this section with the report on Medicare DSH under sec-
2 tion 1112.

3 **PART 2—PREVENTION**

4 **SEC. 1811. REQUIRED COVERAGE OF PREVENTIVE SERV-**
5 **ICES.**

6 (a) **COVERAGE.**—Section 1905 of the Social Security
7 Act (42 U.S.C. 1396d) is amended—

8 (1) in subsection (a)(4)—

9 (A) by striking “and” before “(C)”; and

10 (B) by inserting before the semicolon at
11 the end the following: “and (D) preventive serv-
12 ices described in subsection (y)”; and

13 (2) by adding at the end the following new sub-
14 section:

15 “(y) **PREVENTIVE SERVICES.**—The preventive serv-
16 ices described in this subsection are services not otherwise
17 described in subsection (a) or (r) that the Secretary deter-
18 mines are—

19 “(1)(A) recommended with a grade of A or B
20 by the United States Preventive Services Task
21 Force; or

22 “(B) vaccines recommended for use as appro-
23 priate by the Director of the Centers for Disease
24 Control and Prevention; and

1 “(2) appropriate for individuals entitled to med-
2 ical assistance under this title.”.

3 (b) ELIMINATION OF COST-SHARING.—

4 (1) IN GENERAL.—Subsections (a)(2)(D) and
5 (b)(2)(D) of section 1916 of such Act (42 U.S.C.
6 1396o) are each amended by inserting “preventive
7 services described in section 1905(y),” after “emer-
8 gency services (as defined by the Secretary),”.

9 (2) CONFORMING AMENDMENT.—Section
10 1916A(a)(1) of such Act (42 U.S.C. 1396o–1(a)(1))
11 is amended by inserting “, preventive services de-
12 scribed in section 1905(y),” after “subsection (c)”.

13 (c) ENHANCED FMAP.—The first sentence of section
14 1905(b) of such Act is amended by inserting before the
15 period at the end the following: “and medical assistance
16 for preventive services described in section 1905(y)”.

17 (d) CONFORMING AMENDMENT.—Section 1928 of
18 such Act (42 U.S.C. 1396s) is amended—

19 (1) in subsection (c)(2)(B)(i), by striking “the
20 advisory committee referred to in subsection (e)”
21 and inserting “the Director of the Centers for Dis-
22 ease Control and Prevention” ;

23 (2) in subsection (e), by striking “Advisory
24 Committee” and all that follows and inserting “Di-

1 rector of the Centers for Disease Control and Pre-
2 vention.”; and

3 (3) by striking subsection (g).

4 (e) EFFECTIVE DATE.—

5 (1) Except as provided in paragraph (2), the
6 amendments made by this section shall apply to
7 services furnished on or after July 1, 2010, without
8 regard to whether or not final regulations to carry
9 out such amendments have been promulgated by
10 such date.

11 (2) In the case of a State plan for medical as-
12 sistance under title XIX of the Social Security Act
13 which the Secretary of Health and Human Services
14 determines requires State legislation (other than leg-
15 islation appropriating funds) in order for the plan to
16 meet the additional requirements imposed by the
17 amendments made by this section, the State plan
18 shall not be regarded as failing to comply with the
19 requirements of such title solely on the basis of its
20 failure to meet these additional requirements before
21 the first day of the first calendar quarter beginning
22 after the close of the first regular session of the
23 State legislature that begins after the date of the en-
24 actment of this Act. For purposes of the previous
25 sentence, in the case of a State that has a 2-year

1 legislative session, each year of such session shall be
2 deemed to be a separate regular session of the State
3 legislature.

4 **SEC. 1812. TOBACCO CESSATION.**

5 (a) DROPPING TOBACCO EXCEPTION FROM COV-
6 ERED OUTPATIENT DRUGS.—Section 1927(d)(2) of the
7 Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amend-
8 ed—

9 (1) by striking subparagraph (E);

10 (2) in subparagraph (G), by inserting before the
11 period at the end the following: “, except agents ap-
12 proved by the Food and Drug Administration for
13 purposes of promoting, and when used to promote,
14 tobacco cessation”; and

15 (3) by redesignating subparagraphs (F)
16 through (K) as subparagraphs (E) through (J), re-
17 spectively.

18 (b) COVERAGE OF TOBACCO CESSATION COUN-
19 SELING FOR PREGNANT WOMEN.—Section 1902(a)(10) of
20 such Act (42 U.S.C. 1396a(a)(10)) is amended—

21 (1) in the clause (V) following subparagraph
22 (G), by striking “and postpartum services” and in-
23 serting “postpartum services, and tobacco cessation
24 counseling”; and

1 (2) in the clause (VII) following subparagraph
2 (G), by inserting “tobacco cessation coun-
3 seling,” after “postpartum,” . .

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to drugs and services furnished
6 on or after July 1, 2010.

7 **SEC. 1813. OPTIONAL COVERAGE OF NURSE HOME VISITA-**
8 **TION SERVICES.**

9 (a) IN GENERAL.—Section 1905 of the Social Secu-
10 rity Act (42 U.S.C. 1396d), as amended by —, is amend-
11 ed—

12 (1) in subsection (a)—

13 (A) in paragraph (27), by striking “and”
14 at the end;

15 (B) by redesignating paragraph (28) as
16 paragraph (29); and

17 (C) by inserting after paragraph (27) the
18 following new paragraph:

19 “(28) nurse home visitation services (as defined
20 in subsection (bb)); and”; and.

21 (2) by adding at the end the following new sub-
22 section:

23 “(bb) The term ‘nurse home visitation services’
24 means home visits by trained nurses to families with a
25 first-time pregnant woman, or a child (under 2 years of

1 age), who is eligible for medical assistance under this title,
2 but only, to the extent determined by the Secretary based
3 upon evidence, that such services are effective in one or
4 more of the following:

5 “(1) Improving maternal or child health and
6 pregnancy outcomes or increasing birth intervals be-
7 tween pregnancies.

8 “(2) Reducing the incidence of child abuse, ne-
9 glect, and injury, improving family stability (includ-
10 ing reduction incidence of intimate partner violence),
11 or reducing maternal and child involvement in crimi-
12 nal justice system.

13 “(3) Increasing economic self-sufficiency, em-
14 ployment advancement, school-readiness, and edu-
15 cational achievement, or reducing dependence on
16 public assistance.”.

17 (b) INCREASE IN PAYMENT USING ENHANCED
18 FMAP.— Section 1905(b) of such Act (42 U.S.C.
19 1396b(b)) is amended by adding at the end the following:
20 “Notwithstanding the first sentence, with respect to med-
21 ical assistance for nurse home visitation services, the Fed-
22 eral medical assistance percentage shall be the enhanced
23 FMAP described in section 2105(b).”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 2010.

4 (d) CONSTRUCTION.—Nothing in the amendments
5 made by this section shall be construed as affecting the
6 ability of a State under title XIX or XXI of the Social
7 Security Act to provide nurse home visitation services as
8 part of another class of items and services falling within
9 the definition of medical assistance or child health assist-
10 ance under the respective title, or as an administrative ex-
11 penditure for which payment is made under section
12 1903(a) or 2105(a) of such Act, respectively, on or after
13 the date of the enactment of this Act.

14 **SEC. 1814. STATE ELIGIBILITY OPTION FOR FAMILY PLAN-**
15 **NING SERVICES.**

16 (a) COVERAGE AS OPTIONAL CATEGORICALLY
17 NEEDY GROUP.—

18 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
19 of the Social Security Act (42 U.S.C.
20 1396a(a)(10)(A)(ii)), as amended by section
21 1831(a)(1) of this title, is amended—

22 (A) in subclause (XIX), by striking “or” at
23 the end;

24 (B) in subclause (XX), by adding “or” at
25 the end; and

1 (C) by adding at the end the following new
2 subclause:

3 “(XXI) who are described in subsection (hh)
4 (relating to individuals who meet certain income
5 standards);”.

6 (2) GROUP DESCRIBED.—Section 1902 of such
7 Act (42 U.S.C. 1396a), as amended by section 1803,
8 is amended by adding at the end the following new
9 subsection:

10 “(hh)(1) Individuals described in this subsection are
11 individuals—

12 “(A) whose income does not exceed an in-
13 come eligibility level established by the State
14 that does not exceed the highest income eligi-
15 bility level established under the State plan
16 under this title (or under its State child health
17 plan under title XXI) for pregnant women; and

18 “(B) who are not pregnant.

19 “(2) At the option of a State, individuals de-
20 scribed in this subsection may include individuals
21 who, had individuals applied on or before January 1,
22 2007, would have been made eligible pursuant to the
23 standards and processes imposed by that State for
24 benefits described in clause (XV) of the matter fol-
25 lowing subparagraph (G) of section subsection

1 (a)(10) pursuant to a waiver granted under section
2 1115.

3 “(3) At the option of a State, for purposes of
4 subsection (a)(17)(B), in determining eligibility for
5 services under this subsection, the State may con-
6 sider only the income of the applicant or recipient.”.

7 (3) LIMITATION ON BENEFITS.—Section
8 1902(a)(10) of the Social Security Act (42 U.S.C.
9 1396a(a)(10)) is amended in the matter following
10 subparagraph (G)—

11 (A) by striking “and (XIV)” and inserting
12 “(XIV)”; and

13 (B) by inserting “, and (XV) the medical
14 assistance made available to an individual de-
15 scribed in subsection (ee) shall be limited to
16 family planning services and supplies described
17 in section 1905(a)(4)(C) including medical di-
18 agnosis and treatment services that are pro-
19 vided pursuant to a family planning service in
20 a family planning setting” after “cervical can-
21 cer”.

22 (4) CONFORMING AMENDMENTS.—Section
23 1905(a) of the Social Security Act (42 U.S.C.
24 1396d(a)), as amended by section 1831(c) of this

1 title, is amended in the matter preceding paragraph

2 (1)—

3 (A) in clause (xiii), by striking “or” at the

4 end;

5 (B) in clause (xiv), by adding “or” at the

6 end; and

7 (C) by inserting after clause (xiii) the fol-

8 lowing:

9 “(xv) individuals described in section

10 1902(hh),”.

11 (b) PRESUMPTIVE ELIGIBILITY.—

12 (1) IN GENERAL.—Title XIX of the Social Se-

13 curity Act (42 U.S.C. 1396 et seq.) is amended by

14 inserting after section 1920B the following:

15 “PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING

16 SERVICES

17 “SEC. 1920C. (a) STATE OPTION.—State plan ap-

18 proved under section 1902 may provide for making med-

19 ical assistance available to an individual described in sec-

20 tion 1902(hh) (relating to individuals who meet certain

21 income eligibility standard) during a presumptive eligi-

22 bility period. In the case of an individual described in sec-

23 tion 1902(hh), such medical assistance shall be limited to

24 family planning services and supplies described in

25 1905(a)(4)(C) and, at the State’s option, medical diag-

26 nosis and treatment services that are provided in conjunc-

1 tion with a family planning service in a family planning
2 setting.

3 “(b) DEFINITIONS.—For purposes of this section:

4 “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
5 term ‘presumptive eligibility period’ means, with re-
6 spect to an individual described in subsection (a),
7 the period that—

8 “(A) begins with the date on which a
9 qualified entity determines, on the basis of pre-
10 liminary information, that the individual is de-
11 scribed in section 1902(hh); and

12 “(B) ends with (and includes) the earlier
13 of—

14 “(i) the day on which a determination
15 is made with respect to the eligibility of
16 such individual for services under the State
17 plan; or

18 “(ii) in the case of such an individual
19 who does not file an application by the last
20 day of the month following the month dur-
21 ing which the entity makes the determina-
22 tion referred to in subparagraph (A), such
23 last day.

24 “(2) QUALIFIED ENTITY.—

1 “(A) IN GENERAL.—Subject to subpara-
2 graph (B), the term ‘qualified entity’ means
3 any entity that—

4 “(i) is eligible for payments under a
5 State plan approved under this title; and

6 “(ii) is determined by the State agen-
7 cy to be capable of making determinations
8 of the type described in paragraph (1)(A).

9 “(B) RULE OF CONSTRUCTION.—Nothing
10 in this paragraph shall be construed as pre-
11 venting a State from limiting the classes of en-
12 tities that may become qualified entities in
13 order to prevent fraud and abuse.

14 “(c) ADMINISTRATION.—

15 “(1) IN GENERAL.—The State agency shall pro-
16 vide qualified entities with—

17 “(A) such forms as are necessary for an
18 application to be made by an individual de-
19 scribed in subsection (a) for medical assistance
20 under the State plan; and

21 “(B) information on how to assist such in-
22 dividuals in completing and filing such forms.

23 “(2) NOTIFICATION REQUIREMENTS.—A quali-
24 fied entity that determines under subsection
25 (b)(1)(A) that an individual described in subsection

1 (a) is presumptively eligible for medical assistance
2 under a State plan shall—

3 “(A) notify the State agency of the deter-
4 mination within 5 working days after the date
5 on which determination is made; and

6 “(B) inform such individual at the time
7 the determination is made that an application
8 for medical assistance is required to be made by
9 not later than the last day of the month fol-
10 lowing the month during which the determina-
11 tion is made.

12 “(3) APPLICATION FOR MEDICAL ASSIST-
13 ANCE.—In the case of an individual described in
14 subsection (a) who is determined by a qualified enti-
15 ty to be presumptively eligible for medical assistance
16 under a State plan, the individual shall apply for
17 medical assistance by not later than the last day of
18 the month following the month during which the de-
19 termination is made.

20 “(d) PAYMENT.—Notwithstanding any other provi-
21 sion of law, medical assistance that—

22 “(1) is furnished to an individual described in
23 subsection (a)—

24 “(A) during a presumptive eligibility pe-
25 riod;

1 “(B) by a entity that is eligible for pay-
2 ments under the State plan; and

3 “(2) is included in the care and services covered
4 by the State plan,
5 shall be treated as medical assistance provided by such
6 plan for purposes of clause (4) of the first sentence of
7 section 1905(b).”.

8 (2) CONFORMING AMENDMENTS.—

9 (A) Section 1902(a)(47) of the Social Se-
10 curity Act (42 U.S.C. 1396a(a)(47)) is amend-
11 ed by inserting before the semicolon at the end
12 the following: “and provide for making medical
13 assistance available to individuals described in
14 subsection (a) of section 1920C during a pre-
15 sumptive eligibility period in accordance with
16 such section”.

17 (B) Section 1903(u)(1)(D)(v) of such Act
18 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

19 (i) by striking “or for” and inserting
20 “for”; and

21 (ii) by inserting before the period the
22 following: “, or for medical assistance pro-
23 vided to an individual described in sub-
24 section (a) of section 1920C during a pre-

1 sumptive eligibility period under such sec-
2 tion”.

3 (c) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
4 NING SERVICES AND SUPPLIES.—Section 1937(b) of the
5 Social Security Act (42 U.S.C. 1396u–7(b)) is amended
6 by adding at the end the following:

7 “(5) COVERAGE OF FAMILY PLANNING SERV-
8 ICES AND SUPPLIES.—Notwithstanding the previous
9 provisions of this section, a State may not provide
10 for medical assistance through enrollment of an indi-
11 vidual with benchmark coverage or benchmark-equiv-
12 alent coverage under this section unless such cov-
13 erage includes for any individual described in section
14 1905(a)(4)(C), medical assistance for family plan-
15 ning services and supplies in accordance with such
16 section.”.

17 (d) EFFECTIVE DATE.—The amendments made by
18 this section take effect on the date of the enactment of
19 this Act and shall apply to items and services furnished
20 on or after such date.

21 **SEC. 1815. PAYMENT FOR ITEMS AND SERVICES FUR-**
22 **NISHED BY CERTAIN SCHOOL-BASED HEALTH**
23 **CLINICS.**

24 (a) STATE PLAN REQUIREMENT.—Section 1902(a)
25 of the Social Security Act (42 U.S.C. 1396a(a)), as

1 amended by sections 1631(b)(1)(D) and 1803, is amend-
2 ed—

3 (1) in paragraph (74), by striking “and” at the
4 end;

5 (2) in paragraph (75), by striking the period at
6 the end and inserting “; and”; and

7 (3) by inserting after paragraph (75) the fol-
8 lowing new paragraph:

9 “(76) provide that the State shall certify to the
10 Secretary that the State has implemented proce-
11 dures to pay for medical assistance (including care
12 and services described in subsections (a)(4)(B) and
13 (r) of section 1905 and provided in accordance with
14 section 1902(a)(43)) furnished in a school-based
15 health clinic, if payment would be made under the
16 State plan for the same items and services if fur-
17 nished in a physician’s office or other outpatient
18 clinic (including if such payment would be included
19 in the determination of a prepaid capitation or other
20 risk-based rate of payment to an entity under a con-
21 tract pursuant to section 1903(m)).”.

22 (b) **RULE OF CONSTRUCTION.**—Nothing in this sec-
23 tion or the amendments made by this section shall be con-
24 strued to preempt or supersede State or local law with

1 respect to whether a school-based health clinic provides
2 family planning services and supplies.

3 (c) EFFECTIVE DATE.—

4 (1) Except as provided in paragraph (2), the
5 amendments made by this section shall apply to
6 services furnished on or after July 1, 2010, without
7 regard to whether or not final regulations to carry
8 out such amendments have been promulgated by
9 such date.

10 (2) In the case of a State plan for medical as-
11 sistance under title XIX of the Social Security Act
12 which the Secretary of Health and Human Services
13 determines requires State legislation (other than leg-
14 islation appropriating funds) in order for the plan to
15 meet the additional requirement imposed by the
16 amendments made by this section, the State plan
17 shall not be regarded as failing to comply with the
18 requirements of such title solely on the basis of its
19 failure to meet this additional requirement before
20 the first day of the first calendar quarter beginning
21 after the close of the first regular session of the
22 State legislature that begins after the date of the en-
23 actment of this Act. For purposes of the previous
24 sentence, in the case of a State that has a 2-year
25 legislative session, each year of such session shall be

1 deemed to be a separate regular session of the State
2 legislature.

3 **PART 3—ACCESS**

4 **SEC. 1821. PAYMENTS TO PRIMARY CARE PRACTITIONERS.**

5 (a) IN GENERAL.—

6 (1) FEE-FOR-SERVICE PAYMENTS.—Section
7 1902(a)(13) of the Social Security Act (42 U.S.C.
8 1396b(a)(13)) is amended—

9 (A) by striking “and” at the end of sub-
10 paragraph (A);

11 (B) by adding “and” at the end of sub-
12 paragraph (B); and

13 (C) by adding at the end the following new
14 subparagraph:

15 “(C) payment for primary care services (as
16 defined in section 1842(i)(4)) furnished by phy-
17 sicians (or for services furnished by other
18 health care professionals that would be primary
19 care services under such section if furnished by
20 a physician) at a rate not less than 80 percent
21 of the payment rate applicable to such services
22 under part B of title XVIII for services fur-
23 nished in 2010, 90 percent of such rate for
24 services furnished in 2011, and 100 percent of

1 such payment rate for services furnished in
2 2012 or a subsequent year;”.

3 (2) UNDER MEDICAID MANAGED CARE
4 PLANS.—Section 1923(f) of such Act (42 U.S.C.
5 1396u–2(f)) is amended—

6 (A) in the heading, by adding at the end
7 the following: “; ADEQUACY OF PAYMENT FOR
8 PRIMARY CARE SERVICES”; and

9 (B) by inserting before the period at the
10 end the following: “and, in the case of primary
11 care services described in section
12 1902(a)(13)(C), consistent with the minimum
13 payment rates specified in such section (regard-
14 less of the manner in which such payments are
15 made, including in the form of capitation or
16 partial capitation).”.

17 (b) INCREASE IN PAYMENT USING 100% FMAP.—
18 The third sentence of section 1905(b) of such Act (42
19 U.S.C. 1396d(b)) is amended by inserting before the pe-
20 riod at the end the following: “and also with respect to
21 the portion of the payment for medical assistance for serv-
22 ices described in section 1902(a)(13)(C) furnished on or
23 after January 1, 2010, and before December 31, 2012,
24 that is attributable the amount by which the minimum
25 payment rate required under such section (or, by applica-

1 tion, section 1932(f)) exceeds the payment rate applicable
2 to such services under the State plan as of June 16, 2009,
3 and also with respect to payment for medical assistance
4 for services described in section 1902(a)(13)(C) furnished
5 on or after January 1, 2013, insofar as the amount of
6 such payment does not exceed the payment rate estab-
7 lished for such services under part B of title XVIII”.

8 (c) EFFECTIVE DATE.—The amendments made by
9 this section shall apply to services furnished on or after
10 January 1, 2010.

11 **SEC. 1822. MEDICAL HOME PILOT PROGRAM.**

12 (a) IN GENERAL.—The Secretary of Health and
13 Human Services shall establish under this section a med-
14 ical home pilot program under which a State may apply
15 to the Secretary for approval of a medical home pilot
16 project described in subsection (b) (in this section referred
17 to as a “pilot project”) for the application of the medical
18 home concept under title XIX of the Social Security Act.
19 The pilot program shall operate for a period of up to 5
20 years.

21 (b) PILOT PROJECT DESCRIBED.—

22 (1) IN GENERAL.—A pilot project is a project
23 that applies one or more of the medical home models
24 described in section 1866E(a)(3) of the Social Secu-
25 rity Act (as inserted by section —), or such other

1 model as the Secretary may approve, to high need
2 beneficiaries who are eligible for medical assistance
3 under title XIX of the Social Security Act. The Sec-
4 retary shall provide for appropriate coordination of
5 the pilot program under this section with the med-
6 ical home pilot program under section 1866E of
7 such Act.

8 (2) LIMITATION.—A pilot project shall be for a
9 duration of not more than 5 years.

10 (c) ADDITIONAL INCENTIVES.—In the case of a pilot
11 project, the Secretary may—

12 (1) waive the requirements of section
13 1902(a)(1) of the Social Security Act (relating to
14 statewideness) and section 1902(a)(10)(B) of such
15 Act (relating to comparability); and

16 (2) increase to up to 90 percent (for the first
17 2 years of the pilot program) or 75 percent (for the
18 next 3 years) the matching percentage for adminis-
19 trative expenditures (such as those for community
20 care workers).

21 (d) EVALUATION; REPORT.—

22 (1) EVALUATION.—The Secretary, using the
23 criteria described in section 1866E(g)(1) of the So-
24 cial Security Act (as inserted by section 1123), shall

1 conduct an evaluation of the pilot program under
2 this section.

3 (2) REPORT.—Not later than 60 days after the
4 date of completion of the evaluation under para-
5 graph (1), the Secretary shall submit to Congress
6 and make available to the public a report on the
7 findings of the evaluation under such paragraph.

8 (e) FUNDING.—The additional Federal financial par-
9 ticipation resulting from the implementation of the pilot
10 program under this section may not exceed in the aggre-
11 gate \$1,235,000,000 over the 5-year period of the pro-
12 gram.

13 **SEC. 1823. TRANSLATION SERVICES.**

14 (a) IN GENERAL.—Section 1903(a)(2)(E) of the So-
15 cial Security Act (42 U.S.C. 1396b(a)(2)), as added by
16 section 201(b)(2)(A) of the Children’s Health Insurance
17 Program Reauthorization Act of 2009 (Public Law 111–
18 3), is amended by inserting “and other individuals” after
19 “children of families”.

20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall apply to payment for translation serv-
22 ices furnished on or after January 1, 2010.

1 **SEC. 1824. OPTIONAL COVERAGE FOR FREESTANDING**
2 **BIRTH CENTER SERVICES.**

3 (a) IN GENERAL.—Section 1905 of the Social Secu-
4 rity Act (42 U.S.C. 1396d), as previously amended, is
5 amended—

6 (1) in subsection (a)—

7 (A) by redesignating paragraph (29) as
8 paragraph (30);

9 (B) in paragraph (28), by striking at the
10 end “and”; and

11 (C) by inserting after paragraph (28) the
12 following new paragraph:

13 “(29) freestanding birth center services (as de-
14 fined in subsection (l)(3)(A)) and other ambulatory
15 services that are offered by a freestanding birth cen-
16 ter (as defined in subsection (l)(3)(B)) and that are
17 otherwise included in the plan; and”;

18 (2) in subsection (l), by adding at the end the
19 following new paragraph:

20 “(3)(A) The term ‘freestanding birth center services’
21 means services furnished to an individual at a freestanding
22 birth center (as defined in subparagraph (B)), including
23 by a licensed birth attendant (as defined in subparagraph
24 (C)) at such center.

25 “(B) The term ‘freestanding birth center’ means a
26 health facility—

1 **PART 4—COVERAGE**

2 **SEC. 1831. OPTIONAL MEDICAID COVERAGE OF LOW-IN-**
3 **COME HIV-INFECTED INDIVIDUALS.**

4 (a) IN GENERAL.— Section 1902 of the Social Secu-
5 rity Act (42 U.S.C. 1396a) is amended—

6 (1) in subsection (a)(10)(A)(ii)—

7 (A) by striking “or” at the end of sub-
8 clause (XVIII);

9 (B) by adding “or” at the end of subclause
10 (XIX); and

11 (C) by adding at the end the following:

12 “(XX) who are described in subsection (ii) (re-
13 lating to HIV-infected individuals);” and

14 (2) by adding at the end, as amended by sec-
15 tions 1803 and 1814(a), the following:

16 “(ii) individuals described in this subsection are indi-
17 viduals not described in subsection (a)(10)(A)(i)—

18 “(1) who have HIV infection;

19 “(2) whose income (as determined under the
20 State plan under this title with respect to disabled
21 individuals) does not exceed the maximum amount
22 of income a disabled individual described in sub-
23 section (a)(10)(A)(i) may have and obtain medical
24 assistance under the plan; and

25 “(3) whose resources (as determined under the
26 State plan under this title with respect to disabled

1 individuals) do not exceed the maximum amount of
2 resources a disabled individual described in sub-
3 section (a)(10)(A)(i) may have and obtain medical
4 assistance under the plan.”.

5 (b) ENHANCED MATCH.—The first sentence of sec-
6 tion 1905(b) of the Social Security Act (42 U.S.C.
7 1396d(b)) is amended by striking “section
8 1902(a)(10)(A)(ii)(XVIII)” and inserting “subclause
9 (XVIII) or (XX) of section 1902(a)(10)(A)(ii)”.

10 (c) CONFORMING AMENDMENTS.—Section 1905(a) of
11 the Social Security Act (42 U.S.C. 1396d(a)) is amended
12 in the matter preceding paragraph (1)—

13 (1) by striking “or” at the end of clause (xii);

14 (2) by adding “or” at the end of clause (xiii);

15 and

16 (3) by inserting after clause (xiii) the following:

17 “(xiv) individuals described in section
18 1902(ii);”.

19 (d) EXEMPTION FROM FUNDING LIMITATION FOR
20 TERRITORIES.—Section 1108(g) of the Social Security
21 Act (42 U.S.C. 1308(g)) is amended by adding at the end
22 the following:

23 “(4) DISREGARDING MEDICAL ASSISTANCE FOR
24 OPTIONAL LOW-INCOME HIV-INFECTED INDIVID-
25 UALS.—The limitations under subsection (f) and the

1 previous provisions of this subsection shall not apply
2 to amounts expended for medical assistance for indi-
3 viduals described in section 1902(ii) who are only el-
4 igible for such assistance on the basis of section
5 1902(a)(10)(A)(ii)(XX).”.

6 (e) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to calendar quarters beginning on
8 or after the date of the enactment of this Act, without
9 regard to whether or not final regulations to carry out
10 such amendments have been promulgated by such date.

11 **SEC. 1832. EXTENDING TRANSITIONAL MEDICAID ASSIST-**
12 **ANCE (TMA).**

13 Sections 1902(e)(1)(B) and 1925(f) of the Social Se-
14 curity Act (42 U.S.C. 1396a(e)(1)(B), 1396r-6(f)), as
15 amended by section 5004(a)(1) of the American Recovery
16 and Reinvestment Act of 2009 (Public Law 111–5) are
17 each amended by striking “December 31, 2010” and in-
18 serting “December 31, 2012”.

19 **SEC. 1833. UPGRADING ELECTRONIC ELIGIBILITY SYSTEMS.**

20 Section 1903 of the Social Security Act (42 U.S.C.
21 1396b) is amended—

22 (1) in subsection (a)(3)—

23 (A) by striking “and” at the end of sub-
24 paragraph (D);

1 (B) by striking “plus” at the end of sub-
2 paragraph (E) and inserting “and”; and

3 (C) by adding at the end the following new
4 subparagraph:

5 “(F)(i) subject to subsection (r)(4) for cal-
6 endar quarters beginning on or after January
7 1, 2010, and before January 1, 2013, 90 per-
8 cent of so much of the sums expended during
9 such quarter as are attributable to the design,
10 development, or installation of an electronic eli-
11 gibility system, including the upgrading of an
12 existing system to perform new functions, and
13 including the State’s share of the cost of install-
14 ing such a system to be used jointly in the ad-
15 ministration of such State’s plan and the plan
16 of any other State approved under this title;
17 and

18 “(ii) subject to subsection (r)(5), for cal-
19 endar quarters beginning on or after January
20 1, 2010, and before January 1, 2013, 75 per-
21 cent of so much of the sums expended during
22 such quarter as are attributable to the oper-
23 ation of such a system (whether or not such
24 system is designed, developed, or installed with
25 assistance under clause (i), which may include

1 building the capability for the system for the
2 State to develop on-line applications that inter-
3 face with eligibility systems or use of data-
4 matching to identify individuals who appear to
5 be eligible for the purpose of conducting out-
6 reach and providing application assistance;
7 plus”; and

8 (2) in subsection (r), as amended by section
9 3(a) of Public Law 110–379—

10 (A) in paragraph (1), by striking “this
11 subsection” and inserting “this paragraph and
12 paragraph (2)”; and

13 (B) by adding at the end the following new
14 paragraphs:

15 “(4) In order for a State to receive payments
16 under subsection (a)(3)(F)(i) with respect to an elec-
17 tronic eligibility system, the Secretary must have re-
18 viewed and approved the system as meeting the fol-
19 lowing requirements:

20 “(A) The system is adequate to provide ef-
21 ficient, economical, and effective administration
22 of such State plan.

23 “(B) The system is compatible with eligi-
24 bility, enrollment, and information retrieval sys-

1 tems used in the administration of title XVIII,
2 .

3 “(C) The system is capable of providing
4 accurate and timely data.

5 “(D) The system is complying with the ap-
6 plicable provisions of part C of title XI.

7 “(E) The system is compatible with sys-
8 tems of the type described in subsection
9 (a)(3)(A)(i) operated by the State.

10 “(F) If the State uses a contractor with
11 respect to the system, such contractor meets
12 such requirements for integrity as are specified
13 by the Secretary, in consultation with the In-
14 spector General of the Department of Health
15 and Human Services.

16 “(G) The system allows the State to con-
17 duct paperless verification of components of eli-
18 gibility at the time of application and renewal
19 without beneficiaries being required to provide
20 information that is already available to the
21 State through other programs and databases.

22 “(H) The system is compatible with and is
23 able to access, to the extent permitted by law,
24 electronic data bases, including data bases re-
25 lating to the following:

1 “(i)(I) The temporary assistance for
2 needy families program funded under part
3 A or E of title IV.

4 “(II) A State program funded
5 under part D of title IV and new-hire
6 data bases under such part.

7 “(III) The State CHIP plan
8 under title XXI.

9 “(IV) Vital records data bases.

10 “(V) Section 1137(d) (relating to
11 immigration-related income and eligi-
12 bility verification system) or section
13 1903(x) (relating to citizenship docu-
14 mentation system).

15 “(VI) A food stamp program op-
16 erating under the Food and Nutrition
17 Act of 2008 (7 U.S.C. 2011 et seq.).

18 “(VII) The Head Start Act (42
19 U.S.C. 9801 et seq.).

20 “(VIII) The Richard B. Russell
21 National School Lunch Act (42
22 U.S.C. 1751 et seq.).

23 “(IX) The Child Nutrition Act of
24 1966 (42 U.S.C. 1771 et seq.).

1 “(X) The Child Care and Devel-
2 opment Block Grant Act of 1990 (42
3 U.S.C. 9858 et seq.).

4 “(XI) The Stewart B. McKinney
5 Homeless Assistance Act (42 U.S.C.
6 11301 et seq.).

7 “(XII) The United States Hous-
8 ing Act of 1937 (42 U.S.C. 1437 et
9 seq.).

10 “(XIII) The Native American
11 Housing Assistance and Self-Deter-
12 mination Act of 1996 (25 U.S.C.
13 4101 et seq.).

14 “(ii) Unemployment insurance pay-
15 ments.

16 “(iii) Employment wage data main-
17 tained by Federal or State agencies.

18 “(iv) Social Security data.

19 “(v) Affordability credits under sub-
20 title C of title I of the **[short title]**.

21 “(vi) Other public benefit programs
22 and databases (as specified by Secretary).

23 The Secretary may waive the application of any of
24 such requirements if the Secretary determines that
25 the application of such requirement is not feasible.

1 “(5) In order for a State to receive payments
2 under subsection (a)(3)(F)(ii) with respect to an
3 electronic eligibility system, the State must dem-
4 onstrate, to the satisfaction of the Secretary, that
5 the system meets the following requirements:

6 “(A) The Secretary has reviewed and ap-
7 proved the system as meeting the requirements
8 under paragraph (4).

9 “(B) The system accesses all public data
10 bases listed in paragraph (4)(G) to the extent
11 such access is permitted by law and is deter-
12 mined by the Secretary to be practicable and
13 useful to the operation of the system.

14 “(C) The system is operating properly,
15 consistent with Federal and State law, based on
16 a periodic automated audit conducted in accord-
17 ance with standards specified by the Secretary.

18 “(D) The system is used by the State to
19 conduct ex parte reviews at the point of renew-
20 als by relying on such data bases, to the extent
21 practicable.”.

22 **SEC. 1834. EXPANDED OUTSTATIONING.**

23 (a) IN GENERAL.—Section 1902(a)(55) of the Social
24 Security Act (42 U.S.C. 1396a(a)(55)) is amended by
25 striking “under subsection (a)(10)(A)(i)(IV),

1 (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or
2 (a)(10)(A)(ii)(IX)''.

3 (b) EFFECTIVE DATE.—

4 (1) Except as provided in paragraph (2), the
5 amendment made by subsection (a) shall apply to
6 services furnished on or after July 1, 2010, without
7 regard to whether or not final regulations to carry
8 out such amendment have been promulgated by such
9 date.

10 (2) In the case of a State plan for medical as-
11 sistance under title XIX of the Social Security Act
12 which the Secretary of Health and Human Services
13 determines requires State legislation (other than leg-
14 islation appropriating funds) in order for the plan to
15 meet the additional requirement imposed by the
16 amendment made by this section, the State plan
17 shall not be regarded as failing to comply with the
18 requirements of such title solely on the basis of its
19 failure to meet this additional requirement before
20 the first day of the first calendar quarter beginning
21 after the close of the first regular session of the
22 State legislature that begins after the date of the en-
23 actment of this Act. For purposes of the previous
24 sentence, in the case of a State that has a 2-year
25 legislative session, each year of such session shall be

1 (2) by adding at the end of subsection (k), as
2 amended by section 1181, the following new para-
3 graph:

4 “(11) RETAIL COMMUNITY PHARMACY.—The
5 term ‘retail community pharmacy’ means a tradi-
6 tional independent pharmacy, traditional chain phar-
7 macy, a supermarket pharmacy, or a mass merchan-
8 diser pharmacy that is licensed as a pharmacy by a
9 State and that dispenses medications to the general
10 public at retail prices. Such term does not include a
11 pharmacy that dispenses prescription medications to
12 patients primarily through the mail, nursing home
13 pharmacies, long-term care facility pharmacies, hos-
14 pital pharmacies, clinics, charitable or not-for-profit
15 pharmacies, government pharmacies, or pharmacy
16 benefit managers.”.

17 (b) DISCLOSURE OF PRICE INFORMATION TO THE
18 PUBLIC.—Section 1927(b)(3) of such Act (42 U.S.C.
19 1396r-8(b)(3)) is amended—

20 (1) in subparagraph (A)—

21 (A) in clause (i), in the matter preceding
22 subclause (I), by inserting “month of a” after
23 “each”; and

1 (B) in the last sentence, by striking “and
2 shall,” and all that follows through the period;
3 and

4 (2) in subparagraph (D)—

5 (A) in clause (iii), by inserting “and” after
6 the comma;

7 (B) in clause (iv), by striking “, and” and
8 inserting a period; and

9 (C) by striking clause (v).

10 (c) EFFECTIVE DATE.—The amendments made by
11 this section shall take effect on October 1, 2009.

12 **SEC. 1842. PRESCRIPTION DRUG REBATES.**

13 (a) ADDITIONAL REBATE FOR NEW FORMULATIONS
14 OF EXISTING DRUGS.—

15 (1) IN GENERAL.—Section 1927(c)(2) of the
16 Social Security Act (42 U.S.C. 1396r–8(c)(2)) is
17 amended by adding at the end the following new
18 subparagraph:

19 “(C) TREATMENT OF NEW FORMULA-
20 TIONS.—In the case of a drug that is a new for-
21 mulation, such as an extended-release version,
22 of a single source drug or an innovator multiple
23 source drug, the rebate obligation with respect
24 such drug under this section shall be the
25 amount computed under this section for such

1 new drug or, if greater, the amount computed
2 under this section for the original single source
3 drug or innovator multiple source drug.”.

4 (2) EFFECTIVE DATE.—The amendment made
5 by paragraph (1) shall apply to drugs dispensed
6 after December 31, 2009.

7 (b) INCREASE MINIMUM REBATE PERCENTAGE FOR
8 SINGLE SOURCE DRUGS.—Section 1927(c)(1)(B)(i) of the
9 Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)(i)) is
10 amended—

11 (1) in subclause (IV), by striking “and” at the
12 end;

13 (2) in subclause (V)—

14 (A) by inserting “and before January 1,
15 2010” after “December 31, 1995,”; and

16 (B) by striking the period at the end and
17 inserting “; and”; and

18 (3) by adding at the end the following new sub-
19 clause:

20 “(VI) after December 31, 2009,
21 22.1 percent.”.

1 **SEC. 1843. EXTENSION OF PRESCRIPTION DRUG DIS-**
2 **COUNTS TO ENROLLEES OF MEDICAID MAN-**
3 **AGED CARE ORGANIZATIONS.**

4 (a) IN GENERAL.—Section 1903(m)(2)(A) of the So-
5 cial Security Act (42 U.S.C. 1396b(m)(2)(A)) is amend-
6 ed—

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

8 (2) in clause (xii), by striking the period at the
9 end and inserting “; and”; and

10 (3) by adding at the end the following:

11 “(xiii) such contract provides that (I)
12 payment for covered outpatient drugs dis-
13 pensed to individuals eligible for medical
14 assistance who are enrolled with the entity
15 shall be subject to the same rebate re-
16 quired by the agreement entered into
17 under section 1927 as the State is subject
18 to, and (II) capitation rates paid to the en-
19 tity shall be based on actual cost experi-
20 ence related to rebates and subject to the
21 Federal regulations requiring actuarially
22 sound rates.”.

23 (b) CONFORMING AMENDMENT.—Section 1927(j) of
24 such Act (42 U.S.C. 1396r-8) is amended by striking
25 paragraph (1) and inserting the following:

1 “(1) Covered outpatients drugs are not subject
2 to the requirements of this section if such drugs
3 are—

4 “(A) dispensed by health maintenance or-
5 ganizations, including Medicaid managed care
6 organizations that contract under section
7 1903(m); and

8 “(B) subject to discounts under section
9 340B of the Public Health Service Act.”.

10 (c) REPORTING.—On a quarterly basis, the States
11 shall report to the Department of Health and Human
12 Services the total amount of rebates in dollars and volume
13 received from pharmacy manufacturers for drugs provided
14 to individuals enrolled with Medicaid managed care orga-
15 nizations that contract under section 1903(m) of the So-
16 cial Security Act (42 U.S.C. 1396b(m)) as a result of this
17 section for both brand-name and generic drugs. This re-
18 port shall be made publicly available.

19 (d) EFFECTIVE DATE.—The amendments made by
20 this section take effect on the date of the enactment of
21 this Act and apply to rebate agreements entered into or
22 renewed under section 1927 of the Social Security Act (42
23 U.S.C. 1396r-8) on or after such date.

1 **SEC. 1844. PAYMENTS FOR GRADUATE MEDICAL EDU-**
2 **CATION.**

3 (a) IN GENERAL.—Section 1905 of the Social Secu-
4 rity Act (42 U.S.C. 1396d), as amended by section
5 1811(a)(2), is amended by adding at the end the following
6 new subsection:

7 “(z) PAYMENT FOR GRADUATE MEDICAL EDU-
8 CATION.—

9 “(1) IN GENERAL.—The term ‘medical assist-
10 ance’ includes payment for costs of graduate medical
11 education consistent with this subsection., whether
12 provided in or outside of a hospital.

13 “(2) SUBMISSION OF INFORMATION.—For pur-
14 poses of paragraph (1) and section
15 1902(a)(13)(A)(v), payment for such costs is not
16 consistent with this subsection unless—

17 “(A) the State submits to the Secretary, in
18 a timely manner and on an annual basis speci-
19 fied by the Secretary, information on how such
20 payments are being used for graduate medical
21 education, including—

22 “(i) the institutions receiving the
23 funding;

24 “(ii) the manner in which such pay-
25 ments are calculated;

1 “(iii) the types and fields of education
2 being supported;

3 “(iv) the workforce or other goals to
4 which the funding is being applied; and

5 “(v) such other information as the
6 Secretary determines will assist in carrying
7 out paragraphs (3) and (4); and

8 “(B) such expenditures are made con-
9 sistent with such goals and requirements as are
10 established under paragraph (4).

11 “(3) REVIEW OF INFORMATION.—The Advisory
12 Committee on Health Workforce Evaluation and As-
13 sessment (established under section 764 of the Pub-
14 lic Health Service Act) and the Secretary shall inde-
15 pendently review the information submitted under
16 paragraph (2).

17 “(4) SPECIFICATION OF GOALS AND REQUIRE-
18 MENTS.—The Secretary shall specify by rule, ini-
19 tially published by not later than December 31,
20 2011—

21 “(A) program goals for the use of funds
22 described in paragraph (1), taking into account
23 recommendations of the such Advisory Com-
24 mittee and the goals for approved medical resi-

1 dency training programs described in section
2 1886(h)(1)(B); and

3 “(B) requirements for use of such funds
4 consistent with such goals.

5 Such rule may be effective on an interim basis pend-
6 ing revision after an opportunity for public com-
7 ment.”.

8 (b) CONFORMING AMENDMENT.—Section
9 1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A))
10 is amended—

11 (1) by striking “and” at the end of clause (iii);

12 (2) by striking “; and” and inserting “, and”;

13 and

14 (3) by adding at the end the following new
15 clause:

16 “(v) in the case of hospitals and at
17 the option of a State, such rates may in-
18 clude, to the extent consistent with section
19 1905(z), payment for graduate medical
20 education; and”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 this section shall take effect on the date of the enactment
23 of this Act. Nothing in this section shall be construed as
24 affecting payments made before such date under a State

1 plan under title XIX of the Social Security Act for grad-
2 uate medical education.

3 **PART 6—WASTE, FRAUD, AND ABUSE**

4 **SEC. 1851. HEALTH-CARE ACQUIRED CONDITIONS.**

5 (a) **MEDICAID NON-PAYMENT FOR CERTAIN HEALTH**
6 **CARE-ACQUIRED CONDITIONS.**—Section 1902(a)(13)(A)
7 of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)),
8 as amended by 1844, is amended—

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

10 (2) in clause (v), by striking “; and” and insert-
11 ing “, and”; and

12 (3) by adding at the end the following new
13 clause:

14 “(vi) for ensuring that higher pay-
15 ments are not made for services related to
16 the presence of a condition that could be
17 identified by a secondary diagnostic code
18 described in section 1886(d)(4)(D)(iv) and
19 nonpayment for any health care acquired
20 condition determined as a non-covered
21 service under title XVIII, or such other
22 health care-acquired condition as the Sec-
23 retary may specify; and”.

24 (b) **PERMISSION TO INCLUDE ADDITIONAL HEALTH**
25 **CARE-ACQUIRED CONDITIONS.**—Nothing in this section

1 shall prevent a State from including additional health
2 care-acquired conditions for non-payment in its Medicaid
3 program under title XIX of the Social Security Act.

4 (c) **AUTHORITY FOR SECRETARY TO EXCLUDE CER-**
5 **TAIN CONDITIONS.**—The Secretary of Health and Human
6 Services may exclude certain conditions identified under
7 title XVIII of the Social Security Act for payment limita-
8 tion or non-coverage under title XIX of the Social Security
9 Act when the Secretary of Health and Human Services
10 finds the inclusion of such condition to be inapplicable to
11 populations under such title XIX.

12 (d) **EFFECTIVE DATE.**—

13 (1) **IN GENERAL.**—Except as provided in para-
14 graphs (2) and (3), the amendments made by sub-
15 section (a) shall take effect for discharges occurring
16 on or after January 1, 2011.

17 (2) **EFFECTIVE DATE FOR EXISTING STATE**
18 **PLANS.**—In the case of a State plan under title XIX
19 of the Social Security Act which the Secretary of
20 Health and Human Services determines meets the
21 requirements provided in the amendment made by
22 subsection (a), the effective date of such State plan
23 shall remain.

24 (3) **EXTENSION OF EFFECTIVE DATE.**—In the
25 case of a State plan for medical assistance under

1 title XIX of the Social Security Act which the Sec-
2 retary of Health and Human Services determines re-
3 quires State legislation (other than legislation appro-
4 priating funds) in order for the plan to meet the ad-
5 ditional requirements imposed by the amendment
6 made by subsection (a), the State plan shall not be
7 regarded as failing to comply with the requirements
8 of such title solely on the basis of its failure to meet
9 this additional requirement before the first day of
10 the first calendar quarter beginning after the close
11 of the first regular session of the State legislature
12 that begins after the date of the enactment of this
13 Act. For purposes of the previous sentence, in the
14 case of a State that has a 2-year legislative session,
15 each year of such session shall be deemed to be a
16 separate regular session of the State legislature.

17 **SEC. 1852. EVALUATIONS AND REPORTS REQUIRED UNDER**
18 **MEDICAID INTEGRITY PROGRAM.**

19 Section 1936(c)(2)) of the Social Security Act (42
20 U.S.C. 1396u-7(c)(2)) is amended—

21 (1) by redesignating subparagraph (D) as sub-
22 paragraph (E); and

23 (2) by inserting after subparagraph (C) the fol-
24 lowing new subparagraph:

1 “(D) For the contract year beginning in
2 2011 and each subsequent contract year, the
3 entity provides assurances to the satisfaction of
4 the Secretary that the entity will conduct peri-
5 odic evaluations of the effectiveness of the ac-
6 tivities carried out by such entity under the
7 Program and will submit to the Secretary an
8 annual report on such activities.”.

9 **SEC. 1853. REQUIRE PROVIDERS AND SUPPLIERS TO**
10 **ADOPT PROGRAMS TO REDUCE WASTE,**
11 **FRAUD, AND ABUSE.**

12 Section 1902(a) of such Act (42 U.S.C. 42 U.S.C.
13 1396a(a)), as amended by sections 1631(b)(1), 1803, and
14 1815, is further amended—

15 (1) in paragraph (75), by striking at the end
16 “and”;

17 (2) in paragraph (76), by striking at the end
18 the period and inserting “; and”; and

19 (3) by adding at the end the following new
20 paragraph:

21 “(77) provide that any provider or supplier pro-
22 viding services under such plan shall, subject to
23 paragraph (5) of section 1866(k), establish a compli-
24 ance program described in paragraph (1) of such
25 subsection in accordance with such subsection.”.

1 **SEC. 1854. OVERPAYMENTS.**

2 (a) IN GENERAL.—Section 1903(d)(2)(C) of the So-
3 cial Security Act (42 U.S.C. 1396b(d)(2)(C)) is amended
4 by inserting “(or 1 year in the case of overpayments due
5 to fraud)” after “60 days”.

6 (b) EFFECTIVE DATE.—In the case overpayments
7 discovered on or after the date of the enactment of this
8 Act.

9 **SEC. 1855. MINIMUM MEDICAL LOSS RATIO FOR MEDICAID**
10 **MANAGED CARE ORGANIZATIONS.**

11 (a) IN GENERAL.—Section 1903(m)(2)(A) of the So-
12 cial Security Act (42 U.S.C. 1396b(m)(2)(A)), as amend-
13 ed by section 1843(a)(3), is amended—

14 (1) by striking “and” at the end of clause (xii);

15 (2) by striking the period at the end of clause
16 (xiii) and inserting “; and”; and

17 (3) by adding at the end the following new
18 clause:

19 “(xiv) such contract has a medical loss ratio, as
20 determined in accordance with a methodology speci-
21 fied by the Secretary, that is at least 85 percent.”.

22 (b) EFFECTIVE DATE.—The amendments made by
23 subsection (a) shall apply to contracts entered into or re-
24 newed on or after July 1, 2010.

1 **PART 7—PUERTO RICO AND THE TERRITORIES**

2 **SEC. 1861. PUERTO RICO AND TERRITORIES.**

3 (a) INCREASE IN CAP.—

4 (1) IN GENERAL.—Section 1008(g) of the So-
5 cial Security Act (42 U.S.C. 1308(g)) is amended—

6 (A) in paragraph (4)—

7 (i) by striking “and (3)” and by in-
8 serting “(3), and (4)”; and

9 (ii) by redesignating such paragraph
10 as paragraph (5); and

11 (B) by inserting after paragraph (3) the
12 following new paragraph:

13 “(4) FISCAL YEAR 2011.—The amounts other-
14 wise determined under this subsection for Puerto
15 Rico, the Virgin Islands, Guam, the Northern Mar-
16 iana Islands, and American Samoa for fiscal year
17 2011 and each succeeding fiscal year shall be in-
18 creased by the percentage specified under section
19 1861(c) of the [short title] for purposes of this
20 paragraph of the amounts otherwise determined
21 under this section (without regard to this para-
22 graph).”.

23 (2) COORDINATION WITH ARRA.—Section
24 5001(d) of the American Recovery and Reinvestment
25 Act of 2009 shall not apply during any period for

1 which section 1008(g)(4), as added by paragraph
2 (1), applies.

3 (b) INCREASE IN FMAP.—

4 (1) IN GENERAL.—Section 1905(b)(2) of the
5 Social Security Act (42 U.S.C. 1396d(b)(2)) is
6 amended by striking “50 per centum” and inserting
7 “the percentage specified under section 1861(c) of
8 the [short title] for purposes of this clause”.

9 (2) EFFECTIVE DATE.—The amendment made
10 by subsection (a) shall apply to items and services
11 furnished on or after January 1, 2011.

12 (c) SPECIFICATION OF PERCENTAGES.—The Sec-
13 retary of Health and Human Services shall specify, before
14 January 1, 2011, the percentages to be applied under sec-
15 tion 1108(g)(4) of the Social Security Act, as added by
16 subsection (a)(1), and under section 1905(b)(2) of such
17 Act, as amended by subsection (b)(1), in a manner so that
18 for the period beginning with 2011 and ending with 2019
19 the total estimated additional Federal expenditures result-
20 ing from the application of such percentages will be equal
21 to \$10,350,000,000.

22 **PART 8—MISCELLANEOUS**

23 **SEC. 1871. TECHNICAL CORRECTIONS.**

24 (a) TECHNICAL CORRECTION TO SECTION 1144 OF
25 THE SOCIAL SECURITY ACT.—The first sentence of sec-

1 tion 1144(c)(3) of the Social Security Act (42 U.S.C.
2 1320b—14(c)(3)) is amended—

3 (1) by striking “transmittal”; and

4 (2) by inserting before the period the following:
5 “as specified in section 1935(a)(4)”.

6 (b) CLARIFYING AMENDMENT TO SECTION 1935 OF
7 THE SOCIAL SECURITY ACT.—Section 1935(a)(4) of the
8 Social Security Act (42 U.S.C. 1396u—5(a)(4)), as
9 amended by section 113(b) of Public Law 110–275, is
10 amended—

11 (1) by striking the second sentence;

12 (2) by redesignating the first sentence as a sub-
13 paragraph (A) with appropriate indentation and
14 with the following heading: “IN GENERAL”;

15 (3) by adding at the end the following subpara-
16 graphs:

17 “(B) FURNISHING MEDICAL ASSISTANCE
18 WITH REASONABLE PROMPTNESS.—For the
19 purpose of a State’s obligation under section
20 1902(a)(8) to furnish medical assistance with
21 reasonable promptness, the date of the elec-
22 tronic transmission of low-income subsidy pro-
23 gram data, as described in section 1144(c),
24 from the Commissioner of Social Security to the
25 State Medicaid Agency, shall constitute the date

1 of filing of such application for benefits under
2 the Medicare Savings Program.

3 “(C) DETERMINING AVAILABILITY OF
4 MEDICAL ASSISTANCE.—For the purpose of de-
5 termining when medical assistance will be made
6 available, the State shall consider the date of
7 the individual’s application for the low income
8 subsidy program to constitute the date of filing
9 for benefits under the Medicare Savings Pro-
10 gram.”.

11 (c) EFFECTIVE DATE RELATING TO MEDICAID
12 AGENCY CONSIDERATION OF LOW-INCOME SUBSIDY AP-
13 PPLICATION AND DATA TRANSMITTAL.—The amendments
14 made by subsections (a) and (b) shall be effective as if
15 included in the enactment of section 113(b) of Public Law
16 110–275.

17 (d) TECHNICAL CORRECTION TO SECTION 605 OF
18 CHIPRA.—Section 605 of the Children’s Health Insur-
19 ance Program Reauthorization Act of 2009 (Public Law
20 111–3) is amended by striking “legal residents” and in-
21 serting “lawfully residing in the United States”.

22 **SEC. 1872. MAKING QI PROGRAM PERMANENT.**

23 (a) IN GENERAL.—Section 1902(a)(10)(E)(iv) of the
24 Social Security Act (42 U.S.C. 1396b(a)(10)(E)(iv)) is
25 amended—

1 (1) by striking “sections 1933 and” and by in-
2 serting “section”; and

3 (2) by striking “(but only for” and all that fol-
4 lows through “December 2010”).

5 (b) ELIMINATION OF FUNDING LIMITATION.—

6 (1) IN GENERAL.—Section 1933 of such Act
7 (42 U.S.C. 1396u–3) is amended—

8 (A) in subsection (a), by striking “who are
9 selected to receive such assistance under sub-
10 section (b)”;

11 (B) by striking subsections (b), (c), (e),
12 and (g);

13 (C) in subsection (d), by striking “fur-
14 nished in a State” and all that follows and in-
15 serting “the Federal medical assistance percent-
16 age shall be equal to 100 percent.”; and

17 (D) by redesignating subsections (d) and
18 (f) as subsections (b) and (e), respectively.

19 (2) CONFORMING AMENDMENT.—Section
20 1905(b) of such Act (42 U.S.C. 1396d(b)) is amend-
21 ed by striking “1933(d)” and inserting “1933(b)”.

22 (3) EFFECTIVE DATE.—The amendments made
23 by paragraph (1) shall take effect on January 1,
24 2011.

1 **DIVISION C—PUBLIC HEALTH**
2 **AND WORKFORCE DEVELOP-**
3 **MENT**

4 **SEC. 2001. TABLE OF CONTENTS; REFERENCES.**

5 (a) TABLE OF CONTENTS.—The table of contents of
6 this division is as follows:

Sec. 2001. Table of contents; references.

Sec. 2002. Public health investment fund.

TITLE I—COMMUNITY HEALTH CENTERS

Sec. 2101. Increased funding.

TITLE II—WORKFORCE

Subtitle A—Primary Care Workforce

CHAPTER 1—NATIONAL HEALTH SERVICE CORPS

Sec. 2201. National Health Service Corps.

Sec. 2202. Authorization of appropriations.

CHAPTER 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

Sec. 2211. Frontline health providers.

“SUBPART XI—HEALTH PROFESSIONAL NEEDS AREAS

“Sec. 340H. In general.

“Sec. 340I. Scholarships.

“Sec. 340J. Loan repayment program.

“Sec. 340K. Reports.

“Sec. 340L. Allocation.

Sec. 2212. Primary care student loan funds.

Sec. 2213. Training in family medicine, general internal medicine, general pedi-
atrics, geriatrics, and physician assistantship.

“Sec. 747. Primary care training and enhancement.

Sec. 2214. Training for general, pediatric, and public health dentists and dental
hygienists.

“Sec. 748. Training in general, pediatric, and public health dentistry.

Sec. 2215. Authorization of appropriations.

Subtitle B—Nursing Workforce

Sec. 2221. Amendments to Public Health Service Act.

“PART H—FUNDING

“Sec. 871. Funding.

Subtitle C—Public Health Workforce

Sec. 2231. Public Health Workforce Corps.

“SUBPART XII—PUBLIC HEALTH WORKFORCE

“Sec. 340M. Public Health Workforce Corps.

“Sec. 340N. Public health workforce scholarship program.

“Sec. 340O. Public Health Workforce Loan Repayment Program.

Sec. 2232. Enhancing the public health workforce.

“Sec. 765. General provisions.

Sec. 2233. Public health training centers.

Sec. 2234. Preventive medicine and public health training grant program.

“Sec. 768. Preventive medicine and public health training grant program.

Sec. 2235. Authorization of appropriations.

Subtitle D—Adapting Workforce to Evolving Health System Needs

CHAPTER 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY

Sec. 2241. Centers of excellence.

Sec. 2242. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds.

Sec. 2243. Nursing workforce diversity grants.

Sec. 2244. Coordination of diversity and cultural competency programs.

“Sec. 740. Coordination of diversity and cultural competency programs.

CHAPTER 2—INTERDISCIPLINARY TRAINING PROGRAMS

Sec. 2251. Cultural and linguistic competence training for health care professionals.

“Sec. 741. Cultural and linguistic competence training for health care professionals.

“Sec. 807. Cultural and linguistic competence training for nurses.

Sec. 2252. Innovations in interdisciplinary care training.

“Sec. 759. Innovations in interdisciplinary care training.

CHAPTER 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

Sec. 2261. Health workforce evaluation and assessment.

“Sec. 764. Health workforce evaluation and assessment.

CHAPTER 4—NATIONAL CENTER FOR HEALTH WORKFORCE ANALYSIS

Sec. 2271. Health care workforce program assessment.

Sec. 2272. Reports.

CHAPTER 5—AUTHORIZATION OF APPROPRIATIONS

Sec. 2281. Authorization of appropriations.

TITLE III—PREVENTION AND WELLNESS

Sec. 2301. Prevention and Wellness.

“TITLE XXXI—PREVENTION AND WELLNESS

“Subtitle A—Prevention and Wellness Trust

“Sec. 3111. Prevention and Wellness Trust.

“Subtitle B—National Prevention and Wellness Strategy

“Sec. 3121. National Prevention and Wellness Strategy.

“Subtitle C—Prevention Task Forces

“Sec. 3131. Task Force on Clinical Preventive Services.

“Sec. 3132. Task Force on Community Preventive Services.

“Subtitle D—Prevention and Wellness Research

“Sec. 3141. Prevention and Wellness Research Activity Coordination.

“Sec. 3142. Community-Based Prevention and Wellness Research Grants.

“Subtitle E—Delivery of Community-Based Prevention and Wellness Services

“Sec. 3151. Community-Based Prevention and Wellness Services Grants.

“Subtitle F—Core Public Health Infrastructure and Activities

“Sec. 3161. Core public health infrastructure and activities for State and local health departments.

“Sec. 3162. Core public health infrastructure and activities for CDC.

“Subtitle G—General Provisions

“Sec. 3171. Definitions.

TITLE IV—QUALITY AND SURVEILLANCE

Sec. 2401. Implementation of best practices in the delivery of health care.

“PART D—IMPLEMENTATION OF BEST PRACTICES IN THE DELIVERY OF HEALTH CARE

“Sec. 931. Center for Quality Improvement.

Sec. 2402. Assistant Secretary for Health Information.

“Sec. 1709. Assistant Secretary for Health Information.

Sec. 2403. Authorization of appropriations.

TITLE V—OTHER PROVISIONS

Sec. 2501. Expanded participation in 340B program.

Sec. 2502. Establishment of grant program.

1 (b) REFERENCES.—Except as otherwise specified,
 2 whenever in this division an amendment is expressed in
 3 terms of an amendment to a section or other provision,
 4 the reference shall be considered to be made to a section
 5 or other provision of the Public Health Service Act (21
 6 U.S.C. 201 et seq.).

1 **SEC. 2002. PUBLIC HEALTH INVESTMENT FUND.**

2 (a) ESTABLISHMENT OF FUNDS.—

3 (1) IN GENERAL.—There is established a fund
4 to be known as the “Public Health Investment
5 Fund” (referred to in this section as the “Fund”).

6 (2) FUNDING.—

7 (A) There shall be deposited into the
8 Fund—

9 (i) for fiscal year 2010,
10 \$4,700,000,000;

11 (ii) for fiscal year 2011,
12 \$5,600,000,000;

13 (iii) for fiscal year 2012,
14 \$6,900,000,000;

15 (iv) for fiscal year 2013,
16 \$7,700,000,000; and

17 (v) for fiscal year 2014,
18 \$8,800,000,000.

19 (B) Funds deposited into the Fund shall
20 be derived from general revenues of the Treas-
21 ury.

22 (b) AUTHORIZATION OF APPROPRIATIONS FROM THE
23 FUND.—

24 (1) IN GENERAL.—Amounts in the Fund are
25 authorized to be appropriated by the Committees on
26 Appropriations of the House of Representatives and

1 the Senate to increase funding, over the fiscal year
2 2008 level, for carrying out activities under des-
3 ignated public health provisions.

4 (2) DESIGNATED PROVISIONS.—For purposes of
5 this section, the term “designated public health pro-
6 visions” means the provisions of—

7 (A) titles I, II, III, and IV of this division;
8 and

9 (B) each section of the Public Health Serv-
10 ice Act (42 U.S.C. 201 et seq.) that is amended
11 or added by such titles, except for such sections
12 amended or added only for technical or con-
13 forming changes.

14 (3) BUDGETARY IMPLICATIONS.—Amounts ap-
15 propriated under this section, and outlays flowing
16 from such appropriations, shall not be taken into ac-
17 count for purposes of any budget enforcement proce-
18 dures including allocations under section 302(a) and
19 (b) of the Balanced Budget and Emergency Deficit
20 Control Act and budget resolutions for fiscal years
21 during which appropriations are made from the
22 Fund.

1 **TITLE I—COMMUNITY HEALTH**
2 **CENTERS**

3 **SEC. 2101. INCREASED FUNDING.**

4 Section 330(r) (42 U.S.C. 254b(r)) is amended by
5 striking paragraph (1) and inserting the following:

6 “(1) IN GENERAL.—For the purpose of car-
7 rying out this section, in addition to the amounts
8 authorized to be appropriated under subsection (d),
9 there are authorized to be appropriated, out of any
10 monies in the Public Health Investment Fund, the
11 following:

12 “(A) For fiscal year 2010,
13 \$1,000,000,000.

14 “(B) For fiscal year 2011,
15 \$1,500,000,000.

16 “(C) For fiscal year 2012, \$2,500,000,000.

17 “(D) For fiscal year 2013,
18 \$3,000,000,000.

19 “(E) For fiscal year 2014,
20 \$4,000,000,000.”.

1 **TITLE II—WORKFORCE**
2 **Subtitle A—Primary Care**
3 **Workforce**
4 **CHAPTER 1—NATIONAL HEALTH SERVICE**
5 **CORPS**

6 **SEC. 2201. NATIONAL HEALTH SERVICE CORPS.**

7 (a) FULFILLMENT OF OBLIGATED SERVICE RE-
8 QUIREMENT THROUGH PART-TIME SERVICE.—Subsection
9 (i) of section 331 (42 U.S.C. 331) is amended to read
10 as follows:

11 “(i) In carrying out the National Health Service
12 Corps Scholarship and Loan Repayment Programs under
13 subpart III, the Secretary may grant waivers under
14 which—

15 “(1) an individual is allowed to satisfy all or
16 part of the service obligation under section 338C
17 through providing clinical service that is not full
18 time; and

19 “(2) the Secretary extends the period of obli-
20 gated service, or reduces the amount of loan repay-
21 ments on behalf of the individual, to account for any
22 decrease in the amount of service that would other-
23 wise be performed through full-time service.”.

24 (b) REAPPOINTMENT TO NATIONAL ADVISORY COUN-
25 CIL.—Section 337(b)(1) (42 U.S.C. 254j(b)(1)) is amend-

1 ed by striking “Members may not be reappointed to the
2 Council.”.

3 (c) LOAN REPAYMENT AMOUNT.—Section
4 338B(g)(2)(A) is amended (42 U.S.C. 254I–1(g)(2)(A))
5 by striking “\$35,000” and inserting “\$50,000, plus, in
6 the case of fiscal years beginning after fiscal year 2011,
7 an amount determined by the Secretary on an annual
8 basis to reflect inflation.”.

9 **SEC. 2202. AUTHORIZATION OF APPROPRIATIONS.**

10 (a) NATIONAL HEALTH SERVICE CORPS PRO-
11 GRAM.—Subsection (a) of section 338 (42 U.S.C. 254k)
12 is amended by striking “(a)” and all that follows through
13 the end of the subsection and inserting the following: “(a)
14 For the purpose of carrying out this subpart, there is au-
15 thorized to be appropriated, out of any monies in the Pub-
16 lic Health Investment Fund, \$75,000,000 for each of fis-
17 cal years 2010 through 2014.”

18 (b) SCHOLARSHIP AND LOAN REPAYMENT PRO-
19 GRAMS.—Subsection (a) of section 338H (42 U.S.C.
20 254q) is amended to read as follows:

21 “(a) AUTHORIZATION OF APPROPRIATIONS.—For the
22 purpose of carrying out this subpart, there is authorized
23 to be appropriated, out of any monies in the Public Health
24 Investment Fund, \$300,000,000 for each of fiscal years
25 2010 through 2014.”.

1 **CHAPTER 2—PROMOTION OF PRIMARY**
2 **CARE AND DENTISTRY**

3 **SEC. 2211. FRONTLINE HEALTH PROVIDERS.**

4 Part D of title III (42 U.S.C. 254b et seq.) is amend-
5 ed by adding at the end the following:

6 **“Subpart XI—Health Professional Needs Areas**

7 **“SEC. 340H. IN GENERAL.**

8 “(a) PURPOSE.—The purpose of this subpart is to
9 address unmet health care needs—

10 “(1) in areas experiencing an insufficient capaci-
11 ty of health professionals or high needs for health
12 services in one or more fields; and

13 “(2) not addressed by the National Health
14 Service Corps program.

15 “(b) HEALTH PROFESSIONALS.—Health profes-
16 sionals participating under this subpart shall include the
17 following:

18 “(1) Physicians or other health professionals
19 providing primary health services.

20 “(2) Other health professionals.

21 “(c) DESIGNATION OF AREAS.—

22 “(1) IN GENERAL.—In this subpart, the term
23 ‘health professional needs area’ means a geographic
24 area that is designated by the Secretary in accord-
25 ance with paragraph (2).

1 “(2) DESIGNATION.—To be designated by the
2 Secretary as a health care professional needs area
3 under this subpart:

4 “(A) FOR PRIMARY HEALTH SERVICES
5 PROVIDERS.—For physicians and other health
6 professionals described in subsection (b)(1), a
7 geographic area shall be determined by the Sec-
8 retary—

9 “(i) to be a rational area for the deliv-
10 ery of primary health services;

11 “(ii) to have—

12 “(I) insufficient capacity of
13 health professionals in a field for the
14 population served; or

15 “(II) high needs for primary
16 health services, as determined by the
17 Secretary;

18 “(iii) to not include a health profes-
19 sional shortage area (as designated under
20 section 332) for such field; and

21 “(iv) to have fewer than 1 physician
22 or other health professional in such field
23 per 2,000 residents in the area.

1 “(B) FOR OTHER PROVIDERS.—For other
2 health professionals described in subsection
3 (b)(2)—

4 “(i) to be a rational area for the deliv-
5 ery of health services; and

6 “(ii) to have—

7 “(I) insufficient capacity of
8 health professionals in a field for the
9 population served; or

10 “(II) high needs for health serv-
11 ices, as determined by the Secretary.

12 “(d) DEFINITIONS.—In this subpart:

13 “(1) The term ‘field’ includes a health-related
14 discipline or specialty.

15 “(2) The term ‘primary health services’ has the
16 meaning given to such term in section 331(a)(3)(d).

17 **“SEC. 340I. SCHOLARSHIPS.**

18 “(a) IN GENERAL.—The Secretary, acting through
19 the Administrator of the Health Resources and Services
20 Administration, shall carry out a program of entering into
21 contracts with eligible individuals under which—

22 “(1) the Secretary agrees to provide the indi-
23 vidual with a scholarship for each school year (not
24 to exceed 4 school years) in which the individual is
25 enrolled as a full-time student at an accredited

1 school in a course of study or program leading to a
2 degree in a health field, as deemed appropriate by
3 the Secretary; and

4 “(2) the individual agrees—

5 “(A) to maintain an acceptable level of
6 academic standing;

7 “(B) if applicable, to complete an intern-
8 ship or residency; and

9 “(C) after completing such course of study
10 or program and, if applicable, such internship
11 or residency, to serve as a full-time physician or
12 other health professional in a health profes-
13 sional needs area in a field for which the indi-
14 vidual was provided a scholarship under this
15 section for a time period equal to the greater
16 of—

17 “(i) one year for each school year for
18 which the individual was provided a schol-
19 arship under this section; or

20 “(ii) two years.

21 “(b) AMOUNT.—

22 “(1) IN GENERAL.—The amount paid by the
23 Secretary to an individual under a scholarship under
24 this section for any school year shall be not more
25 than 50 percent of the tuition and other reasonable

1 costs charged by the institution for that school year
2 and the stipend payment shall be no more than 50
3 percent of that paid under the National Health
4 Service Corps Scholarship Program.

5 “(2) CONSIDERATIONS.—In determining the
6 amount of a scholarship to be provided to an indi-
7 vidual under this section, the Secretary may take
8 into consideration the individual’s financial need, ge-
9 ographic differences in cost of living, and edu-
10 cational costs.

11 “(3) EXCLUSION FROM GROSS INCOME.—For
12 purposes of the Internal Revenue Code of 1986,
13 gross income shall not include any amount received
14 as a scholarship under this section.

15 “(4) INSUFFICIENT NUMBER OF APPLICANTS.—
16 If there is an insufficient number of qualified appli-
17 cants for scholarships under this section to obligate
18 the full amount of funds appropriated to carry out
19 this section for a year, the reference to 50 percent
20 in paragraph (1) is deemed to be 75 percent, except
21 that this paragraph shall not apply if the Secretary
22 determines there is an insufficient supply of quali-
23 fied applicants for the National Health Service
24 Corps Scholarship Program with respect to such
25 year. If there are an insufficient number of appli-

1 cants for the scholarship program under this section
2 to obligate all appropriated funds, the unobligated
3 funds may be reprogrammed to the National Health
4 Service Corps for the purpose of recruitment of suf-
5 ficient applicants for the following year.

6 “(c) APPLICATION OF CERTAIN PROVISIONS.—The
7 provisions of subpart III of part D shall, except as incon-
8 sistent with this section, apply to the program established
9 in subsection (a) in the same manner and to the same
10 extent as such provisions apply to the National Health
11 Service Corps Scholarship Program established in such
12 subpart.

13 “(d) ELIGIBLE INDIVIDUAL.—In this section, the
14 term ‘eligible individual’ means an individual who is en-
15 rolled, or accepted for enrollment, as a full-time student
16 in an accredited school in a course of study or program
17 leading to a degree in a health field, as deemed appro-
18 priate by the Secretary .

19 **“SEC. 340J. LOAN REPAYMENT PROGRAM.**

20 “(a) LOAN REPAYMENTS.—The Secretary, acting
21 through the Administrator of the Health Resources and
22 Services Administration, shall establish a program of en-
23 tering into contracts with eligible individuals under
24 which—

25 “(1) the individual agrees to serve—

1 “(A) as a full-time health care provider;
2 and

3 “(B) in a health professional needs area in
4 a field for which the individual was provided a
5 loan repayment under this section; and

6 “(2) the Secretary agrees to pay, for each year
7 of such service, an amount on the principal and in-
8 terest of the undergraduate or graduate educational
9 loans (or both) of the individual that is not more
10 than 50 percent of the average award made under
11 the National Health Service Corps Loan Repayment
12 Program in the previous fiscal year.

13 “(b) SERVICE REQUIREMENT.—A contract entered
14 into under this section shall allow the individual receiving
15 the loan repayment to satisfy the service requirement de-
16 scribed in subsection (a)(1) through employment in a solo
17 or group practice, a clinic, a public or private nonprofit
18 hospital, or any other health care entity, as deemed appro-
19 priate by the Secretary.

20 “(c) APPLICATION OF CERTAIN PROVISIONS.—The
21 provisions of subpart III of part D shall, except as incon-
22 sistent with this section, apply to the program established
23 in subsection (a) in the same manner and to the same
24 extent as such provisions apply to the National Health

1 Service Corps Loan Repayment Program established in
2 such subpart.

3 “(d) INSUFFICIENT NUMBER OF APPLICANTS.—If
4 there is an insufficient number of qualified applicants for
5 loan repayments under this section to obligate the full
6 amount of funds appropriated to carry out this section for
7 a year, the reference to 50 percent in subsection (a)(2)
8 is deemed to be 75 percent, except that this paragraph
9 shall not apply if the Secretary determines there is an in-
10 sufficient number of qualified applicants for the National
11 Health Service Corps Loan Repayment Program with re-
12 spect to such year. If there are an insufficient number of
13 applicants for the loan repayment program under this sec-
14 tion to obligate all appropriated funds, the unobligated
15 funds may be reprogrammed to the National Health Serv-
16 ice Corps for the purpose of recruitment of sufficient ap-
17 plicants for the following year.

18 “(e) DEFINITION.—In this section, the term ‘eligible
19 individual’ means an individual who holds a degree from
20 an accredited school in a health field, as deemed appro-
21 priate by the Secretary.

22 **“SEC. 340K. REPORTS.**

23 “Not later than 18 months after the date of the en-
24 actment of this section, and annually thereafter, the Sec-
25 retary shall submit to the Congress a report that describes

1 the programs carried out under this subpart, including the
2 impact of the program on applications to and participation
3 in the National Health Service Corps scholarship and loan
4 repayment programs; and an evaluation of the programs.

5 **“SEC. 340L. ALLOCATION.**

6 “Of the amount of funds obligated under this subpart
7 each fiscal year for scholarships and loan repayments—

8 “(1) 90 percent shall be for physicians and
9 other health professionals providing primary health
10 services;

11 “(2) 10 percent shall be for other health profes-
12 sionals described in section 340H(b)(2); and

13 “(3) of the amount allocated under paragraph
14 (2), half shall be for such health professionals in
15 generalist physician specialties (as defined by the
16 Secretary).”.

17 **SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.**

18 (a) LOAN PROVISIONS.—Section 722 (42 U.S.C.
19 292r) is amended by striking subsection (e) and inserting
20 the following:

21 “(e) RATE OF INTEREST.—Such loans shall bear in-
22 terest, on the unpaid balance of the loan, computed only
23 for periods for which the loan is repayable, at the rate
24 of 2 percent less than the applicable rate of interest de-

1 scribed in section 427A(l)(1) of the Higher Education Act
2 of 1965 per year.”.

3 (b) MEDICAL SCHOOLS AND PRIMARY HEALTH
4 CARE.—Subsection (a) of section 723 (42 U.S.C. 292s)
5 is amended—

6 (1) in paragraph (1), by striking subparagraph
7 (B) and inserting the following:

8 “(B) to practice in such care for 10 years
9 (including residency training in primary health
10 care) or through the date on which the loan is
11 repaid in full, whichever occurs first.”; and

12 (2) by striking paragraph (3) and inserting the
13 following:

14 “(3) NONCOMPLIANCE BY STUDENT.—If an in-
15 dividual fails to comply with an agreement entered
16 into pursuant to paragraph (1), such agreement
17 shall provide that the total interest to be paid on the
18 loan, over the course of the loan period, shall equal
19 the total amount of interest that would have been in-
20 curred by the individual if, from the outset of the
21 loan, the loan was repayable at the rate of interest
22 described in section 427A(l)(1) of the Higher Edu-
23 cation Act of 1965 per year instead of the rate of
24 interest described in section 722(e).”.

25 (c) STUDENT LOAN GUIDELINES.—

1 (1) IN GENERAL.—Section 723 (42 U.S.C.
2 292s) is amended—

3 (A) by redesignating subsection (c) as sub-
4 section (d); and

5 (B) by inserting after subsection (b) the
6 following:

7 “(c) DETERMINATION OF FINANCIAL NEED.—The
8 Secretary of Health and Human Services may require pa-
9 rental or student financial information from the student
10 to determine financial need under this section, and the de-
11 termination of need for such information shall be at the
12 discretion of the applicable school loan officer.”.

13 (2) REVISED GUIDELINES.—The Secretary of
14 Health and Human Services shall make such revi-
15 sions to guidelines in effect as of the date of the en-
16 actment of this Act as may be necessary for consist-
17 ency with the amendment made by the preceding
18 paragraph.

19 **SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL IN-**
20 **TERNAL MEDICINE, GENERAL PEDIATRICS,**
21 **GERIATRICS, AND PHYSICIAN**
22 **ASSISTANTSHIP.**

23 Part C of title VII (42 U.S.C. 293k et seq.) is amend-
24 ed by striking section 747 and inserting the following:

1 **“SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.**

2 “(a) SUPPORT AND DEVELOPMENT OF PRIMARY
3 CARE TRAINING PROGRAMS.—

4 “(1) IN GENERAL.—The Secretary shall make
5 grants to, or enter into contracts with, an accredited
6 public or nonprofit private hospital, school of medi-
7 cine or osteopathic medicine, accredited physician
8 assistant training program, or a public or private
9 nonprofit entity—

10 “(A) to plan, develop, operate, or partici-
11 pate in an accredited professional training pro-
12 gram, including an accredited residency or in-
13 ternship program in the field of family medi-
14 cine, general internal medicine, general pediatri-
15 cs, or geriatrics for medical students, interns,
16 residents, or practicing physicians as defined by
17 the Secretary;

18 “(B) to provide need-based financial assist-
19 ance in the form of traineeships and fellowships
20 to medical students, interns, residents, prac-
21 ticing physicians, or other medical personnel,
22 who are participants in any such program, and
23 who plan to specialize or work in the practice
24 of family medicine, general internal medicine,
25 general pediatrics, or geriatrics;

1 “(C) to plan, develop, and operate a pro-
2 gram for the training of physicians who plan to
3 teach in family medicine, general internal medi-
4 cine, general pediatrics, or geriatrics training
5 programs;

6 “(D) to plan, develop, and operate a pro-
7 gram for the training of physicians teaching in
8 community-based settings;

9 “(E) to provide financial assistance in the
10 form of traineeships and fellowships to physi-
11 cians who are participants in any such pro-
12 grams and who plan to teach or conduct re-
13 search in a family medicine, general internal
14 medicine, general pediatrics, or geriatrics train-
15 ing program; and

16 “(F) to plan, develop, and operate a pro-
17 gram for physician assistant education, and for
18 the training of individuals who will teach in
19 programs to provide such training.

20 “(2) DURATION OF AWARDS.—The period dur-
21 ing which payments are made to an entity from an
22 award of a grant or contract under this subsection
23 shall not exceed 5 years.

24 “(b) CAPACITY BUILDING IN PRIMARY CARE.—

1 “(1) IN GENERAL.—The Secretary shall make
2 grants to or enter into contracts with accredited
3 schools of medicine or osteopathic medicine to estab-
4 lish, maintain, or improve academic units (which
5 may be departments, divisions, or other units) or
6 programs that improve clinical teaching and re-
7 search in family medicine, general internal medicine,
8 general pediatrics, or geriatrics.

9 “(2) PREFERENCE.—In awarding grants and
10 contracts under paragraph (1), the Secretary shall
11 give preference to any qualified applicant that agrees
12 to expend the award for the purpose of—

13 “(A) establishing academic units or pro-
14 grams in family medicine, general internal med-
15 icine, general pediatrics, or geriatrics; or

16 “(B) substantially expanding such units or
17 programs.

18 “(3) DURATION OF AWARDS.—The period dur-
19 ing which payments are made to an entity from an
20 award of a grant or contract under this subsection
21 shall not exceed 5 years.

22 “(c) PREFERENCE.—In awarding grants or contracts
23 under this section, the Secretary shall give preference to
24 the following:

1 “(1) Qualified applicants that have a record of
2 training the greatest percentage of providers or that
3 have demonstrated significant improvements in the
4 percentage of providers who enter and remain in pri-
5 mary care practice.

6 “(2) Qualified applicants that have a record of
7 training individuals who are from underrepresented
8 minority groups or from disadvantaged backgrounds.

9 “(3) Qualified applicants that conduct teaching
10 programs targeting vulnerable populations such as
11 older adults, homeless individuals, victims of abuse
12 or trauma, individuals with mental health or sub-
13 stance-related disorders, and individuals with HIV/
14 AIDS.

15 “(d) APPLICATION.—An entity desiring a grant
16 under this section shall submit to the Secretary an appli-
17 cation at such time, in such manner, and containing such
18 information as the Secretary may require.

19 “(e) DUTIES OF SECRETARY.—The Secretary may,
20 in carrying out this section and section 748—

21 “(1) require—

22 “(A) collaboration among the pertinent
23 workforce programs of the Department of
24 Health and Human Services under this title
25 and other provisions of law; and

1 “(B) consultation with the pertinent work-
2 force programs of the Department of Labor and
3 the Department of Education;

4 “(2) use and adequately support existing pro-
5 grams to address new departmental initiatives, as
6 appropriate; and

7 “(3) take into consideration capabilities of ex-
8 isting programs before creating separate or parallel
9 programs.”.

10 **SEC. 2214. TRAINING FOR GENERAL, PEDIATRIC, AND PUB-**
11 **LIC HEALTH DENTISTS AND DENTAL HYGIEN-**
12 **ISTS.**

13 Part C of Title VII (42 U.S.C. 293k et seq.) is
14 amended by—

15 (1) redesignating section 748 as section 749;

16 and

17 (2) inserting after section 747 the following:

18 **“SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC**
19 **HEALTH DENTISTRY.**

20 “(a) SUPPORT AND DEVELOPMENT OF DENTAL
21 TRAINING PROGRAMS.—

22 “(1) IN GENERAL.—The Secretary shall make
23 grants to, or enter into contracts with, a school of
24 dentistry, public or nonprofit private hospital, or a
25 public or private nonprofit entity—

1 “(A) to plan, develop, and operate, or par-
2 ticipate in, an accredited professional training
3 program in the field of general dentistry, pedi-
4 atric dentistry, or public health dentistry for
5 dental students, residents, practicing dentists,
6 or dental hygienists or other approved dental
7 trainees, that emphasizes training for general,
8 pediatric, or public health dentistry;

9 “(B) to provide financial assistance to den-
10 tal students, residents, practicing dentists, and
11 dental hygiene students who are in need there-
12 of, who are participants in any such program,
13 and who plan to work in the practice of general,
14 pediatric, or public health dentistry, or dental
15 hygiene;

16 “(C) to plan, develop, and operate a pro-
17 gram for the training of oral health care pro-
18 viders who plan to teach in general, pediatric,
19 or public health dentistry, or dental hygiene;

20 “(D) to provide financial assistance in the
21 form of traineeships and fellowships to dentists
22 who plan to teach or are teaching in general,
23 pediatric, or public health dentistry;

24 “(E) to meet the costs of projects to estab-
25 lish, maintain, or improve dental faculty devel-

1 opment programs (which may be departments,
2 divisions, or other academic administrative
3 units);

4 “(F) to meet the costs of projects to estab-
5 lish, maintain, or improve predoctoral and
6 postdoctoral training in general, pediatric, or
7 public health dentistry programs, or training
8 for dental hygienists;

9 “(G) to create a loan repayment program
10 for faculty in dental programs; and

11 “(H) to provide technical assistance to pe-
12 diatric training programs in developing and im-
13 plementing instruction regarding the oral health
14 status, dental care needs, and risk-based clin-
15 ical disease management of all pediatric popu-
16 lations with an emphasis on underserved chil-
17 dren.

18 “(2) FACULTY LOAN REPAYMENT.—A grant or
19 contract under subsection (a)(1)(G) may be awarded
20 to a program of general, pediatric, or public health
21 dentistry described in such subsection to plan, de-
22 velop, and operate a loan repayment program under
23 which—

24 “(A) individuals agree to serve full-time as
25 faculty members; and

1 “(B) the program of general, pediatric or
2 public health dentistry agrees to pay the prin-
3 cipal and interest on the outstanding student
4 loans of the individuals.

5 “(b) ELIGIBLE ENTITY.—For purposes of this sub-
6 section, entities eligible for such grants or contracts in
7 general, pediatric, or public health dentistry shall include
8 entities that have programs in dental or dental hygiene
9 programs, or accredited residency or advanced education
10 programs in the practice of general, pediatric, or public
11 health dentistry. Eligible entities may partner with schools
12 of public health to permit the education of dental students,
13 residents, and dental hygiene students for graduate train-
14 ing in public health.

15 “(c) PREFERENCE.—In awarding grants or contracts
16 under this section, the Secretary shall give preference to
17 the following:

18 “(1) Qualified applicants that have a record of
19 training the greatest percentage of providers, or that
20 have demonstrated significant improvements in the
21 percentage of providers, who enter and remain in
22 general, pediatric, or public health dentistry.

23 “(2) Qualified applicants that have a record of
24 training individuals who are from underrepresented
25 minority groups, or disadvantaged backgrounds.

1 “(3) Qualified applicants that have a high rate
2 of placing graduates in practice settings having the
3 principal focus of serving in underserved areas or
4 populations experiencing health disparities (including
5 serving patients eligible for Medicaid or the Chil-
6 dren’s Health Insurance Program, or those with spe-
7 cial health care needs).

8 “(4) Qualified applicants that conduct teaching
9 programs targeting vulnerable populations such as
10 older adults, homeless individuals, victims of abuse
11 or trauma, individuals with mental health or sub-
12 stance-related disorders, individuals with disabilities,
13 the vulnerable elderly, individuals with HIV/AIDS,
14 and people with developmental disabilities, cognitive
15 impairment, complex medical problems, or signifi-
16 cant physical limitations.

17 “(5) Qualified applicants that provide instruc-
18 tion regarding the oral health status, dental care
19 needs, and risk-based clinical disease management of
20 all pediatric populations with an emphasis on under-
21 served children.

22 “(d) APPLICATION.—An eligible entity desiring a
23 grant under this section shall submit to the Secretary an
24 application at such time, in such manner, and containing
25 such information as the Secretary may require.

1 “(e) DURATION OF AWARD.—The period during
2 which payments are made to an entity from an award of
3 a grant or contract under subsection (a) shall not exceed
4 5 years.

5 “(f) DEFINITION.—In this section, the term ‘health
6 disparities’ has the meaning given the term in section
7 3171.”.

8 **SEC. 2215. AUTHORIZATION OF APPROPRIATIONS.**

9 To carry out subpart XI of part D of title III and
10 sections 723, 747, and 748 of the Public Health Service
11 Act, as amended or added by this chapter, there is author-
12 ized to be appropriated, out of any monies in the Public
13 Health Investment Fund, \$200,000,000 for each of fiscal
14 years 2010 through 2014.

15 **Subtitle B—Nursing Workforce**

16 **SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.**

17 (a) DEFINITIONS.—Section 801 (42 U.S.C. 296 et
18 seq.) is amended—

19 (1) in paragraph (1), by inserting “nurse-man-
20 aged health centers” after “nursing centers,”; and

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

22 “(16) NURSE-MANAGED HEALTH CENTER.—
23 The term ‘nurse-managed health center’ means a
24 nurse-practice arrangement, managed by advanced
25 practice nurses, that provides primary care or

1 wellness services to underserved or vulnerable popu-
2 lations and is associated with a school, college, uni-
3 versity or department of nursing, Federally qualified
4 health center (as defined in section 1905(l)(2)(B) of
5 the Social Security Act), or independent nonprofit
6 health or social services agency.”.

7 (b) **ADVANCED EDUCATION NURSING GRANTS.**—Sec-
8 tion 811(f) (42 U.S.C. 296j(f)) is amended—

9 (1) by striking paragraph (2);

10 (2) by redesignating paragraph (3) as para-
11 graph (2); and

12 (3) in paragraph (2), as so redesignated, by
13 striking “that agrees” and all that follows through
14 the end and inserting: “that agrees to expend the
15 award—

16 “(A) to train advanced education nurses
17 who will practice in health professional shortage
18 areas designated under section 332; or

19 “(B) to increase diversity among advanced
20 education nurses.”.

21 (c) **NURSE EDUCATION, PRACTICE, AND RETENTION**
22 **GRANTS.**—Section 831 (42 U.S.C. 296p) is amended—

23 (1) in subsection (b), by amending paragraph

24 (3) to read as follows:

1 “(3) providing coordinated care, quality care,
2 and other skills needed to practice in existing and
3 emerging health care systems;” and

4 (2) by striking subsection (e) and redesignating
5 subsections (f) through (h) as subsections (e)
6 through (g), respectively.

7 (d) STUDENT LOANS.—Subsection (a) of section 836
8 (42 U.S.C. 297b) is amended—

9 (1) by striking “\$2,500” and inserting
10 “\$3,300”;

11 (2) by striking “\$4,000” and inserting
12 “\$5,200”;

13 (3) by striking “\$13,000” and inserting
14 “\$17,000”; and

15 (4) by adding at the end the following: “For
16 each fiscal year after fiscal year 2011, the dollar
17 amounts specified in this subsection shall be ad-
18 justed by an amount determined by the Secretary on
19 an annual basis to reflect inflation.”.

20 (e) LOAN REPAYMENT.—Paragraph (3) of section
21 846(a) (42 U.S.C. 297n(a)(3)) is amended to read as fol-
22 lows:

23 “(3) who enters into an agreement with the
24 Secretary to serve for a period of not less than 2
25 years—

1 “(A) as a nurse at a health care facility
2 with a critical shortage of nurses; or

3 “(B) as a nurse faculty member at an ac-
4 credited school of nursing;”.

5 (f) NURSE FACULTY LOAN PROGRAM.—Paragraph
6 (2) of section 846A(c) (42 U.S.C. 297n–1(c)) is amended
7 by striking “\$30,000” and all that follows through the
8 semicolon and inserting “\$35,000, plus, in the case of fis-
9 cal years beginning after fiscal year 2011, an amount de-
10 termined by the Secretary on an annual basis to reflect
11 inflation;”.

12 (g) PUBLIC SERVICE ANNOUNCEMENTS.—Title VIII
13 (42 U.S.C. 296 et seq.) is amended by striking part H.

14 (h) FUNDING.—Title VIII (42 U.S.C. 296 et seq.)
15 is amended—

16 (1) in section 831, by striking subsection (h);

17 (2) in section 846, by striking subsection (i);

18 (3) in section 846A, by striking subsection (f);

19 (4) in section 855, by striking subsection (e);

20 and

21 (5) by moving part F to the end of the title, re-
22 designating such part as part H, and amending such
23 part to read as follows:

1 (5) in section 839, by striking “839” and all
2 that follows through “(a)” and inserting “839. (a)”;

3 (6) in part G—

4 (A) by redesignating section 845 as section
5 851; and

6 (B) by redesignating part G as part F; and

7 (7) in part I—

8 (A) by redesignating section 855 as section
9 861; and

10 (B) by redesignating part I as part G.

11 **Subtitle C—Public Health** 12 **Workforce**

13 **SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.**

14 Part D of title III (42 U.S.C. 254b et seq.), as
15 amended by section 2211, is amended by adding at the end
16 the following:

17 **“Subpart XII—Public Health Workforce**

18 **“SEC. 340M. PUBLIC HEALTH WORKFORCE CORPS.**

19 “(a) ESTABLISHMENT.—For the purpose described
20 in subsection (b), there is established, within the Service,
21 the Public Health Workforce Corps (in this subpart re-
22 ferred to as the ‘Corps’), which shall consist of—

23 “(1) such officers of the Regular and Reserve
24 Corps of the Service as the Secretary may designate;

1 “(2) such civilian employees of the United
2 States as the Secretary may appoint; and

3 “(3) such other individuals who are not employ-
4 ees of the United States.

5 “(b) PURPOSE.—The Secretary shall use the Corps
6 to ensure an adequate supply of public health profes-
7 sionals to eliminate critical public health workforce short-
8 ages.

9 “(c) PLACEMENT AND ASSIGNMENT.—The Secretary
10 shall develop a methodology for placing and assigning
11 Corps participants as public health professionals.

12 “(d) APPLICATION OF CERTAIN PROVISIONS.—The
13 provisions of subpart II shall, except as inconsistent with
14 this subpart, apply to the Public Health Workforce Corps
15 in the same manner and to the same extent as such provi-
16 sions apply to the National Health Service Corps.

17 “(e) CONSULTATION.—The Secretary shall carry out
18 this subpart acting through the Administrator of the
19 Health Resources and Services Administration and the Di-
20 rector of the Centers for Disease Control and Prevention.

21 **“SEC. 340N. PUBLIC HEALTH WORKFORCE SCHOLARSHIP**
22 **PROGRAM.**

23 “(a) ESTABLISHMENT.—The Secretary shall estab-
24 lish the Public Health Workforce Scholarship Program

1 (referred to in this section as the ‘Program’) for the pur-
2 pose described in section 340M(b).

3 “(b) ELIGIBILITY.—To be eligible to participate in
4 the Program, an individual shall—

5 “(1) be accepted for enrollment, or be enrolled,
6 as a full-time or part-time student in an accredited
7 graduate school or program of public health; health
8 administration, management, or policy; preventive
9 medicine; veterinary public health; or dental public
10 health; or other accredited graduate school or pro-
11 gram, as deemed appropriate by Secretary;

12 “(2) be eligible for, or hold, an appointment as
13 a commissioned officer in the Regular or Reserve
14 Corps of the Service or be eligible for selection for
15 civilian service in the Corps;

16 “(3) submit an application to the Secretary to
17 participate in the Program; and

18 “(4) sign and submit to the Secretary, at the
19 time of the submission of such application, a written
20 contract (described in subsection (e)) to serve full-
21 time as a public health professional, upon the com-
22 pletion of the course of study or program involved,
23 for the applicable period of obligated service.

24 “(c) CONTRACT.—The written contract between the
25 Secretary and an individual shall contain—

1 “(1) an agreement on the part of the Secretary
2 that the Secretary will—

3 “(A) provide the individual with a scholar-
4 ship for a period of years (not to exceed 4 aca-
5 demic years) during which the individual shall
6 pursue an approved course of study or program
7 to prepare the individual to serve in the public
8 health workforce; and

9 “(B) accept (subject to the availability of
10 appropriated funds) the individual into the
11 Corps;

12 “(2) an agreement on the part of the individual
13 that the individual will—

14 “(A) accept provision of such scholarship
15 to the individual;

16 “(B) maintain full-time or part-time enroll-
17 ment in the approved course of study or pro-
18 gram described in subsection (b)(1) until the in-
19 dividual completes that course of study or pro-
20 gram;

21 “(C) while enrolled in the course of study
22 or program, maintain an acceptable level of aca-
23 demic standing (as determined under regula-
24 tions of the Secretary by the educational insti-

1 tution offering such course of study or pro-
2 gram); and

3 “(D) serve full-time as a public health pro-
4 fessional for a period of time (referred to in this
5 section as the ‘period of obligated service’)
6 equal to the greater of—

7 “(i) 1 year for each academic year for
8 which the individual was provided a schol-
9 arship under the Program; or

10 “(ii) 2 years.

11 “(3) an agreement by both parties as to the na-
12 ture and extent of the scholarship assistance, which
13 may include—

14 “(A) payment of reasonable educational ex-
15 penses of the individual, including tuition, fees,
16 books, equipment, and laboratory expenses; and

17 “(B) payment of a stipend of not more
18 than \$1,269 per month for each month of the
19 academic year involved, with the dollar amount
20 of such a stipend determined by the Secretary
21 taking into consideration whether the individual
22 is enrolled full-time or part-time.

23 For each fiscal year after fiscal year 2011, the dollar
24 amount specified in subparagraph (B) shall be ad-

1 justed by an amount determined by the Secretary on
2 an annual basis to reflect inflation.

3 “(d) POSTPONING OBLIGATED SERVICE.—With re-
4 spect to an individual receiving a degree from a school or
5 program with an appropriate post-graduate internship,
6 residency, or other relevant public health advanced train-
7 ing, under a scholarship under the Program, the date of
8 the initiation of the period of obligated service may be
9 postponed, upon the submission by such individual of a
10 petition for such postponement and approval by the Sec-
11 retary, to the date on which such individual completes an
12 approved internship, residency, or other relevant public
13 health advanced training program.

14 “(e) ADMINISTRATIVE PROVISIONS.—

15 “(1) CONTRACTS WITH INSTITUTIONS.—The
16 Secretary may contract with an educational institu-
17 tion in which a participant in the Program is en-
18 rolled, for the payment to the educational institution
19 of the amounts of tuition, fees, and other reasonable
20 educational expenses described in subsection (c)(3).

21 “(2) EMPLOYMENT CEILINGS.—Notwith-
22 standing any other provision of law, individuals who
23 have entered into written contracts with the Sec-
24 retary under this section, while undergoing academic
25 training, shall not be counted against any employ-

1 “(2) be eligible for, or hold, an appointment as
2 a commissioned officer in the Regular or Reserve
3 Corps of the Service or be eligible for selection for
4 civilian service in the Corps;

5 “(3) submit an application to the Secretary to
6 participate in the Program; and

7 “(4) sign and submit to the Secretary, at the
8 time of the submission of such application, a written
9 contract (described in subsection (c)) to serve full-
10 time as a public health professional for the applica-
11 ble period of obligated service.

12 “(c) CONTRACT.—The written contract (referred to
13 in this section) between the Secretary and an individual
14 shall contain—

15 “(1) an agreement by the Secretary to repay on
16 behalf of the individual loans incurred by the indi-
17 vidual in the pursuit of the relevant public health
18 workforce educational degree in accordance with the
19 terms of the contract;

20 “(2) an agreement by the individual to serve
21 full-time as a public health professional for a period
22 of time (referred to in this section as the ‘period of
23 obligated service’) equal to 2 years or such longer
24 period as the individual may agree to; and

1 “(3) in the case of an individual described in
2 subsection (b)(1)(B) who is in the final year of
3 study and who has accepted employment as a public
4 health professional, in accordance with subsection
5 340M(c), an agreement on the part of the individual
6 to complete the education or training, maintain an
7 acceptable level of academic standing (as determined
8 by the educational institution offering the course of
9 study or training), and agree to the period of obli-
10 gated service.

11 “(d) PAYMENTS.—

12 “(1) IN GENERAL.—A loan repayment provided
13 for an individual under a written contract under the
14 Program shall consist of payment, in accordance
15 with paragraph (2), on behalf of the individual of
16 the principal, interest, and related expenses on gov-
17 ernment and commercial loans received by the indi-
18 vidual regarding the undergraduate or graduate edu-
19 cation of the individual (or both), which loans were
20 made for reasonable educational expenses, including
21 tuition, fees, books, and laboratory expenses, in-
22 curred by the individual.

23 “(2) PAYMENTS FOR YEARS SERVED.—

24 “(A) IN GENERAL.—For each year of obli-
25 gated service that an individual contracts to

1 serve under subsection (d) the Secretary may
2 pay up to \$35,000 on behalf of the individual
3 for loans described in paragraph (1).

4 “(B) REPAYMENT SCHEDULE.—Any ar-
5 rangement made by the Secretary for the mak-
6 ing of loan repayments in accordance with this
7 subsection shall provide that any repayments
8 for a year of obligated service shall be made no
9 later than the end of the fiscal year in which
10 the individual completes such year of service.

11 “(e) POSTPONING OBLIGATED SERVICE.—With re-
12 spect to an individual receiving a degree from a school or
13 program with an appropriate post-graduate internship,
14 residency, or other relevant public health advanced train-
15 ing, with a loan repayment under this section, the date
16 of the initiation of the period of obligated service may be
17 postponed, upon the submission by such individual of a
18 petition for such postponement and approval by the Sec-
19 retary, to the date on which such individual completes an
20 approved internship, residency, or other relevant public
21 health advanced training program.

22 “(f) EMPLOYMENT CEILINGS.—Notwithstanding any
23 other provision of law, individuals who have entered into
24 written contracts with the Secretary under this section,
25 who are serving full-time as public health professionals,

1 or who are in the last year of public health workforce aca-
2 demic preparation, shall not be counted against any em-
3 ployment ceiling affecting the Department or any other
4 Federal agency.

5 “(g) APPLICATION OF CERTAIN PROVISIONS.—The
6 provisions of subpart III shall, except as inconsistent with
7 this subpart, apply to the loan repayment program under
8 this section in the same manner and to the same extent
9 as such provisions apply to the National Health Service
10 Corps Loan Repayment Program.”.

11 **SEC. 2232. ENHANCING THE PUBLIC HEALTH WORKFORCE.**

12 Section 765 (42 U.S.C. 295) is amended to read as
13 follows:

14 **“SEC. 765. GENERAL PROVISIONS.**

15 “(a) IN GENERAL.—The Secretary, acting through
16 the Administrator of the Health Resources and Services
17 Administration and in consultation with the Director of
18 the Centers for Disease Control and Prevention, shall
19 award grants or contracts to eligible entities to increase
20 the number of individuals in the public health workforce,
21 to enhance the quality of such workforce, and to enhance
22 the ability of the workforce to meet national, State, and
23 local health care needs.

24 “(b) ELIGIBILITY.—To be eligible to receive a grant
25 or contract under subsection (a), an entity shall—

1 “(1) be—

2 “(A) a health professions school, including
3 an accredited school or program of public
4 health, health administration, management, or
5 policy, preventive medicine, veterinary public
6 health, or dental public health;

7 “(B) a State or local health department; or

8 “(C) a public or private nonprofit entity;

9 and

10 “(2) prepare and submit to the Secretary an
11 application at such time, in such manner, and con-
12 taining such information as the Secretary may re-
13 quire.

14 “(c) PREFERENCE.—In awarding grants or contracts
15 under this section, the Secretary shall grant a preference
16 to entities that—

17 “(1) train individuals who are from disadvan-
18 taged or underrepresented minority backgrounds;

19 “(2) graduate large proportions of individuals
20 who serve in underserved communities; and

21 “(3) prepare individuals for future or continued
22 employment at Federal, State, and local, and tribal
23 public health agencies.

24 “(d) ACTIVITIES.—Amounts provided under a grant
25 or contract awarded under this section shall be used—

1 “(1) to plan, develop, operate, or participate in,
2 an accredited professional training program in the
3 field of public health, health administration, man-
4 agement, or policy, preventive medicine, veterinary
5 public health, or dental public health for new or ex-
6 isting members of the public health workforce, in-
7 cluding mid-career professionals;

8 “(2) to provide financial assistance in the form
9 of traineeships and fellowships to students who are
10 participants in any such program;

11 “(3) to plan, develop, and operate a program
12 for the training of public health professionals who
13 plan to teach in any such program; and

14 “(4) to provide financial assistance in the form
15 of traineeships and fellowships to public health pro-
16 fessionals who are participants in any such program
17 and who plan to teach or conduct research in the
18 field of public health, health administration, man-
19 agement, or policy, preventive medicine, veterinary
20 public health, or dental public health.

21 “(e) SEVERE SHORTAGE DISCIPLINES.—Amounts
22 provided under grants or contracts under this section may
23 be used for the operation of programs designed to award
24 traineeships to students in accredited schools of public
25 health who enter educational programs in fields where

1 there is a severe shortage of public health professionals,
2 including epidemiology, biostatistics, environmental
3 health, toxicology, public health nursing, nutrition, preven-
4 tive medicine, maternal and child health, and behavioral
5 and mental health professions.”.

6 **SEC. 2233. PUBLIC HEALTH TRAINING CENTERS.**

7 Paragraph (1) of section 766(a) (42 U.S.C. 295a(a))
8 is amended by striking “in furtherance of the goals estab-
9 lished by the Secretary for the year 2000” and inserting
10 “in furtherance of the goals established by the Secretary
11 in the national prevention and wellness strategy under sec-
12 tion 3111”.

13 **SEC. 2234. PREVENTIVE MEDICINE AND PUBLIC HEALTH**
14 **TRAINING GRANT PROGRAM.**

15 Section 768 (42 U.S.C. 295 et seq.) is amended to
16 read as follows:

17 **“SEC. 768. PREVENTIVE MEDICINE AND PUBLIC HEALTH**
18 **TRAINING GRANT PROGRAM.**

19 “(a) GRANTS.—The Secretary, acting through the
20 Administrator of the Health Resources and Services Ad-
21 ministration and in consultation with the Director of the
22 Centers for Disease Control and Prevention, shall award
23 grants to, or enter into contracts with, eligible entities to
24 provide training to graduate medical residents in preven-
25 tive medicine specialties.

1 “(b) ELIGIBILITY.—To be eligible to receive a grant
2 or contract under subsection (a), an entity shall—

3 “(1) be a school of public health, public health
4 department, school of medicine or osteopathic medi-
5 cine, or public or private hospital; and

6 “(2) submit to the Secretary an application at
7 such time, in such manner, and containing such in-
8 formation as the Secretary may require.

9 “(c) USE OF FUNDS.—Amounts received under a
10 grant or contract under this section shall be used to—

11 “(1) plan, develop, and operate residency pro-
12 grams for preventive medicine or public health, in-
13 cluding the development of curricula;

14 “(2) provide financial assistance, including tui-
15 tion and stipends, to resident physicians who plan to
16 specialize in preventive medicine or public health;

17 “(3) defray the costs of practicum experiences;
18 and

19 “(4) meet the costs of projects to establish,
20 maintain, or improve academic units (which may be
21 departments, divisions, or other units) to provide
22 clinical instruction in preventive medicine and public
23 health.

1 “(d) DURATION OF AWARD.—A grant or contract
2 under this section shall be for a term not to exceed 5
3 years.”.

4 **SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.**

5 To carry out subpart XII of part D of title III and
6 sections 765, 766, and 768 of the Public Health Service
7 Act, as amended or added by this chapter, there is author-
8 ized to be appropriated, out of any monies in the Public
9 Health Investment Fund, \$50,000,000 for each of fiscal
10 years 2010 through 2014.

11 **Subtitle D—Adapting Workforce to**
12 **Evolving Health System Needs**

13 **CHAPTER 1—HEALTH PROFESSIONS**

14 **TRAINING FOR DIVERSITY**

15 **SEC. 2241. CENTERS OF EXCELLENCE.**

16 Section 736 (42 U.S.C. 293) is amended—

17 (1) in subsection (b)—

18 (A) in paragraph (2), by inserting “in
19 health professions programs” after “attending
20 the school”;

21 (B) in paragraph (5)—

22 (i) by striking “under-represented mi-
23 nority groups” and inserting “racial and
24 ethnic minority groups”; and

1 (ii) by inserting “culturally com-
2 petent” before “health care”;

3 (C) in paragraph (6)—

4 (i) by striking “a significant number
5 of under-represented minority individuals”
6 and inserting “racial and ethnic minority
7 individuals”; and

8 (ii) by striking “and” at the end;

9 (D) in paragraph (7), by striking the pe-
10 riod at the end and inserting “; and”; and

11 (E) by adding at the end the following:

12 “(8) to conduct accountability and other report-
13 ing activities, as required by the Secretary.”;

14 (2) in clause (i) of subsection (c)(1)(A), by
15 striking “each of the conditions” and inserting “the
16 condition”;

17 (3) in subsection (c)(1)(B)—

18 (A) in clause (i), by striking “minority in-
19 dividuals enrolled in the school” and inserting
20 “minority individuals enrolled in the school in
21 health professions programs”;

22 (B) in clauses (ii), by striking “under-rep-
23 resented minority students” and inserting
24 “such students”;

25 (C) in clause (iii)—

1 (i) by striking “under-represented mi-
2 nority individuals” and inserting “such
3 students”;

4 (ii) by striking “such individuals” and
5 inserting “such students”; and

6 (iii) by striking “under-represented
7 minority students” and inserting “such
8 students”;

9 (D) in clause (iv), by inserting “in health
10 professions” after “minority individuals”;

11 (4) by amending subparagraph (A) of sub-
12 section (c)(2) to read as follows:

13 “(A) CONDITION.—The condition specified
14 in this subparagraph is that a designated health
15 professions school is a school described in sec-
16 tion 799B(1).”;

17 (5) in subparagraph (C) of subsection (c)(2), by
18 striking “paragraphs (2) or (5)” and inserting
19 “paragraph (2) or (5)”;

20 (6) in subparagraph (B) of subsection (c)(5), by
21 inserting “in health professions programs” after
22 “minorities”;

23 (7) in subsection (h)—

24 (A) by striking paragraph (1);

1 (B) by redesignating paragraphs (2)
2 through (4) as paragraphs (1) through (3), re-
3 spectively;

4 (C) in paragraph (1), as so redesignated,
5 by striking “appropriated under paragraph (1)”
6 each place it appears and inserting “appro-
7 priated to carry out this section”;

8 (D) in clause (ii) of paragraph (1)(A), as
9 so redesignated, by striking “and available
10 after” and inserting “of the amount available
11 after”;

12 (E) in subparagraph (C) of paragraph (1),
13 as so redesignated, by striking “are
14 \$30,000,000 or more” and inserting “exceed
15 \$30,000,000 but are less than \$40,000,000”;

16 (F) by adding at the end of paragraph (1),
17 as so redesignated, the following:

18 “(D) FUNDING IN EXCESS OF
19 \$40,000,000.—If amounts appropriated to
20 carry out this section for a fiscal year are
21 \$40,000,000 or more, the Secretary shall make
22 available—

23 “(i) not less than \$16,000,000 for
24 grants under subsection (a) to health pro-

1 fessions schools that meet the conditions
2 described in subsection (c)(2)(A);

3 “(ii) not less than \$16,000,000 for
4 grants under subsection (a) to health pro-
5 fessions schools that meet the conditions
6 described in paragraph (3) or (4) of sub-
7 section (c) (including meeting conditions
8 pursuant to subsection (e));

9 “(iii) not less than \$8,000,000 for
10 grants under subsection (a) to health pro-
11 fessions schools that meet the conditions
12 described in subsection (c)(5); and

13 “(iv) after grants are made with
14 funds under clauses (i) through (iii), any
15 remaining funds for grants under sub-
16 section (a) to health professions schools
17 that meet the conditions described in para-
18 graph (2)(A), (3), (4), or (5) of subsection
19 (c).”; and

20 (G) by amending subparagraph (B) of
21 paragraph (4) to read as follows:

22 “(B) USE OF FEDERAL FUNDS.—With re-
23 spect to any Federal amounts received by a cen-
24 ter of excellence and available for carrying out
25 activities for which a grant under this part is

1 authorized to be expended, the center shall, be-
2 fore expending the grant, expend the Federal
3 amounts obtained from sources other than the
4 grant, unless given prior approval from the Sec-
5 retary.”.

6 **SEC. 2242. SCHOLARSHIPS FOR DISADVANTAGED STU-**
7 **DENTS, LOAN REPAYMENTS AND FELLOW-**
8 **SHIPS REGARDING FACULTY POSITIONS, AND**
9 **EDUCATIONAL ASSISTANCE IN THE HEALTH**
10 **PROFESSIONS REGARDING INDIVIDUALS**
11 **FROM DISADVANTAGED BACKGROUNDS.**

12 (a) LOAN REPAYMENTS AND FELLOWSHIPS REGARD-
13 ING FACULTY POSITIONS.—Paragraph (1) of section
14 738(a) (42 U.S.C. 293b(a)) is amended by striking “not
15 more than \$20,000” and all that follows through the end
16 of the paragraph and inserting: “not more than—

17 “(A) for contracts entered into during or
18 before fiscal year 2011, \$30,000 of the prin-
19 cipal and interest of the educational loans of
20 such individuals; and

21 “(B) for contracts entered into after fiscal
22 year 2011, the amount authorized to be paid
23 under this paragraph for the preceding fiscal
24 year shall be adjusted by the Secretary on an
25 annual basis to reflect inflation.”.

1 **SEC. 2243. NURSING WORKFORCE DIVERSITY GRANTS.**

2 Subsection (b) of section 821 (42 U.S.C. 296m) is
3 amended by striking “shall take into consideration” and
4 all that follows through “consult with nursing associa-
5 tions” and inserting “shall, as appropriate, consult with
6 nursing associations”.

7 **SEC. 2244. COORDINATION OF DIVERSITY AND CULTURAL**
8 **COMPETENCY PROGRAMS.**

9 Section 740 (42 U.S.C. 293 et seq.) is amended to
10 read as follows:

11 **“SEC. 740. COORDINATION OF DIVERSITY AND CULTURAL**
12 **COMPETENCY PROGRAMS.**

13 “The Secretary shall, to the extent practicable, co-
14 ordinate the activities carried out under this part, section
15 807, and section 821 in order to enhance the effectiveness
16 of such activities and avoid duplication of effort.”.

17 **CHAPTER 2—INTERDISCIPLINARY**
18 **TRAINING PROGRAMS**

19 **SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCE**
20 **TRAINING FOR HEALTH CARE PROFES-**
21 **SIONALS.**

22 (a) AMENDMENT TO TITLE VII.—Section 741 (42
23 U.S.C. 293e) is amended to read as follows:

1 **“SEC. 741. CULTURAL AND LINGUISTIC COMPETENCE**
2 **TRAINING FOR HEALTH CARE PROFES-**
3 **SIONALS.**

4 “(a) IN GENERAL.—The Secretary, acting through
5 the Administrator of the Health Resources and Services
6 Administration and in consultation with the heads of ap-
7 propriate agencies and offices within the Department of
8 Health and Human Services, shall award grants to eligible
9 entities to address health disparities by promoting cultural
10 and linguistic competency.

11 “(b) ACTIVITIES.—The Secretary shall award a grant
12 under subsection (a) only if the applicant agrees to use
13 the grant to—

14 “(1) test, develop, implement, and evaluate
15 models of cultural and linguistic competence train-
16 ing, including continuing education, for health pro-
17 fessionals; and

18 “(2) facilitate faculty and student research on
19 culturally and linguistically competent health care.

20 “(c) ELIGIBILITY.—To be eligible to receive a grant
21 under subsection (a), an entity shall—

22 “(1) be an accredited health professions school,
23 academic health center, State or local government,
24 or other appropriate (as determined by the Sec-
25 retary) public or private entity (or consortium of en-
26 tities); and

1 appropriate agencies and offices within the Department of
2 Health and Human Services, shall award grants to eligible
3 entities to address health disparities by promoting cultural
4 and linguistic competency.

5 “(b) APPLICABLE PROVISIONS.—Except as incon-
6 sistent with this section, the provisions of section 741 shall
7 apply to grants under this section.

8 “(c) DEFINITION.—In this section, the term ‘health
9 disparities’ has the meaning given the term in section
10 3171.”.

11 **SEC. 2252. INNOVATIONS IN INTERDISCIPLINARY CARE**
12 **TRAINING.**

13 Part D of title VII (42 U.S.C. 294 et seq.) is amend-
14 ed by adding at the end the following:

15 **“SEC. 759. INNOVATIONS IN INTERDISCIPLINARY CARE**
16 **TRAINING.**

17 “(a) IN GENERAL.—The Secretary shall award
18 grants to, or enter into contracts with, eligible entities to
19 develop and operate a program for innovations in inter-
20 disciplinary care training to promote—

21 “(1) interdisciplinary and team-based models to
22 prepare and train health professionals to reduce
23 health disparities or improve patient care; and

24 “(2) coordination within academic health cen-
25 ters and across health professions settings for train-

1 ing and practice, including community-based set-
2 tings.

3 “(b) ELIGIBLE ENTITY.—For purposes of this sub-
4 section, the term ‘eligible entity’ means an accredited
5 health professions school or program, a public or nonprofit
6 private hospital, a public or private nonprofit entity (in-
7 cluding an area health education center), or a consortium
8 of such entities.

9 “(c) APPLICATION.—To seek a grant or contract
10 under this section, an eligible entity shall submit to the
11 Secretary an application at such time, in such manner,
12 and containing such information as the Secretary may re-
13 quire, including—

14 “(1) a description of community health needs
15 and barriers to health care in a target population,
16 including, where applicable, any analysis conducted
17 in accordance with section 3161 (relating to core
18 public health infrastructure and activities);

19 “(2) a proposal of demonstrated or promising
20 interdisciplinary approaches to addressing such bar-
21 riers; and

22 “(3) a plan for how the applicant will establish
23 and maintain, as appropriate, formal partnerships
24 with community-based partners and health facilities

1 focused on the social and health needs of the target
2 population identified under paragraph (1).

3 “(d) **REQUIRED ACTIVITIES.**—The Secretary may not
4 award a grant or contract to an applicant under this sec-
5 tion unless the applicant agrees—

6 “(1) to plan, develop, and implement inter-
7 disciplinary training curricula that address the bar-
8 riers to health care, as identified under subsection
9 (c), and incorporate the approaches to addressing
10 such barriers, as proposed under subsection (c);

11 “(2) to conduct interdisciplinary research and
12 outreach that addresses such barriers and incor-
13 porates such approaches; and

14 “(3) to create new models of teaching and eval-
15 uating patient care based on interdisciplinary inte-
16 grated models of effective patient care.

17 Models of care funded under this section may include the
18 patient centered medical home model, medication therapy
19 management, models that address both physical and men-
20 tal health, or other models.

21 “(e) **VOLUNTARY ACTIVITIES.**—The Secretary may
22 allow the recipient of a grant or contract under this sec-
23 tion to use the grant to integrate programs along the edu-
24 cational continuum, including high school and college pipe-
25 line programs, pregraduate or doctoral education, resi-

1 dency training, faculty development, fellowship programs,
2 research infrastructure programs, and interdisciplinary
3 joint degree programs in health professions.

4 “(f) TERM.—The term of a grant or contract under
5 this section shall not exceed 5 years.

6 “(g) PREFERENCES.—In awarding grants and con-
7 tracts under this section, the Secretary shall give pref-
8 erence to eligible entities that—

9 “(1) have a record of broad interdisciplinary
10 team-based collaborations;

11 “(2) have a high rate for placing graduates in
12 underserved and rural areas, populations experi-
13 encing health disparities, or regions experiencing sig-
14 nificant changes in the cultural and linguistic demo-
15 graphics of populations, including communities along
16 the United States-Mexico border; and

17 “(3) have a record of training the greatest per-
18 centage of health professionals, or have dem-
19 onstrated significant improvements in the percentage
20 of health professionals, who enter and remain in pri-
21 mary care practice and other disciplines, specialties,
22 and subspecialties identified as high priority by the
23 Workforce Commission under section 152.

24 “(h) DEFINITIONS.—In this section:

1 “(1) The term ‘health disparities’ has the
2 meaning given the term in section 3171.

3 “(2) The term ‘interdisciplinary’ means collabo-
4 ration across health professions and specialties,
5 which may include public health, nursing, allied
6 health, and relevant medical specialties.”.

7 **CHAPTER 3—ADVISORY COMMITTEE ON**
8 **HEALTH WORKFORCE EVALUATION**
9 **AND ASSESSMENT**

10 **SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESS-**
11 **MENT.**

12 Subpart 1 of part E of title VII (42 U.S.C. 294n
13 et seq.) is amended by adding at the end the following:

14 **“SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESS-**
15 **MENT.**

16 “(a) **ADVISORY COMMITTEE.**—The Secretary shall
17 establish an advisory committee to be known as the Advi-
18 sory Committee on Health Workforce Evaluation and As-
19 sessment (referred to in this section as the ‘Advisory Com-
20 mittee’), for the purpose of advising and making rec-
21 ommendations to—

22 “(1) assess, evaluate, and advise the Secretary
23 on the adequacy and appropriateness of the Nation’s
24 health workforce (including public health profes-
25 sionals); and

1 “(2) make recommendations to the Secretary
2 and the Congress on policies to ensure that such
3 workforce is meeting the Nation’s health and health
4 care needs.

5 “(b) MEMBERSHIP.—

6 “(1) IN GENERAL.—The Secretary shall appoint
7 15 members to serve on the Advisory Committee,
8 which shall include no less than one representative
9 of each of—

10 “(A) the health care workforce and health
11 professionals;

12 “(B) employers;

13 “(C) third-party payers;

14 “(D) individuals skilled in the conduct and
15 interpretation of health care services and health
16 economics research;

17 “(E) representatives of consumers;

18 “(F) labor unions;

19 “(G) State or local workforce investment
20 boards; and

21 “(H) educational institutions, which may
22 include elementary and secondary schools, insti-
23 tutions of higher education (including 2- and 4-
24 year institutions) and registered apprenticeship
25 programs.

1 “(2) REQUIREMENTS.—In appointing the mem-
2 bers of the Advisory Committee, the Secretary shall
3 ensure that—

4 “(A) the members adequately represent
5 urban and federally designated rural and non-
6 metropolitan areas from throughout the Nation;

7 “(B) the members adequately represent
8 populations who are underrepresented in the
9 health professions;

10 “(C) the members are selected based on
11 competence, interest, and knowledge of the mis-
12 sion and professions involved;

13 “(D) individuals who are directly involved
14 in health professions education or practice do
15 not constitute a majority of the members of the
16 Advisory Committee.

17 “(3) CONSULTATION FOR APPOINTMENT.—The
18 Secretary shall appoint the members of the Advisory
19 Committee in consultation with the Comptroller
20 General of the United States.

21 “(4) CHAIRPERSON.—The chairperson of the
22 Advisory Committee shall be selected by a vote of
23 the members of the Committee.

24 “(5) TERMS.—

1 “(A) IN GENERAL.—Except as provided in
2 subparagraph (B), each member of the Advi-
3 sory Committee shall be appointed for a period
4 of 3 years.

5 “(B) STAGGERED TERMS.—Of the mem-
6 bers first appointed to the Advisory Committee
7 under paragraph (1)—

8 “(i) $\frac{1}{3}$ shall be appointed for a term
9 of 1 year;

10 “(ii) $\frac{1}{3}$ shall be appointed for a term
11 of 2 years; and

12 “(iii) $\frac{1}{3}$ shall be appointed for a term
13 of 3 years.

14 “(c) DUTIES.—The Advisory Committee shall carry
15 out the following activities:

16 “(1) Make recommendations regarding the clas-
17 sifications of the health care workforce in consulta-
18 tion with the Department of Labor to ensure the
19 consistency of data collection, and update these rec-
20 ommendations at least every 5 years.

21 “(2) Make recommendations regarding stand-
22 ardized methodology and procedures to enumerate
23 the health care workforce, and update these rec-
24 ommendations at least every 5 years.

1 “(3) Review current and projected health care
2 workforce supply and demand.

3 “(4) Make recommendations to the Secretary
4 and to Congress concerning national health care
5 workforce priorities, goals, and policies, including
6 recommendations for successful performance out-
7 come measures for Federal workforce programs.

8 “(5) By not later than October 1 of each fiscal
9 year (beginning with 2011), submit a report to the
10 Secretary and the Congress containing the results of
11 such reviews and recommendations concerning re-
12 lated policies.

13 “(d) WORKING GROUPS AND SUBCOMMITTEES.—The
14 Advisory Committee shall collaborate with the existing ad-
15 visory bodies at the Health Resources and Services Admin-
16 istration, the National Advisory Council, as authorized in
17 section 337, the Advisory Committee on Training in Pri-
18 mary Care Medicine and Dentistry, as authorized in sec-
19 tion 749, the Advisory Committee on Interdisciplinary,
20 Community-Based Linkages, as authorized in section 756,
21 the Advisory Council on Graduate Medical Education, as
22 authorized in section 762, and the National Advisory
23 Council on Nurse Education and Practice, as authorized
24 in section 845.

1 “(e) MEETINGS.—The Advisory Committee shall
2 meet at least 3 times annually.

3 “(f) TERMINATION.—The Advisory Committee shall
4 not be terminated prior to the date that is 5 years after
5 the date of enactment of this section.

6 “(g) FACA.—The Federal Advisory Committee Act
7 (5 U.S.C. App.) shall apply to the Advisory Committee
8 under this section only to the extent that the provisions
9 of such Act do not conflict with the requirements of this
10 section.”.

11 **CHAPTER 4—NATIONAL CENTER FOR**
12 **HEALTH WORKFORCE ANALYSIS**

13 **SEC. 2271. HEALTH CARE WORKFORCE PROGRAM ASSESS-**
14 **MENT.**

15 (a) IN GENERAL.—Section 761 (42 U.S.C. 294m) is
16 amended by striking subsections (a), (b), and (c) and in-
17 serting the following:

18 “(a) NATIONAL CENTER FOR HEALTH CARE WORK-
19 FORCE ANALYSIS.—

20 “(1) ESTABLISHMENT.—The Secretary, acting
21 through the Director of the Health Resources and
22 Services Administration, shall establish the National
23 Center for Health Workforce Analysis (referred to in
24 this section as the ‘National Center’) to be headed

1 by a director, for the purposes of evaluating the ef-
2 fectiveness of federal workforce programs.

3 “(2) FUNCTIONS.—The National Center, in co-
4 ordination with the Advisory Committee on Health
5 Workforce Evaluation and Assessment established
6 pursuant to section 764, shall—

7 “(A) collect, analyze, and report data de-
8 scribing the health care workforce, and related
9 to federal workforce programs, including longi-
10 tudinal data collection;

11 “(B) develop and publish benchmarks for
12 performance for Federal workforce programs,
13 including tracking health workforce needs over
14 time;

15 “(C) establish, maintain, and make pub-
16 licly available through the Internet a national
17 health workforce database which collects data
18 from internal and external data sources;

19 “(D) establish and maintain a registry of
20 each grant awarded under this title;

21 “(E) in collaboration with the advisory
22 committee established under section 764, annu-
23 ally compile workforce information required
24 under this subsection into a report; and

1 “(F) disseminate this report and other
2 workforce information to state, regional, and
3 national entities

4 “(3) COLLABORATION AND DATA SHARING.—
5 The National Center shall collaborate with Federal
6 agencies, health professions education organizations,
7 health professions organizations, and professional
8 medical societies for the purpose of linking data re-
9 garding programs funded under this title.

10 “(b) CONTRACTS FOR HEALTH WORKFORCE ANAL-
11 YSIS.—

12 “(1) IN GENERAL.—The Secretary, acting
13 through the Director of the National Center, may
14 enter into contracts with eligible entities to carry out
15 functions under subsection (b).

16 “(2) ELIGIBLE ENTITIES.—To be eligible for a
17 grant or contract under this subsection, an entity
18 shall—

19 “(A) be a State, a State workforce invest-
20 ment board, a public health or health profes-
21 sions school, an academic health center, or an
22 appropriate public or private nonprofit entity,
23 or a partnership of such entities; and

24 “(B) submit to the Secretary an applica-
25 tion at such time, in such manner, and con-

1 taining such information as the Secretary may
2 require.”.

3 (b) **TRANSFER OF FUNCTIONS.**—Not later than 180
4 days after the date of enactment of this Act, all of the
5 functions, authorities, and resources of the National Cen-
6 ter for Health Workforce Analysis of the Health Resources
7 and Services Administration, as in effect on the date be-
8 fore the date of enactment of this Act, shall be transferred
9 to the National Center for Health Workforce Analysis es-
10 tablished under section 761 of the Public Health Service
11 Act, as amended by subsection (a).

12 **SEC. 2272. REPORTS.**

13 (a) **REPORTS BY SECRETARY.**—On an annual basis,
14 the Secretary of Health and Human Services shall submit
15 to the appropriate committees of the Congress a report
16 on the activities carried out under the this title and the
17 amendments made by this title, and the effectiveness of
18 such activities.

19 (b) **REPORTS BY RECIPIENTS OF FUNDS.**—The Sec-
20 retary of Health and Human Services may require, as a
21 condition of receiving funds under any provision of this
22 title or any provision amended by this title, that the entity
23 receiving such award submit to such Secretary such re-
24 ports as the such Secretary may require on activities car-

1 ried out with such award, and the effectiveness of such
2 activities.

3 **CHAPTER 5—AUTHORIZATION OF**
4 **APPROPRIATIONS**

5 **SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.**

6 (a) CHAPTER 1.—To carry sections 736, 737, 738,
7 and 739 of the Public Health Service Act, as amended
8 by chapter 1 of this subtitle, there are authorized to be
9 appropriated, out of any monies in the Public Health In-
10 vestment Fund, \$90,000,000 for each of fiscal years 2010
11 through 2014.

12 (b) CHAPTERS 2, 3, AND 4.—To carry out sections
13 741, 759, 761, 764, and 807 of the Public Health Service
14 Act, as amended by chapters 2, 3, and 4 of this subtitle,
15 and section 2253 of this subtitle, there is authorized to
16 be appropriated, out of any monies in the Public Health
17 Investment Fund, \$70,000,000 for each of fiscal years
18 2010 through 2014.

19 **TITLE III—PREVENTION AND**
20 **WELLNESS**

21 **SEC. 2301. PREVENTION AND WELLNESS.**

22 (a) IN GENERAL.—The Public Health Service Act
23 (42 U.S.C. 201 et seq.) is amended by adding at the end
24 the following:

1 **“TITLE XXXI—PREVENTION AND**
2 **WELLNESS**

3 **“Subtitle A—Prevention and**
4 **Wellness Trust**

5 **“SEC. 3111. PREVENTION AND WELLNESS TRUST.**

6 “(a) DEPOSITS INTO TRUST.—There is established
7 a Prevention and Wellness Trust. There are authorized
8 to be appropriated, out of any monies in the Public Health
9 Investment Fund, to the Trust—

10 “(1) for fiscal year 2010, \$2,400,000,000;

11 “(2) for fiscal year 2011, \$2,800,000,000;

12 “(3) for fiscal year 2012, \$3,100,000,000;

13 “(4) for fiscal year 2013, \$3,400,000,000; and

14 “(5) for fiscal year 2014, \$3,500,000,000.

15 “(b) AVAILABILITY OF FUNDS.—Amounts in the Pre-
16 vention and Wellness Trust shall be available, as provided
17 in advance in appropriation Acts, for carrying out this
18 title.

19 “(c) ALLOCATION.—Of the amounts made available
20 made available to carry out this title, there are authorized
21 to be appropriated—

22 “(1) for carrying out subtitle C (Prevention
23 Task Forces), \$30,000,000 for each of fiscal years
24 2010 through 2014;

1 “(2) for carrying out subtitle D (Prevention
2 and Wellness Research)—

3 “(A) for fiscal year 2010, \$100,000,000;

4 “(B) for fiscal year 2011, \$150,000,000;

5 “(C) for fiscal year 2012, \$200,000,000;

6 “(D) for fiscal year 2013, \$250,000,000;

7 and

8 “(E) for fiscal year 2014, \$300,000,000;

9 “(3) for carrying out subtitle E (Delivery of
10 Community-Based Prevention and Wellness Serv-
11 ices)—

12 “(A) for fiscal year 2010, \$1,100,000,000;

13 “(B) for fiscal year 2011, \$1,300,000,000;

14 “(C) for fiscal year 2012, \$1,400,000,000;

15 “(D) for fiscal year 2013, \$1,600,000,000;

16 and

17 “(E) for fiscal year 2014, \$1,600,000,000;

18 “(4) for carrying out section 3161 (Core Public
19 Health Infrastructure and Activities for State and
20 Local Health Departments)—

21 “(A) for fiscal year 2010, \$800,000,000;

22 “(B) for fiscal year 2011, \$1,000,000,000;

23 “(C) for fiscal year 2012, \$1,100,000,000;

24 “(D) for fiscal year 2013, \$1,200,000,000;

25 and

1 “(E) for fiscal year 2014, \$1,300,000,000;
2 and
3 “(5) for carrying out section 3162 (Core Public
4 Health Infrastructure and Activities for CDC)
5 \$350,000,000 for each of fiscal years 2010 through
6 2014.

7 **“Subtitle B—National Prevention**
8 **and Wellness Strategy**

9 **“SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRAT-**
10 **EGY.**

11 “(a) IN GENERAL.—The Secretary shall submit to
12 the Congress within one year of enactment of this section,
13 and at least every 2 years thereafter, a national strategy
14 that is designed to improve the Nation’s health through
15 evidenced-based clinical and community-based prevention
16 and wellness activities (in this section referred to as ‘pre-
17 vention and wellness activities’), including core public
18 health infrastructure improvement activities.

19 “(b) CONTENTS.—The strategy under subsection (a)
20 shall include each of the following:

21 “(1) Identification of specific national goals and
22 objectives in prevention and wellness activities that
23 take into account appropriate public health measures
24 and standards, including departmental measures and

1 standards such as Healthy People and National
2 Public Health Performance Standards.

3 “(2) Establishment of national priorities for
4 prevention and wellness activities, taking into ac-
5 count unmet prevention and wellness needs.

6 “(3) Establishment of national priorities for re-
7 search on prevention and wellness activities, taking
8 into account unanswered research questions on pre-
9 vention and wellness.

10 “(4) Identification of health disparities in pre-
11 vention and wellness activities.

12 “(5) A plan for addressing and implementing
13 paragraphs (1) through (4).

14 “(c) CONSULTATION.—In developing or revising the
15 strategy under subsection (a), the Secretary shall consult
16 with the following:

17 “(1) The heads of appropriate health agencies
18 and offices in the Department, including the Office
19 of the Surgeon General of the Public Health Service,
20 the Office of Minority Health, and the Office on
21 Women’s Health.

22 “(2) As appropriate, the heads of other Federal
23 departments and agencies with significant health-re-
24 lated responsibilities, including the Secretary of De-
25 fense and the Secretary of Veterans Affairs.

1 “(3) Nonprofit and for-profit health-related en-
2 tities.

3 “(4) The Association of State and Territorial
4 Health Officials and the National Association of
5 County and City Health Officials.

6 **“Subtitle C—Prevention Task**
7 **Forces**

8 **“SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERV-**
9 **ICES.**

10 “(a) IN GENERAL.—The Secretary, acting through
11 the Director of the Agency for Healthcare Research and
12 Quality, shall establish a permanent task force to be
13 known as the Task Force on Clinical Preventive Services
14 (in this section referred to as the ‘Task Force’).

15 “(b) RESPONSIBILITIES.—The Task Force shall—

16 “(1) review the scientific evidence related to the
17 benefits, effectiveness, appropriateness, and costs of
18 clinical preventive services for the purpose of devel-
19 oping, updating, publishing, and disseminating evi-
20 dence-based recommendations on the use of clinical
21 preventive services;

22 “(2) identify gaps in clinical preventive services
23 research and recommend priority areas for research
24 activities;

1 “(3) as appropriate, take into account health
2 disparities among subpopulations in developing, up-
3 dating, publishing, and disseminating evidence-based
4 recommendations under this section;

5 “(4) as appropriate, consult with the clinical
6 prevention stakeholders board in accordance with
7 subsection (f); and

8 “(5) as appropriate, consult with the Task
9 Force on Community Preventive Services established
10 under section 3132.

11 “(c) **ROLE OF AGENCY.**—The Secretary shall provide
12 ongoing administrative, research, and technical support
13 for the operations of the Task Force, including coordi-
14 nating and supporting the dissemination of the rec-
15 ommendations of the Task Force.

16 “(d) **MEMBERSHIP.**—

17 “(1) **NUMBER; APPOINTMENT.**—The Task
18 Force shall be composed of 30 members, appointed
19 by the Secretary.

20 “(2) **TERMS.**—

21 “(A) **IN GENERAL.**—The Secretary shall
22 appoint members of the Task Force for a term
23 of 6 years and may reappoint such members,
24 but the Secretary may not appoint any member
25 to serve more than a total of 12 years.

1 “(B) STAGGERED TERMS.—Notwith-
2 standing subparagraph (A), of the members
3 first appointed to serve on the Task Force after
4 the enactment of this title:

5 “(i) 10 shall be appointed for a term
6 of 2 years;

7 “(ii) 10 shall be appointed for a term
8 of 4 years; and

9 “(iii) 10 shall be appointed for a term
10 of 6 years.

11 “(3) QUALIFICATIONS.—Members of the Task
12 Force shall be appointed from among individuals
13 who possess expertise in at least one of the following
14 areas:

15 “(A) Health promotion and disease preven-
16 tion.

17 “(B) Evaluation of research and system-
18 atic evidence review.

19 “(C) Application of systematic evidence re-
20 views to clinical decisionmaking or health pol-
21 icy.

22 “(D) Clinical primary care in child and ad-
23 olescent health.

24 “(E) Clinical primary care in adult health.

25 “(F) Clinical primary care in geriatrics.

1 “(G) Clinical counseling and behavioral
2 services for primary care patients.

3 “(4) REPRESENTATION.—In appointing mem-
4 bers of the Task Force, the Secretary shall ensure
5 that—

6 “(A) all areas of expertise described in
7 paragraph (3) are represented; and

8 “(B) the members of the Task Force in-
9 clude practitioners who, collectively, have sig-
10 nificant experience treating racially and eth-
11 nically diverse populations.

12 “(5) DISCLOSURE AND CONFLICTS OF INTER-
13 EST.—Members of the Task Force shall be consid-
14 ered to be special Government employees within the
15 meaning of section 107 of title 5 and section 208 of
16 title 18, United States Code, for the purposes of dis-
17 closure and management of conflicts of interest
18 under those sections.

19 “(e) SUBGROUPS.—As appropriate to maximize effi-
20 ciency, the Task Force may delegate authority for con-
21 ducting reviews and making recommendations to sub-
22 groups consisting of Task Force members, subject to final
23 approval by the Task Force.

24 “(f) CLINICAL PREVENTION STAKEHOLDERS
25 BOARD.—

1 “(1) IN GENERAL.—The Task Force shall con-
2 vene a clinical prevention stakeholders board com-
3 posed of representatives of appropriate public and
4 private entities with an interest in clinical preventive
5 services to advise the Task Force on developing, up-
6 dating, publishing, and disseminating evidence-based
7 recommendations on the use of clinical preventive
8 services.

9 “(2) MEMBERSHIP.—The members of the clin-
10 ical prevention stakeholders board shall include rep-
11 resentatives of the following:

12 “(A) Health care consumers.

13 “(B) Federal departments and agencies,
14 including—

15 “(i) the heads of appropriate health
16 agencies and offices in the Department, in-
17 cluding the Office of the Surgeon General
18 of the Public Health Service, the Director
19 of the Office of Minority Health, and the
20 Director of the Office on Women’s Health;
21 and

22 “(ii) as appropriate, the heads of
23 other Federal departments and agencies
24 with significant health-related responsibil-

1 ities, including the Secretary of Defense
2 and the Secretary of Veterans Affairs.

3 “(C) Private payors.

4 “(3) DUTIES.—In accordance with subsection
5 (b)(4), the clinical prevention stakeholders board
6 shall—

7 “(A) recommend priority areas of review
8 by the Task Force;

9 “(B) suggest studies for consideration by
10 the Task Force related to reviews undertaken
11 by the Task Force;

12 “(C) provide feedback regarding draft rec-
13 ommendations; and

14 “(D) assist with efforts regarding dissemi-
15 nation of recommendations.

16 “(g) APPLICATION OF FACA.—The Federal Advisory
17 Committee Act shall apply to the Advisory Committee to
18 the extent that the provisions of such Act do not conflict
19 with the provisions of this title.

20 **“SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE**
21 **SERVICES.**

22 “(a) IN GENERAL.—The Secretary, acting through
23 the Director of the Centers for Disease Control and Pre-
24 vention, shall establish a permanent task force to be

1 known as the Task Force on Community Preventive Serv-
2 ices (in this section referred to as the ‘Task Force’).

3 “(b) RESPONSIBILITIES.—The Task Force shall—

4 “(1) review the scientific evidence related to the
5 benefits, effectiveness, appropriateness, and costs of
6 community preventive services for the purpose of de-
7 veloping, updating, publishing, and disseminating
8 evidence-based recommendations on the use of com-
9 munity preventive services;

10 “(2) identify gaps in community preventive
11 services research and recommend priority areas for
12 research activities;

13 “(3) as appropriate, take into account health
14 disparities among subpopulations in developing, up-
15 dating, publishing, and disseminating evidence-based
16 recommendations under this section;

17 “(4) as appropriate, consult with the commu-
18 nity prevention stakeholders board in accordance
19 with subsection (f); and

20 “(5) as appropriate, consult with the Task
21 Force on Clinical Preventive Services established
22 under section 3131.

23 “(c) ROLE OF AGENCY.—The Secretary shall provide
24 ongoing administrative, research, and technical support
25 for the operations of the Task Force, including coordi-

1 nating and supporting the dissemination of the rec-
2 ommendations of the Task Force.

3 “(d) MEMBERSHIP.—

4 “(1) NUMBER; APPOINTMENT.—The Task
5 Force shall be composed of 30 members, appointed
6 by the Secretary.

7 “(2) TERMS.—

8 “(A) IN GENERAL.—The Secretary shall
9 appoint members of the Task Force for a term
10 of 6 years and may reappoint such members,
11 but the Secretary may not appoint any member
12 to serve more than a total of 12 years.

13 “(B) STAGGERED TERMS.—Notwith-
14 standing subparagraph (A), of the members
15 first appointed to serve on the Task Force after
16 the enactment of this section—

17 “(i) 10 shall be appointed for a term
18 of 2 years;

19 “(ii) 10 shall be appointed for a term
20 of 4 years; and

21 “(iii) 10 shall be appointed for a term
22 of 6 years.

23 “(3) QUALIFICATIONS.—Members of the Task
24 Force shall be appointed from among individuals

1 who possess expertise in at least one of the following
2 areas:

3 “(A) Public health.

4 “(B) Evaluation of research and system-
5 atic evidence review.

6 “(C) Disciplines relevant to community
7 preventive services, including health promotion,
8 disease prevention, worksite health, qualitative
9 and quantitative analysis, and health economics,
10 policy, law, and statistics.

11 “(4) REPRESENTATION.—In appointing mem-
12 bers of the Task Force, the Secretary—

13 “(A) shall ensure that such members in-
14 clude at least 4 representatives of each of—

15 “(i) State health officers;

16 “(ii) local health officers;

17 “(iii) health care practitioners; and

18 “(iv) public health practitioners; and

19 “(B) shall appoint individuals who, collec-
20 tively, have significant experience working with
21 racially and ethnically diverse populations.

22 “(5) DISCLOSURE AND CONFLICTS OF INTER-
23 EST.—Members of the Task Force shall be consid-
24 ered to be special Government employees within the
25 meaning of section 107 of title 5 and section 208 of

1 title 18, United States Code, for the purposes of dis-
2 closure and management of conflicts of interest
3 under those sections.

4 “(e) SUBGROUPS.—As appropriate to maximize effi-
5 ciency, the Task Force may delegate authority for con-
6 ducting reviews and making recommendations to sub-
7 groups consisting of Task Force members, subject to final
8 approval by the Task Force.

9 “(f) COMMUNITY PREVENTION STAKEHOLDERS
10 BOARD.—

11 “(1) IN GENERAL.—The Task Force shall con-
12 vene a community prevention stakeholders board
13 composed of representatives of appropriate public
14 and private entities with an interest in community
15 preventive services to advise the Task Force on de-
16 veloping, updating, publishing, and disseminating
17 evidence-based recommendations on the use of com-
18 munity preventive services.

19 “(2) MEMBERSHIP.—The members of the com-
20 munity prevention stakeholders board shall include
21 representatives of the following:

22 “(A) Health care consumers.

23 “(B) Federal departments and agencies,
24 including—

1 “(i) the heads of appropriate health
2 agencies and offices in the Department, in-
3 cluding the Office of the Surgeon General
4 of the Public Health Service, the Office of
5 Minority Health, and the Office on Wom-
6 en’s Health; and

7 “(ii) as appropriate, the heads of
8 other Federal departments and agencies
9 with significant health-related responsibil-
10 ities, including the Secretary of Defense
11 and the Secretary of Veterans Affairs.

12 “(C) Private payors.

13 “(3) DUTIES.—In accordance with subsection
14 (b)(4), the community prevention stakeholders board
15 shall—

16 “(A) recommend priority areas of review
17 by the Task Force;

18 “(B) suggest studies for consideration by
19 the Task Force related to reviews undertaken
20 by the Task Force;

21 “(C) provide feedback regarding draft rec-
22 ommendations; and

23 “(D) assist with efforts regarding dissemi-
24 nation of recommendations.

1 “(g) APPLICATION OF FACA.—The Federal Advisory
2 Committee Act shall apply to the Advisory Committee to
3 the extent that the provisions of such Act do not conflict
4 with the provisions of this title.

5 **“Subtitle D—Prevention and**
6 **Wellness Research**

7 **“SEC. 3141. PREVENTION AND WELLNESS RESEARCH ACTIV-**
8 **ITY COORDINATION.**

9 “In conducting or supporting research on prevention
10 and wellness, the Director of the Centers for Disease Con-
11 trol and Prevention and the Director of the National Insti-
12 tutes of Health shall take into consideration the national
13 strategy under section 3121 and the recommendations of
14 the Task Force on Clinical Preventive Services under sec-
15 tion 3131 and the Task Force on Community Preventive
16 Services under section 3132.

17 **“SEC. 3142. COMMUNITY-BASED PREVENTION AND**
18 **WELLNESS RESEARCH GRANTS.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Director of the Centers for Disease Control and Pre-
21 vention, shall conduct, or award grants to eligible entities
22 to conduct, research in priority areas identified by the Sec-
23 retary in the national strategy under section 3121 or by
24 the Task Force on Community Preventive Services as re-
25 quired by section 3132.

1 “(b) ELIGIBLE ENTITY.—In this section the term ‘el-
2 ible entity’ includes the following:

3 “(1) A State or local department of health.

4 “(2) A public or private nonprofit entity.

5 “(3) A consortium of 2 or more of the entities
6 described in paragraph (1) or (2).

7 “(c) ADMINISTRATIVE EXPENSES.—Not more than
8 10 percent of the funds provided through a grant awarded
9 under this section may be used for administrative ex-
10 penses.

11 “(d) REPORT.—The Secretary shall submit an an-
12 nual report to the Congress on the program of grants
13 awarded under this section.

14 **“Subtitle E—Delivery of Commu-
15 nity-Based Prevention and
16 Wellness Services**

17 **“SEC. 3151. COMMUNITY-BASED PREVENTION AND
18 WELLNESS SERVICES GRANTS.**

19 “(a) IN GENERAL.—The Secretary, acting through
20 the Director of the Centers for Disease Control and Pre-
21 vention, shall establish a program of awarding grants to
22 eligible entities—

23 “(1) to provide evidence-based, community-
24 based prevention and wellness services in priority

1 areas identified by the Secretary in the national
2 strategy under section 3121; or

3 “(2) to plan such services.

4 “(b) ELIGIBLE ENTITY.—

5 “(1) DEFINITION.—In this section, the term
6 ‘eligible entity’ includes the following:

7 “(A) A State, local, or tribal department of
8 health.

9 “(B) A public or private nonprofit entity.

10 “(C) A consortium of 2 or more of the en-
11 tities described in subparagraph (A) or (B), in-
12 cluding a community partnership representing a
13 Health Empowerment Zone.

14 “(2) HEALTH EMPOWERMENT ZONE.—In this
15 subsection, the term ‘Health Empowerment Zone’
16 means an area—

17 “(A) in which multiple community-based
18 prevention and wellness services are imple-
19 mented in order to address one or more health
20 disparities, including those identified by the
21 Secretary in the national strategy under section
22 3121; and

23 “(B) which is represented by a community
24 partnership that demonstrates coordination
25 with State, local, or tribal health departments

1 and includes residents of the community and
2 representatives of entities that have a history of
3 working within and serving the community.

4 “(c) CONSIDERATIONS.—In making grants under this
5 section, the Secretary shall consider, as appropriate, the
6 extent to which the proposal—

7 “(1) addresses one or more goals or objectives
8 identified by the Secretary in the national strategy
9 under section 3121;

10 “(2) targets significant health disparities, in-
11 cluding those identified by the Secretary in the na-
12 tional strategy under section 3121;

13 “(3) addresses unmet prevention and wellness
14 needs and avoids duplication of effort;

15 “(4) has been demonstrated to be effective in
16 populations comparable to the proposed target com-
17 munity;

18 “(5) contributes to the evidence base for com-
19 munity-based services;

20 “(6) demonstrates that the services to be fund-
21 ed will be sustainable;

22 “(7) demonstrates coordination or collaboration
23 across governmental and nongovernmental partners;
24 and

1 “(8) demonstrates the capacity of the applicant
2 to carry out the proposal.

3 “(d) HEALTH DISPARITIES.—Of the funds awarded
4 under this section for a fiscal year, the Secretary shall
5 award not less than 50 percent for planning or imple-
6 menting prevention and wellness services whose primary
7 purpose is to achieve a measurable reduction in one or
8 more health disparities, including those identified by the
9 Secretary in the national strategy under section 3121.

10 “(e) EMPHASIS ON RECOMMENDED SERVICES.—For
11 fiscal year 2013 and subsequent fiscal years, the Secretary
12 shall award grants under this section only for planning
13 or implementing services recommended by the Task Force
14 on Community Preventive Services under section 3122 or
15 a review body of comparable rigor (as determined by the
16 Director of the Centers for Disease Control and Preven-
17 tion).

18 “(f) PLANNING GRANTS.—An eligible entity may re-
19 ceive not more than one grant for planning activities under
20 subsection (a)(2).

21 “(g) ADMINISTRATIVE EXPENSES.—Of the amount
22 of any grant awarded under this section, not more than
23 10 percent may be used for administrative expenses.

1 “(h) REPORT.—The Secretary shall submit an an-
2 nual report to the Congress on the program of grants
3 awarded under this section.

4 “(i) DEFINITIONS.—In this section, the term ‘evi-
5 dence-based’ means that methodologically sound research
6 has demonstrated a beneficial effect, in the judgment of
7 the Director of the Centers for Disease Control and Pre-
8 vention.

9 **“Subtitle F—Core Public Health**
10 **Infrastructure and Activities**

11 **“SEC. 3161. CORE PUBLIC HEALTH INFRASTRUCTURE AND**
12 **ACTIVITIES FOR STATE AND LOCAL HEALTH**
13 **DEPARTMENTS.**

14 “(a) GRANTS.—

15 “(1) AWARD.—For the purpose of addressing
16 core public health infrastructure needs, the Sec-
17 retary, acting through the Director of the Centers
18 for Disease Control and Prevention—

19 “(A) shall award a grant to each State
20 health department; and

21 “(B) may award grants on a competitive
22 basis to State, local, or tribal health depart-
23 ments.

1 “(2) ALLOCATION.—Of the total amount of
2 funds awarded as grants under this subsection for a
3 fiscal year—

4 “(A) 50 percent shall be for grants to
5 State health departments under paragraph
6 (1)(A); and

7 “(B) 50 percent shall be for grants to
8 State, local, or tribal health departments under
9 paragraph (1)(B).

10 “(b) USE OF FUNDS.—The Secretary may award a
11 grant to an entity under paragraph (1) or (2) of sub-
12 section (a) only if the entity agrees to use the grant to
13 address core public health infrastructure needs, including
14 those identified in the accreditation process under sub-
15 section (f).

16 “(c) FORMULA GRANTS TO STATE HEALTH DEPART-
17 MENTS.—In making grants under subsection (a)(1), the
18 Secretary shall award funds to each State health depart-
19 ment in accordance with—

20 “(1) a formula based on population size; burden
21 of preventable disease and disability; and core public
22 health infrastructure gaps, including those identified
23 in the accreditation process under subsection (f);
24 and

1 “(2) application requirements established by the
2 Secretary, including a requirement that the State
3 submit a plan that demonstrates to the satisfaction
4 of the Secretary that the State’s health department
5 will—

6 “(A) address its highest priority core pub-
7 lic health infrastructure needs; and

8 “(B) as appropriate, allocate funds to local
9 health departments.

10 “(d) COMPETITIVE GRANTS TO STATE, LOCAL, AND
11 TRIBAL HEALTH DEPARTMENTS.—In making grants
12 under subsection (a)(2), the Secretary shall give priority
13 to applicants demonstrating core public health infrastruc-
14 ture needs identified in the accreditation process under
15 subsection (f).

16 “(e) MAINTENANCE OF EFFORT.—The Secretary
17 may award a grant to an entity under subsection (a) only
18 if the entity demonstrates to the satisfaction of the Sec-
19 retary that—

20 “(1) funds received through the grant will be
21 expended only to supplement, and not supplant, non-
22 Federal funds otherwise available to the entity for
23 the purpose of addressing core public health infra-
24 structure needs; and

1 “(2) with respect to activities for which the
2 grant is awarded, the entity will maintain expendi-
3 tures of non-Federal amounts for such activities at
4 a level not less than the lesser of such expenditures
5 maintained by the entity for the fiscal year pre-
6 ceding the fiscal year for which the entity receives
7 the grant.

8 “(f) ESTABLISHMENT OF A PUBLIC HEALTH AC-
9 CREDITATION PROGRAM.—

10 “(1) IN GENERAL.—The Secretary, acting
11 through the Director of Centers for Disease Control
12 and Prevention, shall—

13 “(A) develop, and periodically review and
14 update, standards for voluntary accreditation of
15 State or local health departments and public
16 health laboratories for the purpose of advancing
17 the quality and performance of such depart-
18 ments and laboratories; and

19 “(B) implement a program to accredit
20 such health departments and laboratories in ac-
21 cordance with such standards.

22 “(2) COOPERATIVE AGREEMENT.—The Sec-
23 retary may enter into a cooperative agreement with
24 a private nonprofit entity to carry out paragraph
25 (1).

1 “(g) REPORT.—The Secretary shall submit an annual
2 report to the Congress on progress being made to accredit
3 entities under subsection (f), including—

4 “(1) a strategy, including goals and objectives,
5 for accrediting entities under subsection (f) and
6 achieving the purpose described in subsection (f)(1);
7 and

8 “(2) identification of priority areas of research
9 related to core public health infrastructure and re-
10 lated activities.

11 **“SEC. 3162. CORE PUBLIC HEALTH INFRASTRUCTURE AND**
12 **ACTIVITIES FOR CDC.**

13 “The Secretary, acting through the Director of the
14 Centers for Disease Control and Prevention, shall expand
15 and improve the core public health infrastructure and ac-
16 tivities of the Centers for Disease Control and Prevention
17 to address unmet and emerging public health needs.

18 **“Subtitle G—General Provisions**

19 **“SEC. 3171. DEFINITIONS.**

20 “In this title:

21 “(1) The term ‘core public health infrastruc-
22 ture’ means public health activities related to work-
23 force capacity and competency; laboratory systems;
24 data collection and analysis; communications; and

1 other relevant components of organizational capac-
2 ity.

3 “(2) The terms ‘Department’ and ‘depart-
4 mental’ refer to the Department of Health and
5 Human Services.

6 “(3) The term ‘health disparities’ means popu-
7 lation-specific differences in the presence of disease,
8 health outcomes, or access to health care and in-
9 cludes health and health care disparities. For pur-
10 poses of the preceding sentence, a population may be
11 delineated by race, ethnicity, geographic setting, or
12 other category determined appropriate by the Sec-
13 retary.

14 “(4) The term ‘tribal’ refers to an Indian Tribe,
15 Tribal Organization, or an Urban Indian Organiza-
16 tion.”.

17 (b) TRANSITION PROVISIONS APPLICABLE TO TASK
18 FORCES.—

19 (1) FUNCTIONS, PERSONNEL, ASSETS, LIABIL-
20 ITIES, AND ADMINISTRATIVE ACTIONS.—All func-
21 tions, personnel, assets, and liabilities of, and ad-
22 ministrative actions applicable to, the Preventive
23 Services Task Force and the Task Force on Commu-
24 nity Preventive Services on the day before the date
25 of the enactment of this Act shall be transferred to

1 the Task Force on Clinical Preventive Services and
2 the Task Force on Community Preventive Services,
3 respectively, established under sections 3121 and
4 3122 of the Public Health Service Act, as added by
5 subsection (a).

6 (2) RECOMMENDATIONS.—All recommendations
7 of the Preventive Services Task Force and the Task
8 Force on Community Preventive Services, as in ex-
9 istence on the day before the date of the enactment
10 of this Act, shall be considered to be recommenda-
11 tions of the Task Force on Clinical Preventive Serv-
12 ices and the Task Force on Community Preventive
13 Services, respectively, established under sections
14 3121 and 3122 of the Public Health Service Act, as
15 added by subsection (a).

16 (3) MEMBERS ALREADY SERVING.—

17 (A) INITIAL MEMBERS.—The Secretary of
18 Health and Human Services may select those
19 individuals already serving on the Preventive
20 Services Task Force and the Task Force on
21 Community Preventive Services, as in existence
22 on the day before the date of the enactment of
23 this Act, to be among the first members ap-
24 pointed to the Task Force on Clinical Preven-
25 tive Services and the Task Force on Commu-

1 nity Preventive Services, respectively, under sec-
2 tions 3121 and 3122 of the Public Health Serv-
3 ice Act, as added by subsection (a).

4 (B) CALCULATION OF TOTAL SERVICE.—In
5 calculating the total years of service of a mem-
6 ber of a task force for purposes of section
7 3131(d)(2)(A) or 3132(d)(2)(A) of the Public
8 Health Service Act, as added by subsection (a),
9 the Secretary of Health and Human Services
10 shall not include any period of service by the
11 member on the Preventive Services Task Force
12 or the Task Force on Community Preventive
13 Services, respectively, as in existence on the day
14 before the date of the enactment of this Act.

15 (4) PERIOD BEFORE COMPLETION OF NA-
16 TIONAL STRATEGY.—Pending completion of the na-
17 tional strategy under section 3121 of the Public
18 Health Service Act, as added by subsection (a), the
19 Secretary of Health and Human Services, acting
20 through the Director of the Centers for Disease
21 Control and Prevention, may make a judgment
22 about how the strategy will address an issue and
23 rely on such judgment in carrying out any provision
24 of subtitle C, D, E, or F of title XXXI of such Act,

1 as added by subsection (a), that requires the Sec-
2 retary—

3 (A) to take into consideration such strat-
4 egy;

5 (B) to conduct or support research or pro-
6 vide services in priority areas identified in such
7 strategy; or

8 (C) to take any other action in reliance on
9 such strategy.

10 (c) CONFORMING AMENDMENTS.—

11 (1) Paragraph (61) of section 3(b) of the In-
12 dian Health Care Improvement Act (25 U.S.C.
13 1602) is amended by striking “United States Pre-
14 ventive Services Task Force” and inserting “Task
15 Force on Clinical Preventive Services”.

16 (2) Section 126 of the Medicare, Medicaid, and
17 SCHIP Benefits Improvement and Protection Act of
18 2000 (Appendix F of Public Law 106–554) is
19 amended by striking “United States Preventive
20 Services Task Force” each place it appears and in-
21 serting “Task Force on Clinical Preventive Serv-
22 ices”.

23 (3) Paragraph (7) of section 317D of the Pub-
24 lic Health Service Act (42 U.S.C. 247b–5) is amend-
25 ed by striking “United States Preventive Services

1 Task Force” each place it appears and inserting
2 “Task Force on Clinical Preventive Services”.

3 (4) Section 915 of the Public Health Service
4 Act (42 U.S.C. 299b-4) is amended by striking sub-
5 section (a).

6 (5) Subsections (s)(2)(AA)(iii)(II), (xx)(1)(B),
7 and (ddd)(1)(B) of the Social Security Act (42
8 U.S.C. 1395x) are amended by striking “United
9 States Preventive Services Task Force” each place it
10 appears and inserting “Task Force on Clinical Pre-
11 ventive Services”.

12 **TITLE IV—QUALITY AND** 13 **SURVEILLANCE**

14 **SEC. 2401. IMPLEMENTATION OF BEST PRACTICES IN THE** 15 **DELIVERY OF HEALTH CARE.**

16 (a) IN GENERAL.—Title IX of the Public Health
17 Service Act (42 U.S.C. 299 et seq.) is amended—

18 (1) by redesignating part D as part E;

19 (2) by redesignating sections 931 through 938
20 as sections 941 through 948, respectively;

21 (3) in section 938(1), by striking “931” and in-
22 serting “941”; and

23 (4) by inserting after part C the following:

1 **“PART D—IMPLEMENTATION OF BEST**

2 **PRACTICES IN THE DELIVERY OF HEALTH CARE**

3 **“SEC. 931. CENTER FOR QUALITY IMPROVEMENT.**

4 “(a) IN GENERAL.—There is established the Center
5 for Quality Improvement (referred to in this part as the
6 ‘Center’) headed by the Director of the Agency for Health
7 Research and Quality, who shall oversee the operations of
8 the Center.

9 “(b) DUTIES.—

10 “(1) PRIORITIZATION OF QUALITY IMPROVE-
11 MENT ACTIVITIES.—The Center shall identify,
12 prioritize, and develop quality improvement activi-
13 ties, including clinical, managerial, and health care
14 delivery best practices for implementation based
15 on—

16 “(A) the priorities established under sec-
17 tion 1191 of the Social Security Act;

18 “(B) the impact of implementing those ac-
19 tivities on patient outcomes and satisfaction;

20 “(C) any relevant key health indicators
21 identified under section 1709; and

22 “(D) the adaptability of such activities for
23 use by various health providers.

24 “(2) ASSIST WITH THE IMPLEMENTATION OF
25 QUALITY IMPROVEMENT ACTIVITIES.—The Center
26 shall work directly with hospitals, clinical practices,

1 and other health care facilities to assist such prac-
2 tices and facilities in the implementation of quality
3 improvement activities.

4 “(3) MEASUREMENT OF PATIENT OUTCOMES
5 AND SATISFACTION.—The Center shall provide for
6 the measurement of patient outcomes and satisfac-
7 tion before, during, and after implementation of
8 quality improvement activities.

9 “(4) GRANTS TO DEVELOP THE SCIENCE OF
10 QUALITY IMPROVEMENT.—

11 “(A) MEDICAL PRACTICE IMPROVE-
12 MENT.—The Center shall conduct or fund re-
13 search on the factors that facilitate the behavior
14 change necessary to improve quality and foster
15 an environment of continual improvement.

16 “(B) HEALTH CARE DELIVERY DESIGN.—
17 The Center shall conduct or fund research to
18 develop superior designs for the delivery of
19 health services.

20 “(5) REGIONAL GRANTS TO IMPLEMENT QUAL-
21 ITY IMPROVEMENT.—

22 “(A) IN GENERAL.—The Center shall pro-
23 vide for grants to regional qualified entities to
24 enter into voluntary arrangements with hos-
25 pitals, health facilities, and health practitioners

1 in a State or region for the purpose of imple-
2 mentation of quality improvement activities.

3 “(B) REGIONAL QUALIFIED ENTITIES.—
4 For purposes of subparagraph (A), a regional
5 qualified entity is a nonprofit entity that has
6 the capacity—

7 “(i) to carry out activities described in
8 subparagraph (C);

9 “(ii) to operate programs on a state-
10 wide or region-wide basis to improve pa-
11 tient safety and the quality of health care
12 delivered in health care settings; and

13 “(iii) to work with a variety of institu-
14 tional health care providers, physicians,
15 nurses, and other health care practitioners.

16 “(C) ACTIVITIES.—A grant under subpara-
17 graph (A) may be used to—

18 “(i) form collaborative multi-institu-
19 tional teams to address priorities identified
20 under paragraph (1);

21 “(ii) assess existing practices as com-
22 pared to the identified best practices;

23 “(iii) develop an implementation plan
24 for the quality improvement activity se-
25 lected by the entity;

1 “(iv) measure patient outcomes be-
2 fore, during, and after implementation of
3 the quality improvement activities; and

4 “(v) provide comprehensive data and
5 progress reports to the Center on these ac-
6 tivities.

7 “(D) COOPERATION AND COORDINA-
8 TION.—As a condition on receipt of a grant
9 under subparagraph (A), an entity shall agree
10 to cooperate with and avoid duplicating the ac-
11 tivities of the organization holding a contract
12 under section 1153 of the Social Security Act
13 in the area to be served by the entity.

14 “(E) AUDITS.—As a condition on receipt
15 of a grant under subparagraph (A), an entity
16 shall agree to be subject to periodic audits.

17 “(6) PUBLIC DISSEMINATION OF INFORMA-
18 TION.—The Center shall provide for the public dis-
19 semination of information with respect to activities
20 and research conducted under this Act. Such infor-
21 mation shall be made available and in appropriate
22 formats to reflect the varying needs of consumers
23 and diverse levels of health literacy.

24 “(7) REPORTS.—

1 “(A) ANNUAL REPORTS.—The Center shall
2 submit an annual report to the Congress and
3 the Secretary on its activities.

4 “(B) CONTENT.—Each such report shall
5 include information on research conducted or
6 funded by the Center during the year involved
7 and the impact of that research on—

8 “(i) patient safety and quality of care
9 in the delivery of health care services; and

10 “(ii) the science of improvement.”.

11 (b) INITIAL QUALITY IMPROVEMENT ACTIVITIES AND
12 INITIATIVES TO BE IMPLEMENTED.—Until the Center for
13 Quality Improvement has established initial priorities
14 under section 931(b)(1) of the Public Health Service Act,
15 as added by subsection (a), the Center shall prioritize the
16 following:

17 (1) HEALTH CARE-ASSOCIATED INFECTIONS.—
18 Reducing healthcare-associated infections including
19 infections in the nursing home and outpatient set-
20 ting.

21 (2) SURGERY.—Increasing hospital and out-
22 patient perioperative patient safety, including reduc-
23 ing surgical-site infections and surgical errors such
24 as wrong-site surgery and retained foreign bodies.

1 (3) EMERGENCY ROOM.—Improving care in
2 hospital emergency rooms, including through the
3 early identification and treatment for sepsis, and use
4 of principles of efficiency of design and delivery to
5 improve patient flow.

6 (4) OBSTETRICS.—Improving the provision of
7 obstetrical and neonatal care, such as through the
8 appropriate use of cesarean sections and the imple-
9 mentation of best practices for labor and delivery
10 care.

11 Such priorities shall apply for purposes of section
12 931(b)(5)(C)(i) of the Public Health Service Act, as added
13 by subsection (a).

14 **SEC. 2402. ASSISTANT SECRETARY FOR HEALTH INFORMA-**
15 **TION.**

16 Title XVII (42 U.S.C. 300u et seq.) is amended—

17 (1) by redesignating sections 1709 and 1710 as
18 sections 1710 and 1711, respectively; and

19 (2) by inserting after section 1708 the fol-
20 lowing:

21 **“(a) IN GENERAL. ASSISTANT SECRETARY FOR HEALTH INFORMA-**
22 **TION.**

23 “(a) IN GENERAL.—There is established within the
24 Department a Bureau of Health Information, to be headed
25 by an Assistant Secretary for Health Information (in this

1 section referred to as the ‘Assistant Secretary’). The As-
2 sistant Secretary shall be appointed by the Secretary.

3 “(b) DUTIES.—The Assistant Secretary shall ensure
4 the collection, collation, reporting, and publishing of full
5 and complete statistics on—

6 “(1) key health indicators regarding the per-
7 formance of the Nation’s health and health care; and

8 “(2) such other health information regarding
9 such performance as the Secretary may determine.

10 “(c) KEY HEALTH INDICATORS.—In carrying out
11 subsection (b)(1), the Assistant Secretary shall—

12 “(1) identify, and reassess at least once every
13 3 years, key health indicators described in such sub-
14 section;

15 “(2) publish statistics on such key health indi-
16 cators for the public not less than quarterly;

17 “(3) identify gaps in data on such key health
18 indicators, determine the causes of these gaps, and
19 make recommendations on how to address these
20 gaps; and

21 “(4) ensure consistency with the national strat-
22 egy developed by the Secretary under section 3121.

23 “(d) OTHER HEALTH INFORMATION.—In carrying
24 out subsection (b)(2), the Assistant Secretary shall—

1 “(1) ensure the sharing of health and health
2 care information among the agencies of the Depart-
3 ment;

4 “(2) facilitate the sharing of health and health
5 care information by other Federal departments and
6 agencies;

7 “(3)(A) develop standards for the collection of
8 data on health and health care; and

9 “(B) in carrying out subparagraph (A)—

10 “(i) include standards, as appropriate, for
11 the collection of accurate data for use in identi-
12 fying, studying, and reducing health disparities;

13 “(ii) ensure, with respect to data on race
14 and ethnicity, consistency with the 1997 Office
15 of Management and Budget Standards for
16 Maintaining, Collecting and Presenting Federal
17 Data on Race and Ethnicity; and

18 “(iii) develop standards for the collection
19 of data on health and health care by primary
20 language in consultation with the Director of
21 the Office of Minority Health and the Director
22 of the Office of Civil Rights of the Department;

23 “(4) consistent with privacy, proprietary, and
24 other appropriate safeguards, facilitate public acces-
25 sibility of datasets, such as de-identified Medicare

1 datasets or publicly available data on key health in-
2 dicators, by means of the Internet; and

3 “(5) award grants, directly or through other
4 agencies, to States and other entities to address (in-
5 cluding by improving quality and validity) gaps in
6 information on health and health care, including key
7 health indicators.

8 “(e) COORDINATION.—In carrying out this section,
9 the Assistant Secretary shall coordinate with the head of
10 the Office of the National Coordinator for Health Infor-
11 mation Technology to ensure optimal use of health infor-
12 mation technology.

13 “(f) DATA COLLECTION.—

14 “(1) IN GENERAL.—The Assistant Secretary
15 may conduct or support the collection of health or
16 health care information, including through statewide
17 surveys, to supplement other efforts to collect such
18 information by the Department.

19 “(2) REQUEST FOR INFORMATION FROM OTHER
20 DEPARTMENTS AND AGENCIES.—Consistent with ap-
21 plicable law, the Assistant Secretary may secure di-
22 rectly from any Federal department or agency infor-
23 mation necessary to enable the Assistant Secretary
24 to carry out this section.

1 “(g) ANNUAL REPORT.—The Assistant Secretary
2 shall submit to the Secretary and the Congress an annual
3 report containing—

4 “(1) a description of national, regional, or State
5 changes in health or health care, as reflected by the
6 key health indicators identified under subsection
7 (c)(1);

8 “(2) a description of gaps in the collection, col-
9 lation, reporting, and publishing of health and
10 health care information;

11 “(3) recommendations for addressing such
12 gaps; and

13 “(4) a plan for actions to be taken by the As-
14 sistant Secretary to address such gaps.

15 “(h) PROPRIETARY AND PRIVACY PROTECTIONS.—
16 Nothing in this section shall be construed to affect appli-
17 cable proprietary or privacy protections.

18 “(i) RELEASE OF KEY HEALTH INDICATORS.—The
19 regulations, rules, processes, and procedures of the Office
20 of Management and Budget governing the review, release,
21 and dissemination of key health indicators shall be the
22 same as the regulations, rules, processes, and procedures
23 of the Office of Management and Budget governing the
24 review, release, and dissemination of Principal Federal

1 Economic Indicators (or equivalent statistical data) by the
2 Bureau of Labor Statistics.

3 “(j) CONSULTATION.—In carrying out this section,
4 the Assistant Secretary shall consult with—

5 “(1) the heads of appropriate health agencies
6 and offices in the Department, including the Office
7 of the Surgeon General of the Public Health Service,
8 the Director of the Office of Minority Health, and
9 the Director of the Office on Women’s Health; and

10 “(2) as appropriate, the heads of other Federal
11 departments and agencies with significant health-re-
12 lated responsibilities, including the Social Security
13 Administration.

14 “(k) DEFINITION.—In this section:

15 “(1) The term ‘agency’ includes an epidemi-
16 ology center established under section 214 of the In-
17 dian Health Care Improvement Act.

18 “(2) The term ‘Department’ means the Depart-
19 ment of Health and Human Services.

20 “(3) The term ‘health disparities’ has the
21 meaning given the term in section 3171.”.

22 **SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.**

23 To carry out part D of title IX and section 1709 of
24 the Public Health Service Act, as added by this title, there
25 is authorized to be appropriated, out of any monies in the

1 Public Health Investment Fund, \$300,000,000 for each
2 of fiscal years 2010 through 2014.

3 **TITLE V—OTHER PROVISIONS**

4 **SEC. 2501. EXPANDED PARTICIPATION IN 340B PROGRAM.**

5 (a) EXPANSION OF COVERED ENTITIES RECEIVING
6 DISCOUNTED PRICES.—Section 340B(a)(4) (42 U.S.C.
7 256b(a)(4)) is amended by adding at the end the following
8 new subparagraphs:

9 “(M) A children’s hospital excluded from
10 the Medicare prospective payment system pur-
11 suant to section 1886(d)(1)(B)(iii) of the Social
12 Security Act (42 U.S.C. 1395ww(d)(1)(B)(iii))
13 which would meet the requirements of sub-
14 section (a)(4)(L), including the disproportionate
15 share adjustment percentage requirement under
16 clause (ii), if the hospital were a subsection (d)
17 hospital as defined by Section 1886(d)(1)(B) of
18 the Social Security Act.

19 “(N) An entity that is a critical access hos-
20 pital (as determined under section 1820(e)(2)
21 of the Social Security Act (42 U.S.C. 1395i-
22 4(e)(2))).

23 “(O) An entity receiving funds under title
24 V of the Social Security Act (relating to mater-

1 nal and child health) for the provision of health
2 services.

3 “(P) An entity receiving funds under sub-
4 part I of part B of title XIX of the Public
5 Health Service Act (relating to comprehensive
6 mental health services) for the provision of com-
7 munity mental health services.

8 “(Q) An entity receiving funds under sub-
9 part II of such part B (relating to the preven-
10 tion and treatment of substance abuse) for the
11 provision of treatment services for substance
12 abuse.

13 “(R) An entity that is a Medicare-depend-
14 ent, small rural hospital (as defined in section
15 1886(d)(5)(G)(iv) of the Social Security Act).

16 “(S) An entity that is a sole community
17 hospital (as defined in section
18 1886(d)(5)(D)(iii) of the Social Security Act).

19 “(T) An entity that is classified as a rural
20 referral center under section 1886(d)(5)(C) of
21 the Social Security Act.”.

22 (b) PROHIBITION ON GROUP PURCHASING ARRANGE-
23 MENTS.—Section 340B(a) (42 U.S.C. 256b(a)) is amend-
24 ed—

25 (1) in paragraph (4)(L)—

1 (A) by adding “and” at the end of clause
2 (i);

3 (B) by striking “; and” at the end of
4 clause (ii) and inserting a period; and

5 (C) by striking clause (iii);

6 (2) in subsection (a)(5), by redesignating the
7 subparagraphs (C) and (D) as subparagraphs (D)
8 and (E), respectively, and by inserting after sub-
9 paragraph (B) the following new subparagraph:

10 “(C) PROHIBITING USE OF GROUP PUR-
11 CHASING ARRANGEMENTS.—

12 “(i) A hospital described in subpara-
13 graph (L), (M), (N), (R), (S), or (T) of
14 subsection (a)(4) shall not obtain covered
15 outpatient drugs through a group pur-
16 chasing organization or other group pur-
17 chasing arrangement, except as permitted
18 or provided pursuant to clause (ii) or (iii).

19 “(ii) Clause (i) shall not apply to
20 drugs purchased for inpatient use.

21 “(iii) The Secretary shall establish
22 reasonable exceptions to the requirement of
23 clause (i)—

24 “(I) with respect to a covered
25 outpatient drug that is unavailable to

1 be purchased through the program
2 under this section due to a drug
3 shortage problem, manufacturer non-
4 compliance, or any other reason be-
5 yond the hospital's control;

6 “(II) to facilitate generic substi-
7 tution when a generic covered out-
8 patient drug is available at a lower
9 price; and

10 “(III) to reduce in other ways
11 the administrative burdens of man-
12 aging both inventories of drugs ob-
13 tained under this section and not
14 under this section, if such exception
15 does not create a duplicate discount
16 problem in violation of subparagraph
17 (A) or a diversion problem in violation
18 of subparagraph (B).”.

19 **SEC. 2502. ESTABLISHMENT OF GRANT PROGRAM.**

20 (a) PURPOSES.—It is the purpose of this section to
21 authorize grants to—

22 (1) address the projected shortage of nurses by
23 funding comprehensive programs to create a career
24 ladder to nursing (including Certified Nurse Assist-
25 ants, Licensed Practical Nurses, Licensed Vocational

1 Nurses, and Registered Nurses) for incumbent ancil-
2 lary healthcare workers;

3 (2) increase the capacity for educating nurses
4 by increasing both nurse faculty and clinical oppor-
5 tunities through collaborative programs between
6 staff nurse organizations, healthcare providers, and
7 accredited schools of nursing; and

8 (3) provide training programs through edu-
9 cation and training organizations jointly adminis-
10 tered by healthcare providers and healthcare labor
11 organizations or other organizations representing
12 staff nurses and frontline healthcare workers, work-
13 ing in collaboration with accredited schools of nurs-
14 ing and academic institutions.

15 (b) GRANTS.—Not later than 6 months after the date
16 of enactment of this Act, the Secretary of Labor (referred
17 to in this section as the “Secretary”) shall establish a
18 partnership grant program to award grants to eligible en-
19 tities to carry out comprehensive programs to provide edu-
20 cation to nurses and create a pipeline to nursing for in-
21 cumbent ancillary healthcare workers who wish to advance
22 their careers, and to otherwise carry out the purposes of
23 this section.

24 (c) ELIGIBLE ENTITIES.—To be eligible to receive a
25 grant under this section an entity shall—

1 (1) be—

2 (A) a healthcare entity that is jointly ad-
3 ministered by a healthcare employer and a labor
4 union representing the healthcare employees of
5 the employer and that carries out activities
6 using labor management training funds as pro-
7 vided for under section 302 of the Labor-Man-
8 agement Relations Act, 1947 (18 U.S.C.
9 186(c)(6));

10 (B) an entity that operates a training pro-
11 gram that is jointly administered by—

12 (i) one or more healthcare providers
13 or facilities, or a trade association of
14 healthcare providers; and

15 (ii) one or more organizations which
16 represent the interests of direct care
17 healthcare workers or staff nurses and in
18 which the direct care healthcare workers or
19 staff nurses have direct input as to the
20 leadership of the organization; or

21 (C) a State training partnership program
22 that consists of non-profit organizations that
23 include equal participation from industry, in-
24 cluding public or private employers, and labor
25 organizations including joint labor-management

1 training programs, and which may include rep-
2 resentatives from local governments, worker in-
3 vestment agency one-stop career centers, com-
4 munity based organizations, community col-
5 leges, and accredited schools of nursing; and

6 (2) submit to the Secretary an application at
7 such time, in such manner, and containing such in-
8 formation as the Secretary may require.

9 (d) ADDITIONAL REQUIREMENTS FOR HEALTHCARE
10 EMPLOYER DESCRIBED IN SUBSECTION (c).—To be eligi-
11 ble for a grant under this section, a healthcare employer
12 described in subsection (c) shall demonstrate—

13 (1) an established program within their facility
14 to encourage the retention of existing nurses;

15 (2) it provides wages and benefits to its nurses
16 that are competitive for its market or that have been
17 collectively bargained with a labor organization; and

18 (3) support for programs funded under this sec-
19 tion through 1 or more of the following:

20 (A) The provision of paid leave time and
21 continued health coverage to incumbent
22 healthcare workers to allow their participation
23 in nursing career ladder programs, including
24 Certified Nurse Assistants, Licensed Practical

1 Nurses, Licensed Vocational Nurses, and Reg-
2 istered Nurses.

3 (B) Contributions to a joint labor-manage-
4 ment training fund which administers the pro-
5 gram involved.

6 (C) The provision of paid release time, in-
7 centive compensation, or continued health cov-
8 erage to staff nurses who desire to work full- or
9 part-time in a faculty position.

10 (D) The provision of paid release time for
11 staff nurses to enable them to obtain a Bach-
12 elor of Science in Nursing degree, other ad-
13 vanced nursing degrees, specialty training, or
14 certification program.

15 (E) The payment of tuition assistance
16 which is managed by a joint labor-management
17 training fund or other jointly administered pro-
18 gram.

19 (e) OTHER REQUIREMENTS.—

20 (1) MATCHING REQUIREMENT.—

21 (A) IN GENERAL.—The Secretary may not
22 make a grant under this section unless the ap-
23 plicant involved agrees, with respect to the costs
24 to be incurred by the applicant in carrying out
25 the program under the grant, to make available

1 non-Federal contributions (in cash or in kind
2 under subparagraph (B)) toward such costs in
3 an amount equal to not less than \$1 for each
4 \$1 of Federal funds provided in the grant. Such
5 contributions may be made directly or through
6 donations from public or private entities, or
7 may be provided through the cash equivalent of
8 paid release time provided to incumbent worker
9 students.

10 (B) DETERMINATION OF AMOUNT OF NON-
11 FEDERAL CONTRIBUTION.—Non-Federal con-
12 tributions required in subparagraph (A) may be
13 in cash or in kind (including paid release time),
14 fairly evaluated, including equipment or services
15 (and excluding indirect or overhead costs).
16 Amounts provided by the Federal Government,
17 or services assisted or subsidized to any signifi-
18 cant extent by the Federal Government, may
19 not be included in determining the amount of
20 such non-Federal contributions.

21 (2) REQUIRED COLLABORATION.—Entities car-
22 rying out or overseeing programs carried out with
23 assistance provided under this section shall dem-
24 onstrate collaboration with accredited schools of
25 nursing which may include community colleges and

1 other academic institutions providing Associate,
2 Bachelor's, or advanced nursing degree programs or
3 specialty training or certification programs.

4 (f) ACTIVITIES.—Amounts awarded to an entity
5 under a grant under this section shall be used for the fol-
6 lowing:

7 (1) To carry out programs that provide edu-
8 cation and training to establish nursing career lad-
9 ders to educate incumbent healthcare workers to be-
10 come nurses (including Certified Nurse Assistants,
11 Licensed Practical Nurses, Licensed Vocational
12 Nurses, and Registered Nurses). Such programs
13 shall include one or more of the following:

14 (A) Preparing incumbent workers to return
15 to the classroom through English as a second
16 language education, GED education, pre-college
17 counseling, college preparation classes, and sup-
18 port with entry level college classes that are a
19 prerequisite to nursing.

20 (B) Providing tuition assistance with pref-
21 erence for dedicated cohort classes in commu-
22 nity colleges, universities, accredited schools of
23 nursing with supportive services including tu-
24 toring and counseling.

1 (C) Providing assistance in preparing for
2 and meeting all nursing licensure tests and re-
3 quirements.

4 (D) Carrying out orientation and
5 mentorship programs that assist newly grad-
6 uated nurses in adjusting to working at the
7 bedside to ensure their retention post gradua-
8 tion, and ongoing programs to support nurse
9 retention.

10 (E) Providing stipends for release time and
11 continued healthcare coverage to enable incum-
12 bent healthcare workers to participate in these
13 programs.

14 (2) To carry out programs that assist nurses in
15 obtaining advanced degrees and completing specialty
16 training or certification programs and to establish
17 incentives for nurses to assume nurse faculty posi-
18 tions on a part-time or full-time basis. Such pro-
19 grams shall include one or more of the following:

20 (A) Increasing the pool of nurses with ad-
21 vanced degrees who are interested in teaching
22 by funding programs that enable incumbent
23 nurses to return to school.

24 (B) Establishing incentives for advanced
25 degree bedside nurses who wish to teach in

1 nursing programs so they can obtain a leave
2 from their bedside position to assume a full- or
3 part-time position as adjunct or full time fac-
4 ulty without the loss of salary or benefits.

5 (C) Collaboration with accredited schools
6 of nursing which may include community col-
7 leges and other academic institutions providing
8 Associate, Bachelor's, or advanced nursing de-
9 gree programs, or specialty training or certifi-
10 cation programs, for nurses to carry out innova-
11 tive nursing programs which meet the needs of
12 bedside nursing and healthcare providers.

13 (g) PREFERENCE.—In awarding grants under this
14 section the Secretary shall give preference to programs
15 that—

16 (1) provide for improving nurse retention;

17 (2) provide for improving the diversity of the
18 new nurse graduates to reflect changes in the demo-
19 graphics of the patient population;

20 (3) provide for improving the quality of nursing
21 education to improve patient care and safety;

22 (4) have demonstrated success in upgrading in-
23 cumbent healthcare workers to become nurses or
24 which have established effective programs or pilots
25 to increase nurse faculty; or

1 (5) are modeled after or affiliated with such
2 programs described in paragraph (4).

3 (h) EVALUATION.—

4 (1) PROGRAM EVALUATIONS.—An entity that
5 receives a grant under this section shall annually
6 evaluate, and submit to the Secretary a report on,
7 the activities carried out under the grant and the
8 outcomes of such activities. Such outcomes may in-
9 clude—

10 (A) an increased number of incumbent
11 workers entering an accredited school of nurs-
12 ing and in the pipeline for nursing programs;

13 (B) an increasing number of graduating
14 nurses and improved nurse graduation and li-
15 censure rates;

16 (C) improved nurse retention;

17 (D) an increase in the number of staff
18 nurses at the healthcare facility involved;

19 (E) an increase in the number of nurses
20 with advanced degrees in nursing;

21 (F) an increase in the number of nurse
22 faculty;

23 (G) improved measures of patient quality
24 (which may include staffing ratios of nurses,

1 patient satisfaction rates, patient safety meas-
2 ures); and

3 (H) an increase in the diversity of new
4 nurse graduates relative to the patient popu-
5 lation.

6 (2) GENERAL REPORT.—Not later than 2 years
7 after the date of enactment of this Act, and annually
8 thereafter, the Secretary of Labor shall, using data
9 and information from the reports received under
10 paragraph (1), submit to Congress a report con-
11 cerning the overall effectiveness of the grant pro-
12 gram carried out under this section.

13 (i) AUTHORIZATION OF APPROPRIATIONS.—There
14 are authorized to be appropriated to carry out this section,
15 such sums as may be necessary.